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: 0046656

Facility Name: United Methodist Vlg N Cam

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

County: Lawrence

Telephone Number: 618-943-3344 **Fax #** 618-943-2853

HFS ID Number:

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

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) Robert Benson
(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 Vlg N Cam # 0046656 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	98	Skilled (SNF)	98	35,868	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	35,868	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	876	807	5,324	7,007	8
9	SNF/PED					9
10	ICF	11,107	6,379		17,486	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,983	7,186	5,324	24,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.29%

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 [X]

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 _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [Y] NO [ ] If YES, enter number of beds certified 98 and days of care provided 5,324

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 Vlg N Cam # 0046656 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	201,644	15,403	7,748	224,795		224,795		224,795			1
2	Food Purchase		268,612		268,612		268,612	(12,455)	256,157			2
3	Housekeeping	115,763	17,252		133,015		133,015	(3,640)	129,375			3
4	Laundry	39,462	11,753	1,633	52,848		52,848		52,848			4
5	Heat and Other Utilities			91,974	91,974		91,974	(17,349)	74,625			5
6	Maintenance	23,867	14,066	20,424	58,357		58,357	(240)	58,117			6
7	Other (specify):*											7
8	TOTAL General Services	380,736	327,086	121,779	829,601		829,601	(33,684)	795,917			8
	B. Health Care and Programs											
9	Medical Director			8,600	8,600		8,600		8,600			9
10	Nursing and Medical Records	1,335,849	86,159	34,019	1,456,027		1,456,027	(8,236)	1,447,791			10
10a	Therapy			517,895	517,895		517,895		517,895			10a
11	Activities	64,852	1,950	1,547	68,349		68,349		68,349			11
12	Social Services	30,834		1,310	32,144		32,144		32,144			12
13	CNA Training											13
14	Program Transportation	8,816			8,816		8,816		8,816			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,440,351	88,109	563,371	2,091,831		2,091,831	(8,236)	2,083,595			16
	C. General Administration											
17	Administrative	99,996	108	8,897	109,001		109,001		109,001			17
18	Directors Fees											18
19	Professional Services			11,946	11,946		11,946		11,946			19
20	Dues, Fees, Subscriptions & Promotions			23,004	23,004		23,004	(20,935)	2,069			20
21	Clerical & General Office Expenses	163,420	16,019	73,213	252,652		252,652	(66,784)	185,868			21
22	Employee Benefits & Payroll Taxes			293,602	293,602		293,602		293,602			22
23	Inservice Training & Education			4,677	4,677		4,677		4,677			23
24	Travel and Seminar			8,708	8,708		8,708		8,708			24
25	Other Admin. Staff Transportation			247	247		247		247			25
26	Insurance-Prop.Liab.Malpractice			99,176	99,176		99,176		99,176			26
27	Other (specify):* covenant not to compete			100,034	100,034		100,034	(100,000)	34			27
28	TOTAL General Administration	263,416	16,127	623,504	903,047		903,047	(187,719)	715,328			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,084,503	431,322	1,308,654	3,824,479		3,824,479	(229,639)	3,594,840			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 Vlg N Cam #0046656 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			166,922	166,922		166,922	(3,442)	163,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,902	119,902		119,902		119,902			32
33	Real Estate Taxes			90,128	90,128		90,128		90,128			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			376,952	376,952		376,952	(3,442)	373,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,105	68	172,173		172,173		172,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,775	169,775		169,775		169,775			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		172,105	169,843	341,948		341,948		341,948			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,084,503	603,427	1,855,449	4,543,379		4,543,379	(233,081)	4,310,298			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 Vlg N Cam # 0046656 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	(12,455)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,624)	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	(37,216)	21		24
25	Fund Raising, Advertising and Promotional	(20,935)	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)**	$ (514,194)		$	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))**	$ (514,194)		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 Vlg N Cam

ID# 0046656

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Utility Income	$		1
2	Bank Charges	(55)	21	2
3	Covenant not to compete	(100,000)	27	3
4				4
5	Marketing Salary	(17,934)	21	5
6	Chaplin salary	(10,979)	21	6
7	Assisted Living Allocation:			7
8	Depreciation of noncare assets	(3,442)	30	8
9	Utilities	(8,725)	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				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**	(153,851)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number United Methodist Vlg N Cam **#** 0046656 **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	(12,455)	0	0	0	0	0	0	0	0	0	0	(12,455)	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	(17,349)	0	0	0	0	0	0	0	0	0	0	(17,349)	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**	(33,684)	0	0	0	0	0	0	0	0	0	0	(33,684)	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	(20,935)	0	0	0	0	0	0	0	0	0	0	(20,935)	20
21	Clerical & General Office Expenses	(66,784)	0	0	0	0	0	0	0	0	0	0	(66,784)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(100,000)	0	0	0	0	0	0	0	0	0	0	(100,000)	27
28	**TOTAL General Administration**	(187,719)	0	0	0	0	0	0	0	0	0	0	(187,719)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(229,639)	0	0	0	0	0	0	0	0	0	0	(229,639)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number United Methodist Vlg N Cam **#** 0046656 **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	(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)**	(233,081)	0	0	0	0	0	0	0	0	0	0	(233,081)	45

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 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	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 Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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	see page 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 Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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	Depat of Agriculture		X	Mortgage	$13,480.00	10/26/04	$ 3,000	$ 2,719,318	11/26/44	4.3750	$ 119,902	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Illini manor		X			3/4/04	1,000,000	125,000	3/14/13			6
7												7
8												8
9	TOTAL Facility Related				$13,480.00		$ 1,003,000	$ 2,844,318			$ 119,902	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,003,000	$ 2,844,318			$ 119,902	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 Vlg N Cam # 0046656 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.**	$ 88,140	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.)		$ 88,801	2
3. Under or (over) accrual (line 2 minus line 1).		$ 661	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 89,467	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.		$ 90,128	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	89,267	8
	2008	91,783	9
	2009	94,005	10
	2010	87,475	11
	2011	88,801	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 Vlg N Cam 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 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.	06-001-673-40	Long term Care Facility	$ 88,801.00	$ 88,801.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,801.00	$ 88,801.00

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 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 Vlg N Cam # 0046656 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 United Methodist Vlg N Cam # 0046656 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	98		2004	1991	$ 3,982,381	$ 101,347	39	$ 101,347	$	$ 896,841	4
5				2006	12,172	609	20	609		3,857	5
6				2008	198,160	4,954	40	4,954		20,642	6
7				2009	49,324	1,233	40	1,233		6,424	7
8											8
	Improvement Type**										
9	Roof Improvement			2007	5,070	507	10	507		3,253	9
10	Upgrade forFire System			2007	1,629	163	10	163		909	10
11	Handrails			2008	720	48	15	48		240	11
12	25 cartons Tile			2008	1,199	120	10	120		539	12
13	Hickory BaseBoards			2008	1,051	210	5	210		928	13
14	Lock Change & Rekeying Doors			2008	915	183	5	183		808	14
15	Lowes			2008	487	97	5	97		422	15
16	Keypads for Doors			2009	2,020	289	7	289		889	16
17	New Smoke Shack			2009	1,210	121	10	121		403	17
18	N Campus supplies to rekey doors			2010	981	196	5	196		490	18
19	Kitchen Lighting			2010	1,017	68	15	68		152	19
20	Sprinkler Clean Out			2010	28,751	2,875	10	2,875		6,468	20
21	Locks for facility			2010	1,253	179	7	179		387	21
22	Heaters and airconditioners			2011	10,860	2,172	5	2,172		2,748	22
23	5 ton ac unit			2012	4,663	466	10	466		466	23
24	sprinkler cleanout			2012	15,501	517	15	517		517	24
25	ceramic tiles			2012	3,995	17	20	17		17	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 United Methodist Vlg N Cam # 0046656 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			$	$		$	$	$	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)		$ 4,323,359	$ 116,371		$ 116,371	$	$ 947,400	70

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

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 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		$ 4,323,359	$ 116,371		$ 116,371	$	$ 947,400	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)		$ 4,323,359	$ 116,371		$ 116,371	$	$ 947,400	34

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

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 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	$ 1,039,744	$ 51,941	$ 51,941	$		$ 347,000	71
72	Current Year Purchases	60,189	3,077	3,077			3,077	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,099,933	$ 55,018	$ 55,018	$		$ 350,077	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)	$ 5,772,331	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 171,389	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,389	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)	$ 1,297,477	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	$ 14,269	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 68,846	$ 3,442	$ 14,269	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 Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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	$	3,219	$ 209,851	$	3,219	$ 209,851	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		1,124	79,410		1,124	79,410	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		3,453	228,634		3,453	228,634	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				148,283		148,283	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					23,822		23,822	13
14	TOTAL			$	7,796	$ 517,895	$ 172,105	7,796	$ 690,000	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 United Methodist Vlg N Cam # 0046656 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 Vlg N Cam **#** 0046656 **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 Vlg N Cam # 0046656 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	$ 4,923,717	1
2	Discounts and Allowances for all Levels	(1,879,569)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,044,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,264,894	6
7	Oxygen	49,154	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,314,048	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	1,171	13
14	Non-Patient Meals	12,455	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,847	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,411	19
20	Radiology and X-Ray		20
21	Other Medical Services	211,380	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 409,264	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	assisted living	158,398	28
28a	transportation and misc	9,315	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 167,713	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,935,173	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	829,601	31
32	Health Care	2,091,831	32
33	General Administration	903,047	33
	B. Capital Expense		
34	Ownership	376,952	34
	C. Ancillary Expense		
35	Special Cost Centers	172,173	35
36	Provider Participation Fee	169,775	36
	D. Other Expenses (specify):		
37	related party	1,636,573	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,179,952	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 Vlg N Cam # 0046656 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	$ 52,000	$ 25.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,841	15,971	304,754	19.08	3
4	Licensed Practical Nurses	19,616	20,355	330,674	16.25	4
5	CNAs & Orderlies	59,640	63,434	593,012	9.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,625	7,135	64,163	8.99	10
11	Social Service Workers	3,387	3,775	41,919	11.10	11
12	Dietician					12
13	Food Service Supervisor	1,828	2,000	22,000	11.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,726	20,015	178,194	8.90	15
16	Dishwashers					16
17	Maintenance Workers	1,943	2,202	23,743	10.78	17
18	Housekeepers	12,080	12,954	115,198	8.89	18
19	Laundry	4,365	4,635	39,429	8.51	19
20	Administrator	1,960	2,080	70,000	33.65	20
21	Assistant Administrator					21
22	Other Administrative	6,797	7,474	89,849	12.02	22
23	Office Manager					23
24	Clerical	5,997	6,602	91,096	13.80	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	5,360	5,891	55,207	9.37	31
32	Other Health Care(specify)					32
33	Other(specify) child care					33
34	TOTAL (lines 1 - 33)	165,125	176,603	$ 2,071,238 *	$ 11.73	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	117	$ 3,411	1-3	35
36	Medical Director	monthly	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly	2,400	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	1,310	11-3	44
45	Social Service Consultant	15	1,310	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	147	$ 15,631		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 Vlg N Cam # 0046656 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Briana Crutchfield	Administrator		$ 49,756
Robert Benson	CEO		27,692
Other administrative personnel			31,553
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,001

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Cox Phillips, Weber Tedford		$ 1,515
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.)		$ 11,946

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,555
Unemployment Compensation Insurance	7,658
FICA Taxes	127,724
Employee Health Insurance	44,000
Employee Meals	1,518
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	7,345
401K expenses and contribution	13,801
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,601

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	$ 1,990
Advertising: Employee Recruitment	79
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
advertising	20,935
Dues	
Subscriptions	
Less: Public Relations Expense	( )
Non-allowable advertising	(20,935)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,069

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	8,708
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,708

**See instructions.

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 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 Vlg N Cam # 0046656 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? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,334** 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. $ **169,775**
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? **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? **na**
Attach invoices and a summary of services for all architect and appraisal fees.

Who Attended	Job Title	Dates	Location	Title of Seminar	Sponsor	Cost
Out of State						
In State						
Carol Hawkins	adminsistrator	9/1/2012	Peoria IL	OSHA	IHA	742
Ed lancaster	Administrator/finance	5/1/2012	Chicago il	LSN conference	LSN	243
Seminars and webinars		various	illinois/ in house			5067
MDS training	penny	various			CMS	1235
C N A school	employees					1,421
				Total In-state		**8708**

Page 12-13 Schedule XI Ownership Cost

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment and Vehicles	Total
Schedule XI Ownership Cst	$349,039	$4,323,357	$1,099,932	$5,772,328
Non Care Assets	$0	$68,846	$0	$68,846
Related Facility	$159,708	$9,664,280	$4,597,212	$14,421,200
Non-care Assets of Related Facility	$0	$5,102,435	$0	$5,102,435
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

Description	Who Attended	Amount
Red cross Certifications	Nursing staff	162.00
Certifications and license	Social Services	91.00
Certifications and license	activities	140.00
Seminar & Workshop Expenses		
Silverchair inservices	Entire facility	4,284.00
total line 23		4,677.00

Descriptions of Non Care Assets and Depreciation

Description	Year	Cost	Current Depreciation	Accumulated Depreciation
Assisted Living Addition	2009	29,645	1,482	6,917
Assisted Living Addition	2010	34,321	1,716	6,864
Assisted Living Addition	2011	4,880	244	488
Total to 13		$68,846	$3,442	$14,269

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		
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		