FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0005439

Facility Name: THE METHODIST HOME

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

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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) 03/19/12 (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 THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	126	Skilled (SNF)	126	45,990	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	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,909	6,801	5,759	26,469	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,909	6,801	5,759	26,469	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.55%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 126 and days of care provided 4,829

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,111	30,844	128,766	433,721		433,721		433,721			1
2	Food Purchase		255,612		255,612		255,612	(11,274)	244,338			2
3	Housekeeping	142,145	41,612		183,757		183,757		183,757			3
4	Laundry	22,177	5,476		27,653		27,653		27,653			4
5	Heat and Other Utilities			148,532	148,532		148,532		148,532			5
6	Maintenance	134,022	26,079	85,858	245,959		245,959		245,959			6
7	Other (specify):*											7
8	TOTAL General Services	572,455	359,623	363,156	1,295,234		1,295,234	(11,274)	1,283,960			8
	B. Health Care and Programs											
9	Medical Director			55,120	55,120		55,120		55,120			9
10	Nursing and Medical Records	1,945,601	197,457	41,301	2,184,359		2,184,359	(12,135)	2,172,224			10
10a	Therapy	21,407	4,250		25,657		25,657		25,657			10a
11	Activities	37,213	5,326	6,184	48,723		48,723		48,723			11
12	Social Services	101,332	1,317	3,657	106,306		106,306		106,306			12
13	CNA Training											13
14	Program Transportation			24,285	24,285		24,285	(3,466)	20,819			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,105,553	208,350	130,547	2,444,450		2,444,450	(15,601)	2,428,849			16
	C. General Administration											
17	Administrative	134,896			134,896		134,896		134,896			17
18	Directors Fees											18
19	Professional Services			180,501	180,501		180,501		180,501			19
20	Dues, Fees, Subscriptions & Promotions			88,277	88,277		88,277	(38,222)	50,055			20
21	Clerical & General Office Expenses	453,145	50,557	251,181	754,883		754,883	(152,103)	602,780			21
22	Employee Benefits & Payroll Taxes			772,154	772,154		772,154		772,154			22
23	Inservice Training & Education			1,566	1,566		1,566		1,566			23
24	Travel and Seminar			8,660	8,660		8,660		8,660			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			113,386	113,386		113,386		113,386			26
27	Other (specify):*											27
28	TOTAL General Administration	588,041	50,557	1,415,725	2,054,323		2,054,323	(190,325)	1,863,998			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,266,049	618,530	1,909,428	5,794,007		5,794,007	(217,200)	5,576,807			29

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

Facility Name & ID Number THE METHODIST HOME #0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			363,387	363,387		363,387	(60,000)	303,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			335	335		335	(335)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,413	11,413		11,413		11,413			35
36	Other (specify):*											36
37	**TOTAL Ownership**			375,135	375,135		375,135	(60,335)	314,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		353,825	712,202	1,066,027		1,066,027		1,066,027			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,589	165,589		165,589		165,589			42
43	Other (specify):*	46,944		2,969,093	3,016,037		3,016,037	(3,016,037)				43
44	**TOTAL Special Cost Centers**	46,944	353,825	3,846,884	4,247,653		4,247,653	(3,016,037)	1,231,616			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,312,993	972,355	6,131,447	10,416,795		10,416,795	(3,293,572)	7,123,223			45

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(11,274)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,753)	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	(335)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,247)	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	(146,214)	21		24
25	Fund Raising, Advertising and Promotional	(33,466)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,756)	20		28
29	Other-Attach Schedule	(3,085,527)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,293,572)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,293,572)		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

THE METHODIST HOME

ID# 0005439

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (46,944)	43	1
2	Marketing Travel	(3,485)	43	2
3	Marketing Seminar	(804)	43	3
4	Marketing Consulting	(7,815)	43	4
5	Resident Transportation Revenue	(3,466)	14	5
6	Miscellaneous Resident Revenue	(2,888)	10	6
7	Misc Income - Other	(3,136)	21	7
8	Non-Nursing Home Expenses	(2,956,989)	43	8
9	Depreciation on Non-Care Asset	(60,000)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,085,527)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,274)	0	0	0	0	0	0	0	0	0	0	(11,274)	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**	(11,274)	0	0	0	0	0	0	0	0	0	0	(11,274)	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	(12,135)	0	0	0	0	0	0	0	0	0	0	(12,135)	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	(3,466)	0	0	0	0	0	0	0	0	0	0	(3,466)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(15,601)	0	0	0	0	0	0	0	0	0	0	(15,601)	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	(38,222)	0	0	0	0	0	0	0	0	0	0	(38,222)	20
21	Clerical & General Office Expenses	(152,103)	0	0	0	0	0	0	0	0	0	0	(152,103)	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**	(190,325)	0	0	0	0	0	0	0	0	0	0	(190,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,200)	0	0	0	0	0	0	0	0	0	0	(217,200)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(60,000)	0	0	0	0	0	0	0	0	0	0	(60,000)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(335)	0	0	0	0	0	0	0	0	0	0	(335)	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**	(60,335)	0	0	0	0	0	0	0	0	0	0	(60,335)	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):*	(3,016,037)	0	0	0	0	0	0	0	0	0	0	(3,016,037)	43
44	**TOTAL Special Cost Centers**	(3,016,037)	0	0	0	0	0	0	0	0	0	0	(3,016,037)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,293,572)	0	0	0	0	0	0	0	0	0	0	(3,293,572)	45

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 & SERVICI	100%			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
				UNITED NURSING S	CHICAGO	NURSE RECRUITE

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

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Axis Capital Inc		X	DIRECTV Satellite Dish -	$415.00	05/01/07	$ 20,604	$	05/01/2012	0.0800	$ 335	1
2				for resident televison service								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8							Interest Income Offset				(335)	8
9	**TOTAL Facility Related**				$415.00		$ 20,604	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 20,604	$			$	15

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE METHODIST HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005439

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services, UMH&S Foundation, and Home Care.

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 The Methodist Home.

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1922	$ 214,000	$		$	$	$ 214,000	4
5	48			1951	297,000					297,000	5
6				1972	941,207					941,207	6
7	8			1973	541,942					541,942	7
8	28			1974	479,275					479,275	8
	Improvement Type**										
9	Additions - 1975			1975	898,240					898,240	9
10	Additions - 1976			1976	1,203					1,203	10
11	Additions - 1980			1980	1,300					1,306	11
12	Additions - 1983			1983	215					215	12
13	Additions - 1984			1984	1,188					1,188	13
14	Additions - 1985			1985	7,958					7,958	14
15	Additions - 1986			1986	31,965					31,965	15
16	Additions - 1987			1987	3,680					3,680	16
17	Additions - 1988			1988	41,556					41,556	17
18	Additions - 1989			1989	123,634					123,634	18
19	Additions - 1990			1990	81,482					81,555	19
20	Additions - 1991			1991	155,195					154,296	20
21	Additions - 1992			1992	276,411					271,528	21
22	Additions - 1993			1993	226,117					219,587	22
23	Additions - 1994			1994	261,289	312		312		256,694	23
24	Additions - 1995			1995	162,755	14		14		162,636	24
25	Additions - 1996			1996	281,475	7,177		7,177		213,286	25
26	Additions - 1997			1997	55,643	716		716		62,623	26
27	Additions - 1998			1998	110,213	15		15		110,051	27
28	Additions - 1999			1999	34,124	240		240		31,115	28
29	Additions - 2000			2000	136,254	1,967		1,967		119,375	29
30	Additions - 2001			2001	101,321	4,627		4,627		93,407	30
31	Additions - 2002			2002	245,777	24,064		24,064		231,264	31
32	Additions - 2003			2003	230,162	21,417		21,417		183,393	32
33	Additions - 2004			2004	84,046	5,642		5,642		67,509	33
34	Additions - 2005			2005	244,694	24,125		24,125		156,812	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 THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Resident Room - Painting, Sinks, Toilets, Grab Bars, Window Cov	2006	$ 40,854	$ 4,085	10	$ 4,085	$	$ 22,468	37
38	Lobby/Entrance/Utility Room - Vinyl Flooring, Intallation of new	2006	91,208	9,121	10	9,121		50,165	38
39	Roofing for The Methodist Home	2006	2,000	200	10	200		1,100	39
40	Lower Level - Rehab Areas, Painting, Flooring, Electrical, Gym In	2006	44,794	4,479	10	4,479		24,636	40
41	2nd Floor - Swift Corridor - New Doors & Frames, Painting	2006	3,565	357	10	357		1,962	41
42	4th Floor Dining Room - Wall Protection, Handrails, Windows Co	2006	2,588	259	10	259		1,424	42
43	Fire Alarm Smoke Detector/Sprinkler System	2006	70,839	7,084	10	7,084		38,962	43
44	Building Water Cooler	2006	860	43	20	43		236	44
45	Carpeting - Resident Rooms #281, #282, #283, Lower Level-Bush I	2006	16,209	1,620	5	1,620		16,209	45
46	Lawn Sprinkler System	2006	10,200	1,020	10	1,020		5,610	46
47	Perimeter Fence Upgrade Installed	2006	5,500	550	10	550		3,025	47
48	Landscaping -Trees & Shrubs for The Methodist Home	2006	6,300	630	10	630		3,465	48
49									49
50	1st Floor Nursing Station/Utility Room - Plumbing, Carpentry, De	2007	56,005	5,600	10	5,600		25,200	50
51	Chimeney Replacement - The Methodist Home Roof	2007	53,190	5,319	10	5,319		23,936	51
52	Bathrooms - 2nd Floor/LL - Replaced Walls, Tubs, Toilets, Showe	2007	28,572	2,857	10	2,857		12,857	52
53	Resident Room - Painting - Rms 79, 459, 461, 466, 477, 268, 457, 26	2007	18,377	1,838	10	1,838		8,270	53
54	Painting - 2nd Floor - Bush Hall & 4th Floor Dayroom/Hallway/D	2007	5,440	544	10	544		2,448	54
55	Fire Alarm System Sprinklers - 1st Floor - Miller & Swift Hallway	2007	5,240	524	10	524		2,358	55
56	Smoke Dampers & Co2 Exhaust- 2nd Floor Resident Dining Roon	2007	7,519	376	20	376		1,692	56
57	New Feed Pump Assembly - Boiler Room - The Methodist Home	2007	15,990	640	25	640		2,880	57
58	Carpeting/Flooring - 2nd Floor - Bush Hall - Common Areas and I	2007	28,509	5,702	5	5,702		25,659	58
59	Repaving of Parking Lot - The Methodist Home	2007	2,471	247	10	247		1,112	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,787,551	$ 143,411		$ 143,411	$	$ 6,275,174	70

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 6,787,551	$ 143,411		$ 143,411	$	$ 6,275,174	1
2									2
3	Resident Room Painting - #'s 66, 72, 79	2008	6,704	671	10	671		2,349	3
4	Painting - Ground Floor - Dining Room/Common Areas/Bathroom	2008	7,815	782	10	782		2,736	4
5	Installed Fire Sprinkler Pumps and Wiring - Utility Room	2008	3,143	314	10	314		1,099	5
6	Painting and Interior Design - 1st Floor - Foyer/Common Hallway	2008	16,403	1,640	10	1,640		5,740	6
7	Design and Schematics for Day Room and Foyer/Hallways	2008	2,800	280	10	280		980	7
8	Construction/Countertop Installation - 3rd Floor Nursing Station	2008	5,272	527	10	527		1,845	8
9	Emergency Power/Lighting Upgrade - North Entrance/2nd Floor	2008	11,552	577	20	577		2,021	9
10	Hot and Cold Circulating Pumps and Bearing Assemblies	2008	2,112	106	20	106		370	10
11	Boiler Room - Steam Trap/Condensate Pump/Control Switch Insta	2008	6,640	265	25	265		928	11
12	Resident Room - HVAC Fan Motor Replacement	2008	2,503	100	25	100		350	12
13	Chiller/Boiler Room - New Feed Pump, Thermostat & Flush Gun	2008	3,668	147	25	147		514	13
14	Boiler - Retube - Complete	2008	17,282	691	25	691		2,419	14
15	Cooling Tower Replacement	2008	17,644	706	25	706		2,471	15
16	Carpeting/Flooring - 2nd Floor - Bush Hall - 1st Floor Hallways/A	2008	46,410	9,282	5	9,282		32,487	16
17									17
18	Fifth Floor - Masonry/Brick Replacement	2009	9,175	917	10	917		2,292	18
19	Construction of New Nursing Stations - 1st/3rd Floors - Laminate	2009	5,054	505	10	505		1,263	19
20	Third Floor Hallways - Installed ADA Door Closers and Painted H	2009	7,550	755	10	755		1,888	20
21	Fire Smoke Dampers/Sprinkler Heads installed on 1st, 4th Floors,	2009	12,585	1,259	10	1,259		3,147	21
22	Fourth Floor Hallway/Day Room - Installed New Vinyl Flooring a	2009	12,831	1,283	10	1,283		3,208	22
23	Resident Rooms - New Plank and Amtico Flooring - Rooms #55,56	2009	21,055	2,106	10	2,106		5,265	23
24	Front & Rear Elevators - New Power Supply, Transformer, and Sy	2009	4,242	424	10	424		1,060	24
25	Hydraulic Freight Lift - Receiving Dock	2009	3,820	191	20	191		478	25
26	New Fire Stop Actuators and Ductwork	2009	6,600	264	25	264		660	26
27	Resident Rooms - New Ceiling Fan Coil Motors	2009	2,503	100	25	100		250	27
28	Boiler Room - Replacement of Pnuematic Control System, Gas Va	2009	6,737	269	25	269		673	28
29	Chiller Room - HVAC - Replacement of Main Control Board, Cole	2009	23,092	924	25	924		2,310	29
30	Carpeting - Resident Rooms #75, #77, #80; 3rd & 4th Floor Hallwa	2009	24,602	4,920	5	4,920		12,299	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,077,345	$ 173,416		$ 173,416	$	$ 6,366,276	34

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,077,345	$ 173,416		$ 173,416	$	$ 6,366,276	1
2									2
3	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	166	25	166		249	3
4	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	179	25	179		269	4
5	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	180	25	180		269	5
6	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	838	10	838		1,256	6
7	Refinish Fire Escape Stairways	2010	7,800	780	10	780		1,170	7
8	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	396	10	396		595	8
9	Construction of Built-In Laminate Counter Tops, Door - Med Rec	2010	2,960	296	10	296		444	9
10	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	534	10	534		801	10
11	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	1,048	10	1,048		1,572	11
12	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	346	10	346		519	12
13									13
14	HVAC - New Controller, Chilled Water Sensors, Heater Circuit &	2011	7,441	149	25	149		149	14
15	Main Sewer Line Replacement	2011	15,000	750	10	750		750	15
16	Exterior Masonry, Paving - Main Entrance Area	2011	55,349	2,767	10	2,767		2,767	16
17	Life Safety - New Emergency Generator, Vertical Shafts, Elevator	2011	465,050	11,626	20	11,626		11,626	17
18	1st Fl-Locker Room Renovation- Install Tile Floor, Ceiling, Painti	2011	16,735	836	10	836		836	18
19	3rd, 4th Floor Resident Bathroom Renovation - Flooring, Painting	2011	66,570	3,329	10	3,329		3,329	19
20	3rd, 4th Floor Resident Room Renovations - Flooring, Blinds, Pair	2011	101,732	5,087	10	5,087		5,087	20
21	3rd, 4th Floor - Install Handrails on Hallway Walls	2011	8,110	406	10	406		406	21
22	Exterior - Tuckpointing, Brickwork, Chemical Treatment	2011	26,404	1,320	10	1,320		1,320	22
23	3rd, 4th, & 5th Floors - Install Nurse Call/Wander System	2011	95,715	4,786	10	4,786		4,786	23
24	Ground Floor - Sewage Ejector Pump	2011	3,367	168	10	168		168	24
25	Boiler Room - Pnuematic Controls for Hot Water & Fire Pump Pr	2011	3,403	170	10	170		170	25
26	*Architect and General Contractor Fees	2011	195,567	9,778	10	9,778		9,778	26
27									27
28	*Note - Architect and General Contractor Fees are for a major renovation project being done at The Methodist Home. The project includes								28
29	interior, exterior, and life safety work. Interior work includes resident room remodeling with new flooring, windows, lighting, paint, bathroom								29
30	fixtures, carpentry, hallway painting and handrails, and nurse call/wander system. Exterior work includes masonry, brickwork, fencing, signage,								30
31	and electrical. Life Safety includes a new emergency generator, installation of vertical shafts, and an elevator recall.								31
32	The invoices paid to the architect and general contractor are not broken out on an item by item basis.								32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,193,280	$ 219,351		$ 219,351	$	$ 6,414,592	34

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 1,190,333	$ 75,781	$ 75,781	$		$ 847,482	71
72	Current Year Purchases	105,872	5,294	5,294			5,294	72
73	Fully Depreciated Assets	1,032,840					1,032,840	73
74								74
75	TOTALS	$ 2,329,045	$ 81,075	$ 81,075	$		$ 1,885,616	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	Ford Eldorado Passenger Bus, 20	2007	$ 7,000	$ 961	$ 961	$	4	$ 7,000	76
77	Patient Transportation	Nissan Quest Minivan, 2007	2011	16,000	2,000	2,000		4	2,000	77
78										78
79										79
80	TOTALS			$ 23,000	$ 2,961	$ 2,961	$		$ 9,000	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)	$ 12,545,325	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 303,387	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 303,387	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)	$ 8,309,208	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Nursing Home Assets/2006-2011	$ 1,086,066	$ 11,578	$ 20,759	86
87	2010 TMH Bldg Mkt Value Write Up	3,000,000	60,000	60,000	87
88					88
89					89
90					90
91	TOTALS	$ 4,086,066	$ 71,578	$ 80,759	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 11,413 Description: Copiers - Leased - $10,080; Dishwasher - Leased - $1,333
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number THE METHODIST HOME

STATE OF ILLINOIS
0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	L39, C3	hrs	$	3,855	$ 267,329	$	3,855	$ 267,329	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,977	102,487		1,977	102,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,556	311,516		5,556	311,516	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				287,644		287,644	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Med Suppl, Lab, X-Ray	L39, C2, C3				30,870	66,181		97,051	13
14	TOTAL			$	11,388	$ 712,202	$ 353,825	11,388	$ 1,066,027	14

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

STATE OF ILLINOIS

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (568,403)	$	1
2	Cash-Patient Deposits	20,569		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 388,131)	646,717		3
4	Supply Inventory (priced at)	22,411		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	83,150		7
8	Accounts Receivable (owners or related parties)	41,390		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 245,834	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	2,800,000		13
14	Buildings, at Historical Cost	11,407,856		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,423,535		16
17	Accumulated Depreciation (book methods)	(8,389,967)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	1,000,000		22
23	Other(specify): **Other**	1,051		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,277,475	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,523,309	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 214,558	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	82,295		28
29	Short-Term Notes Payable	1,633		29
30	Accrued Salaries Payable	621,378		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Unexpended Restricted Gifts**	36,834		36
37	**Due to Third-Party Payor**	90,803		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,047,501	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,047,501	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,475,808	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,523,309	$	48

***(See instructions.)**

Facility Name & ID Number THE METHODIST HOME # 0005439 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,584,864	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,584,864	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(709,056)	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)**	$ (709,056)	17
	B. Transfers (Itemize):		
18	**Equity Transfer from Parent Corporation**	1,600,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,600,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,475,808	24 *

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,118,922	1
2	Discounts and Allowances for all Levels	(1,207,609)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,911,313	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,248,798	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,248,798	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	11,274	14
15	Telephone, Television and Radio	2,753	15
16	Rental of Facility Space		16
17	Sale of Drugs	287,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,320	19
20	Radiology and X-Ray	5,758	20
21	Other Medical Services	156,034	21
22	Laundry	7,525	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 493,308	23
	D. Non-Operating Revenue		
24	Contributions	16,000	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,000	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other - See attached schedule	3,038,320	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,038,320	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,707,739	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,295,234	31
32	Health Care	2,444,450	32
33	General Administration	2,054,323	33
	B. Capital Expense		
34	Ownership	375,135	34
	C. Ancillary Expense		
35	Special Cost Centers	4,082,064	35
36	Provider Participation Fee	165,589	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,416,795	40
41	**Income before Income Taxes (line 30 minus line 40)****	(709,056)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (709,056)	43

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

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

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

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

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	752	862	$ 38,909	$ 45.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,632	26,254	754,015	28.72	3
4	Licensed Practical Nurses	13,015	13,434	336,344	25.04	4
5	CNAs & Orderlies	65,461	69,641	731,007	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,848	2,037	21,407	10.51	8
9	Activity Director					9
10	Activity Assistants	3,275	3,430	37,213	10.85	10
11	Social Service Workers	4,575	5,083	101,332	19.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,715	4,239	52,342	12.35	14
15	Cook Helpers/Assistants	15,099	16,339	164,579	10.07	15
16	Dishwashers	6,084	6,341	57,190	9.02	16
17	Maintenance Workers	4,808	5,412	134,022	24.76	17
18	Housekeepers	12,727	14,166	142,145	10.03	18
19	Laundry	1,751	2,075	22,177	10.69	19
20	Administrator	1,951	2,376	134,896	56.77	20
21	Assistant Administrator					21
22	Other Administrative	1,792	2,126	49,753	23.40	22
23	Office Manager					23
24	Clerical	17,016	22,083	403,392	18.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,804	2,086	33,554	16.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Suppl Sched.	4,651	4,986	98,716	19.80	33
34	TOTAL (lines 1 - 33)	184,956	202,970	$ 3,312,993 *	$ 16.32	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	520	55,120	L9, C3	36
37	Medical Records Consultant	96	4,512	L10, C3	37
38	Nurse Consultant	23	1,603	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	38	2,438	L12, C3	45
46	Other(specify)				46
47	Dietary Management Fees	Monthly	126,206	L1, C3	47
48					48
49	TOTAL (lines 35 - 48)	677	$ 189,879		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	133	2,774	L10, C3	52
53	TOTAL (lines 50 - 52)	133	$ 2,774		53

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Nelson	Administrator		$ 31,567
E.D. Barnett	Administrator		17,313
William Lowe	CEO		86,016
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,896

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Audit	$ 18,900
FR&R Consulting	Accounting/Consulting	1,325
Medifax	Data Processing	473
KPMG	Data Processing	475
IVANS	Data Processing	2,908
CIMA Services	Consulting	13,284
Legal - See Attached Schedule		25,553
Coporate Allocation -	Data Processing	64,092
Coporate Allocation -	Consulting	53,491
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 180,501

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,771
Unemployment Compensation Insurance	56,584
FICA Taxes	250,482
Employee Health Insurance	377,737
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Recognition	8,580
TOTAL (agree to Schedule V, line 22, col.8)	$ 772,154

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	10,331
Health Care Worker Background Check	1,110
(Indicate # of checks performed 59)	
Patient Background Checks 249	2,990
Books & Subscriptions	11,227
Membership Fees & Fees	20,406
Resident Relations	11
Advertising	38,222
Less: Public Relations Expense	( )
Non-allowable advertising	(33,466)
Yellow page advertising	(4,756)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,055

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,363
Seminar Expense	7,297
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,660

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE METHODIST HOME # 0005439 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. **Life Services Network of IL - $6,237**

(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. $ **49,078** 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. $ **165,589**
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. $ **11,274**

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

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.