FOR BHF USE							

LL1

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

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: 0046656

Facility Name: The United Methodist Village North Campus

Address: 2101 James St (Number) Lawrenceville (City) 62439 (Zip Code)

County: Lawrence

Telephone Number: (618)943-3444 **Fax #** (618) 943-2853

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2004

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code 501(c) (3)
- [ ] 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: Rose Sepulveda Telephone Number: (618)943-3347 ext 1203
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 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) (Date) (Type or Print Name) Briana Crutchfield (Title) Administrator
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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 2/11/2008

	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	98	Skilled (SNF)	98	35,770	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	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,830	810	4,759	7,399	8
9	SNF/PED					9
10	ICF	11,593	5,461		17,054	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,423	6,271	4,759	24,453	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.36%

D. How many bed-hold days during this year were paid by the Department?
None (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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/1/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 4,759

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number: The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	198,640	20,424	6,134	225,198		225,198		225,198			1
2	Food Purchase		217,290		217,290		217,290	(6,846)	210,444			2
3	Housekeeping	120,193	14,769	60	135,022		135,022	(3,640)	131,382			3
4	Laundry	34,663	11,536	381	46,580		46,580		46,580			4
5	Heat and Other Utilities			92,583	92,583		92,583	(18,701)	73,882			5
6	Maintenance	19,052	17,063	33,015	69,130		69,130	(240)	68,890			6
7	Other (specify):*											7
8	**TOTAL General Services**	372,548	281,082	132,173	785,803		785,803	(29,427)	756,376			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,341,170	88,082	33,968	1,463,220		1,463,220	(8,236)	1,454,984			10
10a	Therapy			547,604	547,604		547,604		547,604			10a
11	Activities	68,222	2,391	1,985	72,598		72,598		72,598			11
12	Social Services	38,423	25	1,539	39,987		39,987		39,987			12
13	CNA Training											13
14	Program Transportation	31,665			31,665		31,665		31,665			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,479,480	90,498	592,296	2,162,274		2,162,274	(8,236)	2,154,038			16
	C. General Administration											
17	Administrative	105,058	10	1,703	106,771		106,771		106,771			17
18	Directors Fees											18
19	Professional Services			13,782	13,782		13,782		13,782			19
20	Dues, Fees, Subscriptions & Promotions			27,588	27,588		27,588	(27,189)	399			20
21	Clerical & General Office Expenses	167,478	18,192	57,107	242,777		242,777	(28,626)	214,151			21
22	Employee Benefits & Payroll Taxes			253,387	253,387		253,387		253,387			22
23	Inservice Training & Education					6,375	6,375	(3,315)	3,060			23
24	Travel and Seminar			13,214	13,214	(6,375)	6,839		6,839			24
25	Other Admin. Staff Transportation			644	644		644		644			25
26	Insurance-Prop.Liab.Malpractice			100,092	100,092		100,092		100,092			26
27	Other (specify):* Covenant not to compete			100,000	100,000		100,000	(100,000)				27
28	**TOTAL General Administration**	272,536	18,202	567,517	858,255		858,255	(159,130)	699,125			28
29	**TOTAL Operating Expense** (sum of lines 8, 16 & 28)	2,124,564	389,782	1,291,986	3,806,332		3,806,332	(196,793)	3,609,539			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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			169,480	169,480		169,480	(3,442)	166,038			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,331	145,331		145,331		145,331			32
33	Real Estate Taxes			81,610	81,610		81,610		81,610			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			396,421	396,421		396,421	(3,442)	392,979			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		165,043	913	165,956		165,956		165,956			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,328	54,328		54,328		54,328			42
43	Other (specify):* granny Tax			88,658	88,658		88,658		88,658			43
44	TOTAL Special Cost Centers		165,043	143,899	308,942		308,942		308,942			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,124,564	554,825	1,832,306	4,511,695		4,511,695	(200,235)	4,311,460			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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(6,846)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,799)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,189)	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	(157,401)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (200,235)		$	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))**	$ (200,235)		37

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

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

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

STATE OF ILLINOIS

The United Methodist Village North Campus

ID# 0046656

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES

		Amount	Sch. V Line Reference	
1	Utility Income	$		1
2	Bank Charges	16	21	2
3	Covenant not to compete	(100,000)	27	3
4				4
5	Marketing Salary	(17,914)	21	5
6	Chaplin salary	(10,128)	21	6
7	Assisted Living Allocation:			7
8	Depreciation of noncare assets	(3,442)	30	8
9	Utilities	(9,902)	5	9
10	Maintenance	(240)	6	10
11	Nursing	(8,236)	10	11
12	Billing	(468)	21	12
13	Cash Receipts	(132)	21	13
14	Housekeeping	(3,640)	3	14
15				15
16	unreimbursable expenses	(3,315)	23	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**	(157,401)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(6,846)	0	0	0	0	0	0	0	0	0	0	(6,846)	2
3	Housekeeping	(3,640)	0	0	0	0	0	0	0	0	0	0	(3,640)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(18,701)	0	0	0	0	0	0	0	0	0	0	(18,701)	5
6	Maintenance	(240)	0	0	0	0	0	0	0	0	0	0	(240)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29,427)	0	0	0	0	0	0	0	0	0	0	(29,427)	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	(8,236)	0	0	0	0	0	0	0	0	0	0	(8,236)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(8,236)	0	0	0	0	0	0	0	0	0	0	(8,236)	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	(27,189)	0	0	0	0	0	0	0	0	0	0	(27,189)	20
21	Clerical & General Office Expenses	(28,626)	0	0	0	0	0	0	0	0	0	0	(28,626)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(3,315)	0	0	0	0	0	0	0	0	0	0	(3,315)	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):*	(100,000)	0	0	0	0	0	0	0	0	0	0	(100,000)	27
28	**TOTAL General Administration**	(159,130)	0	0	0	0	0	0	0	0	0	0	(159,130)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(196,793)	0	0	0	0	0	0	0	0	0	0	(196,793)	29

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,442)	0	0	0	0	0	0	0	0	0	0	(3,442)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,442)	0	0	0	0	0	0	0	0	0	0	(3,442)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(200,235)	0	0	0	0	0	0	0	0	0	0	(200,235)	45

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
The United Methodist Village, Inc.	100%	The United Methodist Village	Lawrenceville			

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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number: The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Citizens National Bank		X	Mortgage	$13,480.00	10/26/14	$ 2,000,000	$	6/23/2029	4.2500	$ 17,511	1
2	Dept of Agriculture		X	Mortgage	$13,260.00	10/26/14	3,000,000	2,758,536	11/26/44	4.3750	121,825	2
3												3
4												4
5												5
	Working Capital											
6	Illini Manor	X				3/1/04	1,000,000	275,000				6
7												7
8												8
9	TOTAL Facility Related				$26,740.00		$ 6,000,000	$ 3,033,536			$ 139,336	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,000,000	$ 3,033,536			$ 139,336	15

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

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

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2010 report.	$	94,005	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.)	$	87,475	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,530)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,140	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.	$	81,610	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2006	88,372	8
2007	89,267	9
2008	91,783	10
2009	94,005	11
2010	87,475	12

FOR BHF USE ONLY

Line	Description		Line
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 United Methodist Village North Campus COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0046656

CONTACT PERSON REGARDING THIS REPORT Rose Sepulveda

TELEPHONE 618-943-5566 ext 1203 FAX #: 618-943-1482

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.	06-001-673-40	Long Term Care Facility	$ 87,475.00	$ 87,475.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 87,475.00	$ 87,475.00

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 X 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,415 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

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

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

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

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	Facility		2004	$ 349,039	1
2					2
3	TOTALS			$ 349,039	3

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	98		2004	1991	$ 3,982,381	$ 101,347	39	$ 101,347	$	$ 795,494	4
5				2006	12,172	609	20	609		3,248	5
6				2008	198,160	4,954	40	4,954		15,688	6
7				2009	49,324	1,233	40	1,233		5,191	7
8											8
	Improvement Type**										
9	Roof Improvement			2007	5,070	507	10	507		2,746	9
10	Upgrade forFire System			2007	1,629	163	10	163		747	10
11	Handrails			2008	720	48	15	48		192	11
12	25 cartons Tile			2008	1,199	120	10	120		420	12
13	Hickory BaseBoards			2008	1,051	210	5	210		718	13
14	Lock Change & Rekeying Doors			2008	915	183	5	183		625	14
15	Lowes			2008	487	97	5	97		323	15
16	Keypads for Doors			2009	2,020	289	7	289		602	16
17	New Smoke Shack			2009	1,210	121	10	121		282	17
18	N Campus supplies to rekey doors			2010	981	196	5	196		294	18
19	Kitchen Lighting			2010	1,017	68	15	68		85	19
20	Sprinkler Clean Out			2010	28,751	2,875	10	2,875		3,594	20
21	Locks for facility			2010	1,253	179	7	179		209	21
22	Heaters and airconditioners			2011	10,860	898	5	898		898	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

*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 United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									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)		$ 4,299,200	$ 114,097		$ 114,097	$	$ 831,356	70

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		$ 4,299,200	$ 114,097		$ 114,097	$	$ 831,356	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,200	$ 114,097		$ 114,097	$	$ 831,356	34

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 1,020,774	$ 50,721	$ 50,721	$		$ 345,369	71
72	Current Year Purchases	18,970	1,631	1,631			1,631	72
73	Fully Depreciated Assets							73
74	reclassed lives		(411)	(411)				74
75	TOTALS	$ 1,039,744	$ 51,941	$ 51,941	$		$ 347,000	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,687,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 166,038	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,038	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)	$ 1,178,356	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	See Attached - Various Years	$ 68,846	$ 3,442	$ 10,827	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 68,846	$ 3,442	$ 10,827	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .
9. Option to Buy: YES NO Terms: *

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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-03	hrs	$	2,538	$ 215,972	$	2,538	$ 215,972	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		971	96,496		971	96,496	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		2,586	235,136		2,586	235,136	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				134,741		134,741	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Oxygen & Char. Supp	39-02					30,302		30,302	13
14	TOTAL			$	6,095	$ 547,604	$ 165,043	6,095	$ 712,647	14

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 111,187	$	1
2	Cash-Patient Deposits	43,575		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,517,416		3
4	Supply Inventory (priced at)	48,176		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,827		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,735,181	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,481,162		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,066,579		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,579,673		16
17	Accumulated Depreciation (book methods)	(16,267,046)		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): covenent not to compete	275,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,644,115	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,379,296	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 725,579	$	26
27	Officer's Accounts Payable	43,575		27
28	Accounts Payable-Patient Deposits	218,128		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,104		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	275,205		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other payables	106,165		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,704,756	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,130,050		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Refundable deposits and fees	145,310		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,275,360	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,980,116	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,399,180	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,379,296	$	48

*(See instructions.)

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,438,187	1
2	Restatements (describe):	(3,626)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,434,561	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,035,381)	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)**	$ (1,035,381)	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)**	$ 7,399,180	24 *

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 9,382,075	1
2	Discounts and Allowances for all Levels	(2,964,476)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,417,599	3
	B. Ancillary Revenue		
4	Day Care	115,999	4
5	Other Care for Outpatients		5
6	Therapy	2,380,666	6
7	Oxygen	135,847	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,632,512	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	1,700	13
14	Non-Patient Meals	35,964	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	223,756	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,660	19
20	Radiology and X-Ray		20
21	Other Medical Services	365,761	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 658,841	23
	D. Non-Operating Revenue		
24	Contributions	146,584	24
25	Interest and Other Investment Income***	135,986	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 282,570	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	independent living	121,790	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 121,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,113,312	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,318,976	31
32	Health Care	2,487,002	32
33	General Administration	1,091,285	33
	B. Capital Expense		
34	Ownership	561,276	34
	C. Ancillary Expense		
35	Special Cost Centers	96,052	35
36	Provider Participation Fee	196,848	36
	D. Other Expenses (specify):		
37	related party	5,397,254	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,148,693	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,035,381)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,035,381)	43

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

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

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

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

Facility Name & ID Number The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,864	2,080	$ 52,370	$ 25.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,866	18,140	346,005	19.07	3
4	Licensed Practical Nurses	16,152	17,072	278,978	16.34	4
5	CNAs & Orderlies	64,300	68,341	631,348	9.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,147	7,659	68,222	8.91	10
11	Social Service Workers	3,366	3,624	38,423	10.60	11
12	Dietician					12
13	Food Service Supervisor	2,460	2,763	30,495	11.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,487	19,440	168,145	8.65	15
16	Dishwashers					16
17	Maintenance Workers	1,633	1,775	19,052	10.73	17
18	Housekeepers	13,009	13,810	120,193	8.70	18
19	Laundry	3,846	4,014	34,663	8.64	19
20	Administrator	1,924	2,080	70,731	34.01	20
21	Assistant Administrator					21
22	Other Administrative	10,238	11,215	149,776	13.35	22
23	Office Manager					23
24	Clerical	4,495	4,726	41,901	8.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,813	6,585	64,133	9.74	31
32	Other Health Care(specify)					32
33	Other(specify) Chaplin	858	943	10,128	10.74	33
34	TOTAL (lines 1 - 33)	172,458	184,267	$ 2,124,563 *	$ 11.53	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	116	$ 3,451	1-3	35
36	Medical Director	monthly	7,200	9-3	36
37	Medical Records Consultant	monthly	2,235	10-3	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	12	1,539	11-3	44
45	Social Service Consultant	12	1,539	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	$ 15,964		49

C. CONTRACT NURSES

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

Facility Name & ID Number: The United Methodist Village North Campus # 0046656 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Briana Crutchfield	Administrator		$ 70,731
Other administrative personnel			34,327
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 105,058

B. Administrative - Other

Description	Amount
Miscellaneous administrative expenses	$ 1,703
Volunteer expenses	
Gift Planning	
Other	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,703

C. Professional Services

Vendor/Payee	Type	Amount
Cox Phillips,Weber Tedford		$ 109
Winter Black & Livesay		2,560
Kemper CPA Group		11,113
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,782

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,413
Unemployment Compensation Insurance	3,214
FICA Taxes	112,281
Employee Health Insurance	22,755
Employee Meals	1,350
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	657
401K	12,299
Miscellaneous employee benefits	12,418
TOTAL (agree to Schedule V, line 22, col.8)	$ 253,387

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	165
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Advertising	25,472
Dues	
Subscriptions	234
Less: Public Relations Expense	(3,600)
Non-allowable advertising	(21,872)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 399

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 920
In-State Travel	5,919
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,839

**See instructions.

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

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? **No**
If YES, give association name and amount.

(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 yaers**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,324** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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: **Kemper CPA Group 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) 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule of Travel and Seminar Expenses. Page 21, Part G **PAGE 24**

Who Attended	Job Title	Dates	Location	le of Semi	Sponsor	Cost
Out of State						
Rose Sepulveda	Finance Director	5/19/2011	St Louis MO	HFMA Edu	HFMA	200
Carol Brown/ Steve Bl	Administrator/maintenance	11/16/2011	Evansville IN	workplace	Nat seminar	
Briana Crutchfield	administrator	11/15/2011	Evansville IN	workplace	Nat semina	99
Eric Dorney	maintenance	11/15/2011	Evansville IN	workplace	Nat semina	99
Briana Crutchfield	administrator	2/27/2011	San antonio	UMA confe	UMA	522
				Total Out of State		**920**
In State						
Carol Hawkins	adminsistrator	11/15/2011	books	OSHA		477
Briana Crutchfield	Administrator	3/25/2011	Chicago IL	Annual cor	LSN	1,137
Rose Sepulveda	Finance Director	3/24/11-3/25/11	Collinsville IL	RAC	HFMA	
directors	directors	9/13/11-9/15/11	East Peoria IL	conference	IHA	1,237
Ed Lancaster	DON	6/22/2011	Effinham IL	3.0 in a day	IHCA	200
Briana Crutchfield	administrator	11/1/2011	Effinham IL	PPS Final	IHCA	200
Penny Eckel	MDS	11/2/2011	Effinham IL	PPS Final	IHCA	200
Melissa Gillil	S Services	11/7/2011	Effinham IL	Recent cha	IHA	145
Melissa Gillil	S Services	5/24/2011	Mt vernon IL	Best practices for Soc		200
Ed Lancaster/penny je	don/mds	1/25/11-1/27/11	Springfield IL	medicare u	LSNI	1,783
Briana Crutchfield	administrator	7/20/2011	webinar	nutrition ma	LSNI	99
Carol Hawkins	administrator	books		OSHA		120
Carol Hawkins	administrator	books		OSHA		120
				Total In-state		**5,919**
				Total Travel		**6,839**

Page 12-13 Schedule XI Ownership Cost

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment and Vehicles	Total
Schedule XI Ownership Cst	$349,039	$4,299,199	$1,039,744	$5,687,982
Non Care Assets	$0	$68,846	$0	$68,846
Related Facility	$159,708	$9,657,016	$4,539,929	$14,356,653
Non-care Assets of Related Facility	$0	$5,041,517	$0	$5,041,517
Reconciliation variance	$0			
Schedule XV Balance Sheet	$508,747	$19,066,578	$5,579,673	$25,154,998

Note: The related facility is required to file a separate cost report with the Department of Healthcare and Family Services.
The related facility is The United Methodist Village, Inc., IDPH #0014506

Schedule of Inservice Training & Education. Page 3, Schedule V, Line 23

Description	Who Attended	Amount
Red cross Certifications	Nursing staff	54
Certifications and license	Social Services	140
Silverchair	entire facility	1,428
Silverchair	entire facility	1,428
		3,050

Descriptions of Non Care Assets and Depreciation

Description	Year	Cost	Current Depreciation	Accumulated Depreciation
Assisted Living Addition	2009	29,645	1,482	5,435
Assisted Living Addition	2010	34,321	1,716	5,148
Assisted Living Addition	2011	4,880	244	244
Total to 13		$68,846	$3,442	$10,827

Page 15 XIII. Expenses Relating to Certified Nurse AIDE Training Programs Page 28

No training expense is reported because the Village hires only certified nurses aides.

Expenses of related facility presented on separte cost report: pg 19

Because a separate set of balance sheet accounts is not maintained, The United Methodist Village North Campus must report revenue and expenses of a related party to present balanced financial statements