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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0014506

Facility Name: United Methodist Village

Address: 1616 Cedar (Number) Lawrenceville (City) 62439 (Zip Code)

County: Lawrence

Telephone Number: 618-943-3347 **Fax #** 618-943-3823

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1992

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 1/1/12 to 12/31/12 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) 4/30/13 (Date)
(Type or Print Name) Pamela Ryan
(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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 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	163	Skilled (SNF)	163	59,495	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	163	TOTALS	163	59,495	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	1,803	722	2,220	4,745	8
9	SNF/PED					9
10	ICF	12,708	8,180		20,888	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,511	8,902	2,220	25,633	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.08%

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 [X] NO [ ]

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 01/01/1925

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 [Y] NO [ ] If YES, enter number of beds certified 70 and days of care provided 2,220

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: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	262,532	20,813	13,070	296,415		296,415		296,415			1
2	Food Purchase		184,017		184,017		184,017	(42,698)	141,319			2
3	Housekeeping	146,170	24,879		171,049		171,049	(3)	171,046			3
4	Laundry	62,539	19,409	467	82,415		82,415		82,415			4
5	Heat and Other Utilities			273,718	273,718		273,718	(172,531)	101,187			5
6	Maintenance	174,848	30,774	77,163	282,785		282,785	(5,739)	277,046			6
7	Other (specify):*											7
8	TOTAL General Services	646,089	279,892	364,418	1,290,399		1,290,399	(220,971)	1,069,428			8
	B. Health Care and Programs											
9	Medical Director			13,853	13,853		13,853		13,853			9
10	Nursing and Medical Records	1,584,365	113,568	11,770	1,709,703		1,709,703	(10,361)	1,699,342			10
10a	Therapy			449,738	449,738		449,738		449,738			10a
11	Activities	90,516	2,056	1,473	94,045		94,045		94,045			11
12	Social Services	61,634	39	1,152	62,825		62,825	(131)	62,694			12
13	CNA Training											13
14	Program Transportation	8,822			8,822		8,822		8,822			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,745,337	115,663	477,986	2,338,986		2,338,986	(10,492)	2,328,494			16
	C. General Administration											
17	Administrative	109,475	18	9,020	118,513		118,513		118,513			17
18	Directors Fees											18
19	Professional Services			18,781	18,781		18,781	(4,264)	14,517			19
20	Dues, Fees, Subscriptions & Promotions			21,239	21,239		21,239	(20,704)	535			20
21	Clerical & General Office Expenses	171,341	38,292	161,418	371,051		371,051	(113,730)	257,321			21
22	Employee Benefits & Payroll Taxes			573,425	573,425		573,425	(11,880)	561,545			22
23	Inservice Training & Education			6,749	6,749		6,749		6,749			23
24	Travel and Seminar			21,029	21,029		21,029		21,029			24
25	Other Admin. Staff Transportation			9,634	9,634		9,634		9,634			25
26	Insurance-Prop.Liab.Malpractice			131,125	131,125		131,125	(11,000)	120,125			26
27	Other (specify):*	85,624	927	178	86,729		86,729	(86,747)	(18)			27
28	TOTAL General Administration	366,440	39,237	952,598	1,358,275		1,358,275	(248,325)	1,109,950			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,757,866	434,792	1,795,002	4,987,660		4,987,660	(479,788)	4,507,872			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 United Methodist Village #0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			427,480	427,480		427,480	(140,859)	286,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,071	26,071		26,071		26,071			32
33	Real Estate Taxes			4,120	4,120		4,120	(4,120)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,000,000	1,000,000		1,000,000		1,000,000			36
37	**TOTAL Ownership**			1,457,671	1,457,671		1,457,671	(144,979)	1,312,692			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,162	666	69,828		69,828		69,828			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,103	223,103		223,103		223,103			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		69,162	223,769	292,931		292,931		292,931			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,757,866	503,954	3,476,442	6,738,262		6,738,262	(624,767)	6,113,495			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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(31,282)	2		4
5	Telephone, TV & Radio in Resident Rooms	(58,744)	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	(75,649)	21		24
25	Fund Raising, Advertising and Promotional	(20,704)	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	(434,964)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (621,343)		$	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))**	$ (621,343)		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 **Page 5A**

United Methodist Village

ID# **0014506**

Report Period Beginning: **1/1/12**

Ending: **12/31/12**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Utility Income	$	5	1
2	Transportation Reimbursement		25	2
3	Supplies and misc	(11,075)	21	3
4	Child Care Salaries	(85,624)	27	4
5	Child Care Supplies	(927)	27	5
6	Child Care Meals	(178)	27	6
7	Child Care Education	(18)	27	7
8	Godfrey Bond Expense			8
9	McKiou Food Expense	(11,416)	2	9
10	Bank Charges	(1,925)	21	10
11	Late Fees			11
12	Resident Services	(131)	12	12
13				13
14	Doctor Expense	(3,682)	10	14
15	Hospital Expense	(6,679)	10	15
16			30	16
17	Misc Income		21	17
18	Marketing Salaries	(17,934)	21	18
19	Chaplin Expenses	(361)	21	19
20	Chaplin Salary	(6,786)	21	20
21	Real Estate Taxes	(4,120)	33	21
22				22
23	Independent Living Allocation:			23
24	Maintenance	(5,739)	6	24
25	Housekeeping	(3)	3	25
26	Dietary		2	26
27	Utilities	(113,787)	5	27
28	Social Services		12	28
29	Administrative		17	29
30	**Activities**		11	30
31				31
32	Employee Benefits and workers com	-11880	22	32

33	Insurance	-11000	26	33
34	Depreciation	-140859	30	34
35				35
36	Legal	-4264	19	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**	(438,388)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number United Methodist Village # 0014506 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	(42,698)	0	0	0	0	0	0	0	0	0	0	(42,698)	2
3	Housekeeping	(3)	0	0	0	0	0	0	0	0	0	0	(3)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(172,531)	0	0	0	0	0	0	0	0	0	0	(172,531)	5
6	Maintenance	(5,739)	0	0	0	0	0	0	0	0	0	0	(5,739)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(220,971)	0	0	0	0	0	0	0	0	0	0	(220,971)	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	(10,361)	0	0	0	0	0	0	0	0	0	0	(10,361)	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	(131)	0	0	0	0	0	0	0	0	0	0	(131)	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**	(10,492)	0	0	0	0	0	0	0	0	0	0	(10,492)	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	(4,264)	0	0	0	0	0	0	0	0	0	0	(4,264)	19
20	Fees, Subscriptions & Promotions	(20,704)	0	0	0	0	0	0	0	0	0	0	(20,704)	20
21	Clerical & General Office Expenses	(113,730)	0	0	0	0	0	0	0	0	0	0	(113,730)	21
22	Employee Benefits & Payroll Taxes	(11,880)	0	0	0	0	0	0	0	0	0	0	(11,880)	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	(11,000)	0	0	0	0	0	0	0	0	0	0	(11,000)	26
27	Other (specify):*	(86,747)	0	0	0	0	0	0	0	0	0	0	(86,747)	27
28	**TOTAL General Administration**	(248,325)	0	0	0	0	0	0	0	0	0	0	(248,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(479,788)	0	0	0	0	0	0	0	0	0	0	(479,788)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number United Methodist Village **#** 0014506 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	(140,859)	0	0	0	0	0	0	0	0	0	0	(140,859)	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	(4,120)	0	0	0	0	0	0	0	0	0	0	(4,120)	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**	(144,979)	0	0	0	0	0	0	0	0	0	0	(144,979)	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)**	(624,767)	0	0	0	0	0	0	0	0	0	0	(624,767)	45

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	United Methodist Village North Campus	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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	seepage 30 for board of directors								$		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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Citizens National Bank		X	Mortgage	$4,026.00	6/23/09	$ 650,000	$ 571,095	6/23/2029	4.2500	$ 23,128	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Citizens National Bank		X	Operating Cash		3/14/11	500,000		3/14/12	5.5000	12,456	6
7												7
8												8
9	TOTAL Facility Related				$4,026.00		$ 1,150,000	$ 571,095			$ 35,584	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,150,000	$ 571,095			$ 35,584	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 United Methodist Village # 0014506 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME United Methodist Village COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0014506

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 2011 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 2011.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,538 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	631,620	1924	$ 96,018	1
2		572,380	1987 &1989	63,690	2
3	TOTALS	1,204,000		$ 159,708	3

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	163		1965	1965	$ 1,350,000	$ 27,000	50	$ 27,000	$	$ 1,269,000	4
5			1974	1974	916,911	18,338	50	18,338		705,741	5
6			1979	1979	1,228,695	24,574	50	24,574		1,109,358	6
7			1925	1925	601,097	15,027	40	15,027		472,820	7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets Thru 2010				2,710,283					2,710,283	9
10	Various			1979	117,791	2,612	50	2,612		103,680	10
11	Various			18980	17,695	354	50	354		11,502	11
12	Various			1989	96,708	3,887	20	3,887		91,368	12
13	Various			1990	610,945	24,341	20	24,341		547,847	13
14	Various			1991	132,029	5,327	20	5,327		122,677	14
15	Various			1992	313,917	12,778	20	12,778		261,944	15
16	Various			1993	119,112	6,175	20	6,175		120,416	16
17	Various			1994	67,500	3,816	20	3,816		73,699	17
18	Various			1995	157,262	9,462	20	9,462		165,589	18
19	Various			1996	315,753	17,476	20	17,476		333,882	19
20	Various			1999	13,455	1,021	20	1,021		13,722	20
21	Various			2000	1,637	109	15	109		1,407	21
22	Various			2002	73,057	7,305	10	7,305		77,069	22
23	Various			2002	21,530	1,436	15	1,436		14,902	23
24	HVAC System			2002	14,126	831	17	831		8,379	24
25	Wiring and Circuit Panels			2002	9,048	452	20	452		4,710	25
26	Office Remodeling			2002	2,138	178	12	178		1,855	26
27	Various			2003	3,323	134	25	134		1,318	27
28	Various			2003	56,659	3,778	15	3,778		37,538	28
29	Various			2003	46,484	4,649	10	4,649		44,395	29
30	Dycus Auto Door			2003	1,073		7			1,073	30
31	Building Supplies			2004	3,115	208	15	208		1,733	31
32	Smoke Detectors			5004	2,114	302	7	302		2,466	32
33	Various			2005	9,744	649	15	649		5,213	33
34	Various			2005	96,745	9,675	10	9,675		73,511	34
35	Sidewalk and Ramps			2005	6,000	667	9	667		5,061	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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Therapy Project	2005	$ 272	$	5	$	$	$ 272	37
38	Water Furnace	2006	1,944	130	15	130		910	38
39	Carpet	2006	841	168	5	168		1,162	39
40	Hallway Tile	2006	3,399	340	10	340		2,352	40
41	Handrails	2006	553	31	15	31		223	41
42	Geothermal System	2006	1,686	169	10	169		1,140	42
43	Water Meter	2006	2,194	110	20	110		733	43
44	Locks for Outside Entrance	2006	10,377	1,038	10	1,038		6,920	44
45	Smoke Detectors	2006	17,751	1,775	10	1,775		11,833	45
46	Mig Welder	2006	530	53	10	53		349	46
47	T-1 Computer Line & Equipment	2006	7,752		5			7,752	47
48	Boiler Repair	2006	11,590	773	15	773		5,004	48
49	Tile Floor in Dietary	2006	9,952	995	10	995		6,385	49
50	4 Water Furnaces	2006	7,331	733	10	733		4,703	50
51	Air Conditioner	2006	633	63	10	63		399	51
52	Washer for Laundry Department	2006	9,379	625	15	625		6,906	52
53	Pellet Heater for Dietary	2006	2,659	266	10	266		1,662	53
54	Water Softner	2006	2,925	293	10	293		1,782	54
55	Carbon Monoxide Detectors	2006	2,139	214	10	214		1,302	55
56	Dycus - Replaced Carpet with Tile	2006	12,514	1,251	10	1,251		7,819	56
57	Sidewalk	2007	560	37	15	37		213	57
58	Railing on Dycus ramp	2008	683	46	15	46		222	58
59	Wesley I - painted and added floor tile	2008	2,039	408	5	408		1,972	59
60	Breaker Box	2008	495	71	7	71		325	60
61	Shower Installation	2008	5,000	500	10	500		2,208	61
62	Sprinkler Installation	2008	145,567	7,278	20	7,278		30,932	62
63	Sprinkler System	2008	154,780	7,739	20	7,739		30,956	63
64	Dycus Room - install drop ceiling for sprinkler system	2009	11,245	1,606	7	1,606		6,157	64
65	Elevator Upgrade	2009	39,165	1,004	39	1,004		3,849	65
66	Holden Center Roof Repair	2009	650	43	15	43		154	66
67	Electrical Maintance	2009	259	52	5	52		182	67
68	Paint & Supplies	2009	479	96	5	96		336	68
69	Flooring and Supplies	2009	1,363	273	5	273		955	69
70	TOTAL (lines 4 thru 69)		$ 9,584,652	$ 230,741		$ 230,741	$	$ 8,542,227	70

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		$ 9,584,652	$ 230,741		$ 230,741	$	$ 8,542,227	1
2	Added Cabinets	2009	3,023	246	5	246		788	2
3	Replaced floor coverings and carpet in office	2009	363	73	5	73		231	3
4	Various Supplies	2010	399	57	7	57		171	4
5	Mechanical Door Resistor for Elevator	2010	1,683	84	20	84		231	5
6	Screen and windows	2010	2,539	169	15	169		409	6
7	Flooring	2010	1,260	252	5	252		588	7
8	WesleyI Flooring	2010	21,532	3,076	7	3,076		6,921	8
9	80 boxes of tile flooring	2010	10,080	1,008	10	1,008		2,184	9
10	Tile for Wesley I	2011	35,951	3,460	10	3,460		6,920	10
11	TV, computers and printer	2011	4,747	549	5	549		1,098	11
12	2 Generators	2011	3,068	141	20	141		282	12
13	Hoyer Scale	2011	1,083	103	7	103		206	13
14	Manual Crank Tilt Table	2011	2,146	60	15	60		120	14
15	Commercial Dryer for Laundry	2011	3,678	102	15	102		204	15
16	Ice machine	2012	2,550	234	10	234		234	16
17	vinyl flooring	2012	6,966	639	10	639		639	17
18	air conditioner p tac unit	2012	2,294	232	5	232		232	18
19	push bars and sirens	2012	2,628	197	10	197		197	19
20	6 desktop computers	2012	5,316	759	5	759		759	20
21	Server for computer network	2012	43,703	8,012	5	8,012		8,012	21
22	cabinets for nursing station	2012	442	44	5	44		44	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)		$ 9,740,103	$ 250,238		$ 250,238	$	$ 8,572,697	34

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 1,007,821	$ 21,563	$ 21,563	$		$ 582,095	71
72	Current Year Purchases	53,863	5,386	5,386			5,386	72
73	Fully Depreciated Assets	2,973,448					2,973,448	73
74								74
75	TOTALS	$ 4,035,132	$ 26,949	$ 26,949	$		$ 3,560,929	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		1999 & prior fully depr	Various	$ 63,726	$	$	$		$ 63,726	76
77		see attached page 26		164,087	9,434	9,434			134,284	77
78										78
79										79
80	TOTALS			$ 227,813	$ 9,434	$ 9,434	$		$ 198,010	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)	$ 14,162,756	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,621	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,621	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)	$ 12,331,636	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	$ 5,102,434	$ 140,504	$ 2,879,507	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 5,102,434	$ 140,504	$ 2,879,507	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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$	2,609	$ 201,424	$	2,609	$ 201,424	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		508	63,291		508	63,291	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		2,446	185,022		2,446	185,022	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				49,780		49,780	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Oxygen & charg suppp	39-02					19,382		19,382	13
14	TOTAL			$	5,563	$ 449,737	$ 69,162	5,563	$ 518,899	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 United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 219,702	$	1
2	Cash-Patient Deposits	54,040		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,695)	2,209,042		3
4	Supply Inventory (priced at)	44,135		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,344		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): due from medicare	111,728		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,665,991	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	332,779		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,158,919		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,697,145		16
17	Accumulated Depreciation (book methods)	(16,861,448)		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): not compete covenent	116,667		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,952,809	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,618,800	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 797,545	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,040		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,891		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,556		32
33	Accrued Interest Payable			33
34	Deferred Compensation	122,519		34
35	Federal and State Income Taxes	47,629		35
	Other Current Liabilities(specify):			
36	other payables	640,980		36
37	resident credit balances	62,295		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,926,455	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	435,106		39
40	Mortgage Payable	2,719,318		40
41	Bonds Payable			41
42	Deferred Compensation	239,110		42
	Other Long-Term Liabilities(specify):			
43	refundable deposits	144,410		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,537,944	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,464,399	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,154,401	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,618,800	$	48

*(See instructions.)

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,399,180	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,399,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,244,779)	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)**	$ (1,244,779)	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)**	$ 6,154,401	24 *

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,389,292	1
2	Discounts and Allowances for all Levels	(1,101,163)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,288,129	3
	B. Ancillary Revenue		
4	Day Care	74,038	4
5	Other Care for Outpatients		5
6	Therapy	955,828	6
7	Oxygen	55,184	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,085,050	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	658	13
14	Non-Patient Meals	12,262	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48,255	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,370	19
20	Radiology and X-Ray		20
21	Other Medical Services	150,766	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 215,311	23
	D. Non-Operating Revenue		
24	Contributions	234,590	24
25	Interest and Other Investment Income***	155,858	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 390,448	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	independent living	110,914	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 110,914	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,089,852	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,290,399	31
32	Health Care	2,338,986	32
33	General Administration	1,358,275	33
	B. Capital Expense		
34	Ownership	1,457,671	34
	C. Ancillary Expense		
35	Special Cost Centers	69,828	35
36	Provider Participation Fee	223,103	36
	D. Other Expenses (specify):		
37	related party	(403,631)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,334,631	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,244,779)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,244,779)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,960	2,080	$ 49,000	$ 23.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,841	20,326	355,687	17.50	3
4	Licensed Practical Nurses	24,993	26,944	460,406	17.09	4
5	CNAs & Orderlies	63,765	67,987	654,203	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,491	9,368	90,516	9.66	10
11	Social Service Workers	5,428	6,018	72,613	12.07	11
12	Dietician					12
13	Food Service Supervisor	1,828	2,000	31,340	15.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,040	25,804	231,192	8.96	15
16	Dishwashers					16
17	Maintenance Workers	13,628	14,778	174,848	11.83	17
18	Housekeepers	15,111	16,399	146,170	8.91	18
19	Laundry	5,553	5,977	62,539	10.46	19
20	Administrator	1,960	2,080	80,000	38.46	20
21	Assistant Administrator					21
22	Other Administrative	8,351	9,316	178,833	19.20	22
23	Office Manager					23
24	Clerical	5,906	6,511	90,405	13.88	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	7,143	7,730	73,881	9.56	31
32	Other Health Care(specify)					32
33	Other(specify) child care	8,495	9,765	85,624	8.77	33
34	TOTAL (lines 1 - 33)	215,493	233,083	$ 2,837,257 *	$ 12.17	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	193	$ 11,472	1-3	35
36	Medical Director	monthly	9,600	9-3	36
37	Medical Records Consultant	monthly			37
38	Nurse Consultant	monthly	3,600	10-3	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	15	1,005	11-3	44
45	Social Service Consultant	15	1,005	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	223	$ 26,682		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Hawkins Brown	Administrator		$ 60,641
Robert Benson	CEO		27,692
Other administrative personnel			21,142
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,475

B. Administrative - Other

Description	Amount
Volunteer expense	$ 3,765
TOTAL (agree to Schedule V, line 17, col. 3)	$ 3,765
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cox Phillips, Weber Tedford		$ 4,926
Ungaretti & Harris		3,424
Kemper CPA group		10,431
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,554
Unemployment Compensation Insurance	13,964
FICA Taxes	237,203
Employee Health Insurance	136,653
Employee Meals	2,820
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	11,548
401K expenses and contribution	25,630
TOTAL (agree to Schedule V, line 22, col.8)	$ 567,372

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	$
Advertising: Employee Recruitment	79
Health Care Worker Background Check	2,093
(Indicate # of checks performed)	
Patient Background Checks	
advertising	20,604
Dues	100
Subscriptions	453
Less: Public Relations Expense	( )
Non-allowable advertising	(20,604)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,725

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number United Methodist Village # 0014506 Report Period Beginning: 1/1/12 Ending: 12/31/12

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? **12**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,722** 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 **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** 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. $ **223,103**
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? **yes** 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? **na** 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? **na**
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? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **na**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Kemper CPA Group**

(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.

Page 3 V. Cost Center Expenses, C. General Administration, Line 27 **Page 24**

Breakout of Other General Administrative Expenses

Column 1	
Childcare Salaries	85,624
Column 2	
Child Care Supplies	927
Column 3	
childcare meal cost	178
	86,729

Page 12-13 Schedule XI Ownership Cost

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment and Vehicles	Total
Schedule XI Ownership Cst	$159,708	$9,664,280	$4,597,212	$14,421,200
Non Care Assets	$0	$5,102,435	$0	$5,102,435
Related Facility	$349,039	$4,323,357	$1,099,932	$5,772,328
Non-care Assets of Related Facility	$0	$68,846	$0	$68,846
Reconciliation variance	$0			
Schedule XV Balance Sheet	$508,747	$19,158,918	$5,697,144	$25,364,809

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 North Campus, IDPH #0046656

Fixed Assets Reconciliation

Vehicle Description	Year Acquired	Cost	Current Depreciation	Accumulated Depreciation
Van	2003	$26,685	$0	$26,685
John Deer Tractor	2004	36,884	0	36,884
Oldsmobile Silhouette Van	2004	26,143	0	26,143
Truck	2005	11,782	1,683	11,782
2006 Chevy Silverado	2006	4,673	0	4,673
2008 Ford E250 WC Van	2008	36,878	5,268	20,109
2008 Chevy Van	2009	14,087	1,409	5,165
2000 Ford Taurus	2009	5,551	793	2,445
transmission repair	2011	$1,404	$281	$117
Total to line 79 Page 13		$164,087	$9,434	$134,003

Page 13 Schedule XI Ownership Cost, Item F Non-Care Assets

Description	Year	Cost	Current Depreciation	Accumulated Depreciation
Various Fully Depreciated Non-care Assets		$36,881	$0	$36,881
Apts & Cottage Bldgs	1987	1,165,543	21,926	870,293
Apts & Cottage Bldgs	1988	168,658	6,746	303,468
Apts & Cottage Bldgs	1989	93,293	3,787	85,214
McKiou Center	1994	3,177,429	79,436	1,390,664
Apts & Cottage Bldgs	1997	11,707	780	11,315
McKiou Center	2000	9,211	614	7,010
Apts & Cottage Bldgs	2001	58,609	3,257	58,609
Apts & Cottage Bldgs	2002	64,155	4,401	41,540
Apts & Cottage Bldgs	2004	12,940	863	6,256
McKiou Center and Apts	2006	19,174	1,724	10,344
Day Care	2005	22,743	1,516	9,981
Southern Meadows AC upgrade	2008	133,235	2,339	24,009
Roofing for Bldings 18 & 24	2008	14,000	1,400	5,950
Day Care Remodel	2008	3,287	470	1,918
Southernmeadows A/C Upgrade	2009		210	840
Carpet Cottage #3	2009	1,148	230	920
Cabinets for McKiou	2009	1,725	246	841
Upgrades for 1720 17th st	2009	1,321	264	836
appliances for cottages	2010	9,278	843	2,176
Laminate Flooring for cottages	2011	7,612	1,960	3,920
Carpeting for apartments	2011	1,835	122	244
Applicances for Cottages	2011	12,637	590	1,180
Airconditioning units and installation - So Meadows	2011	10,889	1,089	2,178
New flooring for cottages and upgrade units	2012	60,917	5,691	5,691
Total to 13		$5,098,227	$140,504	$2,882,278

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

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

Name	Provided Services (Y or N)	Type of Service (if applicable)	Ownership That Provided Services	Type of Business (if applicable)
Leon Johnson	N	N/A		
Liz Clark	N	N/A		
Keith Chelsvig	N	N/A		
Rev. Mark Canada	N	N/A		
Rev. Gary Pearce	N	N/A		
Richard Wolfe	N	N/A		
Rev. Gene Ramsey	N	N/A		
Jason Bower	N	N/A		
Deeta Gaither Alvyna Goins	N	N/A		
Rev. Bill Wiggs	N	N/A		
	N	N/A		
Rev. Cynthia Jones	N	N/A		

Description	Who Attended	Amount
Red cross Certifications	Nursing staff	
Manuals	entire facility	154.00
Illinois Department of Public Health	Dietary	140.00
Certifications and license	Social Services	25.00
Seminar & Workshop Expenses		2,146.00
Silverchair inservices	Entire facility	4,284.00
total line 23		6,749.00

Who Attended	Job Title	Dates	Location	Title of Seminar	Sponsor	Cost
Out of State						
Rose Sepulveda steve farris, Sue Finley, Pam Ryan,	Finance Director IT, Nurse, Fiance	5/1/2012	Ft Lauderdale FL	Software users conference	AOD	12837
Carol Brown/ Rose Sepulveda	Administrator/finance	5/1/2012	Chicago il	LSN conference	LSN	1128
Eunice Glasser	Volunteer coordinator	3/1/2012	Ft Lauderdale FL	UMA conference	UMA	3777
				Total out of state		**17742**
In State						
Carol Hawkins	adminsistrator	9/1/2012	Peoria IL	OSHA	IHA	742
Seminars and webinars		various	illinois/ in house			2545
				Total In-state		**3287**
				Total Travel		**21029**