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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0046656

Facility Name: United Methodist Vlg N Cam

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

County: Lawrence

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		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: Curt Benson, CPA **Telephone Number:** (812) 882-7730
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Paula McKnight
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Curt Benson, CPA, Partner
(Firm Name & Address) Kemper CPA Group LLP, 505 N 6TH Street, PO Box 297, Vincennes, IN 47591
(Telephone) (812) 882-7730 Fax # (812) 882-7778

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 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	66	562	3,473	4,101	8
9	SNF/PED					9
10	ICF	11,080	7,902	3	18,985	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,146	8,464	3,476	23,086	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.54%

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 03/01/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 3,476

Medicare Intermediary Wisconsin Physicans Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	210,406	15,193	14,884	240,483		240,483		240,483			1
2	Food Purchase		181,864		181,864		181,864	(18,062)	163,802			2
3	Housekeeping	112,660	16,260	172	129,092		129,092	(3,640)	125,452			3
4	Laundry	54,562	14,448	806	69,816		69,816		69,816			4
5	Heat and Other Utilities			95,666	95,666		95,666	(11,689)	83,977			5
6	Maintenance	39,357	14,335	25,674	79,366		79,366	(240)	79,126			6
7	Other (specify):*											7
8	TOTAL General Services	416,985	242,100	137,202	796,287		796,287	(33,631)	762,656			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,458,928	70,527	59,768	1,589,223		1,589,223	(8,236)	1,580,987			10
10a	Therapy			389,873	389,873		389,873		389,873			10a
11	Activities	65,272	1,856	1,239	68,367		68,367		68,367			11
12	Social Services	34,663	397	1,204	36,264		36,264		36,264			12
13	CNA Training											13
14	Program Transportation	11,723			11,723		11,723		11,723			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,570,586	72,780	461,684	2,105,050		2,105,050	(8,236)	2,096,814			16
	C. General Administration											
17	Administrative	115,316	70	9,761	125,147		125,147	(19,194)	105,953			17
18	Directors Fees											18
19	Professional Services			189,568	189,568		189,568	(136,045)	53,523			19
20	Dues, Fees, Subscriptions & Promotions			23,563	23,563		23,563	(18,291)	5,272			20
21	Clerical & General Office Expenses	122,439	9,289	99,423	231,151		231,151	(757)	230,394			21
22	Employee Benefits & Payroll Taxes			431,402	431,402		431,402		431,402			22
23	Inservice Training & Education					17,135	17,135		17,135			23
24	Travel and Seminar			20,884	20,884	(17,135)	3,749		3,749			24
25	Other Admin. Staff Transportation			2,510	2,510		2,510	(8,155)	(5,645)			25
26	Insurance-Prop.Liab.Malpractice			83,273	83,273		83,273		83,273			26
27	Other (specify):*			20,386	20,386		20,386	(16,667)	3,719			27
28	TOTAL General Administration	237,755	9,359	880,770	1,127,884		1,127,884	(199,109)	928,775			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,225,326	324,239	1,479,656	4,029,221		4,029,221	(240,976)	3,788,245			29

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

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: 01/01/2014 Ending: 12/31/2014

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			184,030	184,030		184,030	(3,442)	180,588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,322	116,322		116,322	(961)	115,361			32
33	Real Estate Taxes			91,122	91,122		91,122		91,122			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			391,474	391,474		391,474	(4,403)	387,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,284	28,467	195,751		195,751		195,751			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,844	172,844		172,844		172,844			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		167,284	201,311	368,595		368,595		368,595			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,225,326	491,523	2,072,441	4,789,290		4,789,290	(245,379)	4,543,911			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(18,062)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,903)	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	(961)	32		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	(136,045)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,291)	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 See Pg 5A	(69,117)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (245,379)		$	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))**	$ (245,379)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

United Methodist Vlg N Cam

ID# 0046656

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (157)	21	1
2	Covenant Not To Compete	(16,667)	27	2
3	Transportation Reimbursement	(8,155)	25	3
4	Marketing Salary	(19,194)	17	4
5				5
6				6
7	ASSISTED LIVING ALLOCATION:			7
8	Depreciation	(3,442)	30	8
9	Electric	(5,214)	5	9
10	Gas	(1,559)	5	10
11	Water	(573)	5	11
12	Telephone	(1,440)	5	12
13	Maintenance	(240)	6	13
14	Nursing	(936)	10	14
15	Cert. Nursing Assistant	(7,300)	10	15
16	Billing	(468)	21	16
17	Cash Receipts	(132)	21	17
18	Housekeeping	(3,640)	3	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**	(69,117)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number United Methodist Vlg N Cam **#** 0046656 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(18,062)	0	0	0	0	0	0	0	0	0	0	(18,062)	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	(11,689)	0	0	0	0	0	0	0	0	0	0	(11,689)	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**	(33,631)	0	0	0	0	0	0	0	0	0	0	(33,631)	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	(19,194)	0	0	0	0	0	0	0	0	0	0	(19,194)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(136,045)	0	0	0	0	0	0	0	0	0	0	(136,045)	19
20	Fees, Subscriptions & Promotions	(18,291)	0	0	0	0	0	0	0	0	0	0	(18,291)	20
21	Clerical & General Office Expenses	(757)	0	0	0	0	0	0	0	0	0	0	(757)	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	(8,155)	0	0	0	0	0	0	0	0	0	0	(8,155)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(16,667)	0	0	0	0	0	0	0	0	0	0	(16,667)	27
28	**TOTAL General Administration**	(199,109)	0	0	0	0	0	0	0	0	0	0	(199,109)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(240,976)	0	0	0	0	0	0	0	0	0	0	(240,976)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number United Methodist Vlg N Cam **#** 0046656 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(961)	0	0	0	0	0	0	0	0	0	0	(961)	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**	(4,403)	0	0	0	0	0	0	0	0	0	0	(4,403)	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)**	(245,379)	0	0	0	0	0	0	0	0	0	0	(245,379)	45

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The United Methodist Village, Inc.	100	The United Methodist Village	Lawrenceville			

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 31 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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	USDA		X	Mortgage	$13,260.00	10/26/04	$ 3,000,000	$ 2,635,551	11/26/2014	4.3750	$ 116,322	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Illini Manor		X		$8,333.00		1,000,000		3/14/2013			6
7												7
8												8
9	TOTAL Facility Related				$21,593.00		$ 4,000,000	$ 2,635,551			$ 116,322	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 2,635,551			$ 116,322	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 87,274	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.)		$ 88,212	2
3. Under or (over) accrual (line 2 minus line 1).		$ 938	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 90,184	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.		$ 91,122	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	94,005	8
	2010	87,475	9
	2011	88,801	10
	2012	85,947	11
	2013	83,093	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2013 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 Curt Benson, CPA

TELEPHONE (812) 882-7730 FAX #: (812) 882-7778

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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	$ 88,212.00	$ 88,212.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,212.00	$ 88,212.00

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 102,224	39	$ 102,224	$	$ 1,103,045	4
5				2006	12,172	609	20	609		5,075	5
6				2008	198,160	4,954	40	4,954		30,550	6
7				2009	49,324	1,233	40	1,233		8,890	7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets Thru 2014				2,453					2,453	9
10	Roof Improvements			2007	5,070	507	10	507		4,267	10
11	Upgrade For Fire System			2007	1,629	163	10	163		1,235	11
12	Handrails			2008	720	48	15	48		336	12
13	25 Cartons of Tile			2008	1,199	120	10	120		779	13
14	Keypad for Doors			2009	2,020	289	7	289		1,467	14
15	New Smoke Shack			2009	1,210	121	10	121		645	15
16	N Campus Supplies to Rekey Doors			2010	981	196	5	196		882	16
17	Kitchen Lighting			2010	1,017	68	15	68		288	17
18	Sprinkler Clean Out			2010	28,751	2,875	10	2,875		12,218	18
19	Locks for Facility			2010	1,253	179	7	179		746	19
20	Heaters and Air Conditioners			2011	10,860	1,850	5	1,850		6,447	20
21	5 Ton Air Conditioner Unit			2012	4,663	466	10	466		1,399	21
22	Sprinkler Clean Out			2012	15,501	1,033	15	1,033		2,583	22
23	Ceramic tiles			2012	3,995	200	20	200		417	23
24	Water Heaters			2013	7,540	754	10	754		1,382	24
25	Canopy for Resident Smoke Areas			2013	920	61	15	61		112	25
26	Walk-In Refrigerator			2013	770	5	15	5		68	26
27	Air Conditioner - 5 ton R22 Unit			2014	1,497	75	10	75		75	27
28	Sprinkler System Repair			2014	9,991	100	25	100		100	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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)		$ 4,344,077	$ 118,130		$ 118,130	$	$ 1,185,459	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/2014 Ending: 12/31/2014

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	$ 1,023,098	$ 60,687	$ 60,687	$	Various	$ 378,040	71
72	Current Year Purchases	10,636	1,771	1,771		5	1,771	72
73	Fully Depreciated Assets	135,203					135,203	73
74								74
75	TOTALS	$ 1,168,937	$ 62,458	$ 62,458	$		$ 515,014	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)	$ 5,862,053	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,588	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,588	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)	$ 1,700,473	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 Page 25 - Various	$ 68,846	$ 3,442	$ 21,153	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 68,846	$ 3,442	$ 21,153	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	9,026	$ 150,602	$	9,026	$ 150,602	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		705	44,263		705	44,263	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		11,081	195,008		11,081	195,008	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				106,648		106,648	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Oxygen & Supplies	39-02					60,636		60,636	13
14	TOTAL			$	20,812	$ 389,873	$ 167,284	20,812	$ 557,157	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 311,177	$	1
2	Cash-Patient Deposits	49,606		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 214,765)	3,008,651		3
4	Supply Inventory (priced at)	27,420		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd-party payors	4,176		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,401,030	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	117,752		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,213,175		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,868,187		16
17	Accumulated Depreciation (book methods)	(18,039,901)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,667,960	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,068,990	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,621,788	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,606		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,525		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,912		32
33	Accrued Interest Payable			33
34	Deferred Compensation	89,833		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Payables	455,447		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,435,111	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,182,520		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Refundable Deposits and Fees	91,605		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,274,125	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,709,236	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,359,754	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,068,990	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,656,159	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,656,159	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(296,407)	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) **Rounding**	2	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (296,405)	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)**	$ 5,359,754	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 9,080,226	1
2	Discounts and Allowances for all Levels	(2,201,729)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,878,497	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,977,251	6
7	Oxygen	49,878	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,027,129	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	700	13
14	Non-Patient Meals	48,784	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	189,300	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,479	19
20	Radiology and X-Ray		20
21	Other Medical Services	161,738	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 418,001	23
	D. Non-Operating Revenue		
24	Contributions	292,201	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 292,201	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	121,957	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 121,957	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,737,785	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	796,287	31
32	Health Care	2,105,050	32
33	General Administration	1,127,884	33
	B. Capital Expense		
34	Ownership	391,474	34
	C. Ancillary Expense		
35	Special Cost Centers	195,751	35
36	Provider Participation Fee	172,844	36
	D. Other Expenses (specify):		
37	Expenses Reported on Related Party Costs Report	5,244,902	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,034,192	40
41	**Income before Income Taxes (line 30 minus line 40)****	(296,407)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (296,407)	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? Yes 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	6,573	7,193	$ 157,549	$ 21.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,310	14,258	272,199	19.09	3
4	Licensed Practical Nurses	17,491	18,557	309,886	16.70	4
5	CNAs & Orderlies	65,698	69,547	683,418	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,870	6,441	65,272	10.13	10
11	Social Service Workers	2,580	2,732	34,662	12.69	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,000	10.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,883	20,218	188,406	9.32	15
16	Dishwashers					16
17	Maintenance Workers	6,118	6,651	68,947	10.37	17
18	Housekeepers	8,554	9,358	94,793	10.13	18
19	Laundry	5,821	6,193	54,561	8.81	19
20	Administrator	2,008	2,080	115,316	55.44	20
21	Assistant Administrator					21
22	Other Administrative	6,751	7,438	116,723	15.69	22
23	Office Manager					23
24	Clerical	354	396	4,836	12.21	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	3,412	3,619	35,877	9.91	31
32	Other Health Care(specify)					32
33	Other(specify) Chaplain	100	100	881	8.81	33
34	TOTAL (lines 1 - 33)	165,603	176,861	$ 2,225,326 *	$ 12.58	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	200	$ 11,421	1-3	35
36	Medical Director	Monthly	9,600	9-3	36
37	Medical Records Consultant	Monthly	714	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,856	11-3	44
45	Social Service Consultant	38	1,204	12-3	45
46	Other(specify)				46
47	Director of Nursing Consultant	252	56,859	10-3	47
48					48
49	TOTAL (lines 35 - 48)	528	$ 81,654		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: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula McKnight	Administrator	0	$ 115,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,316

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
Kemper CPA Group	Accounting Serivces	$ 14,993
Duane Morris	Legal Services	169,345
Cameron Brenner	Accounting Serivces	5,230
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 189,568

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,009
Unemployment Compensation Insurance	25,108
FICA Taxes	154,052
Employee Health Insurance	111,343
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	883
401(k)	5,533
Miscellaneous Employee Benefits	26,474
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,402

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	75
Health Care Worker Background Check	
(Indicate # of checks performed 87)	
Patient Background Checks	
Advertising / Public Relations	18,291
Dues	5,197
Less: Public Relations Expense	( )
Non-allowable advertising	(18,291)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,272

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,749
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,749

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,760** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **172,844**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment and Vehciles	Total
Schedule XI Ownership Cost	$ 349,039	$ 4,344,077	$ 1,168,937	$ 5,862,053
Non-care Assets	-	68,846	-	68,846
Related Facility	159,708	9,693,561	4,669,034	14,522,303
Non-care Assets of Related Facility	-	5,136,068	-	5,136,068
Reconciliation variance	-	(29,377)	30,216	839
Schedule XV Balance Sheet	$ 508,747	$ 19,213,175	$ 5,868,187	$ 25,590,109

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

SEE ACCOUNTANTS' COMPILATION REPORT.

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

Description of Non Care Assets and Depreciation

Description	Year	Cost	Depreciation	Accumulated Depreciation
Assisted Living Addition	2009	$ 29,645	$ 1,482	$ 9,881
Assisted Living Project	2010	34,321	1,716	10,296
Assisted Living Addition	2011	4,880	244	976
TOTAL - To Page 13		$ 68,846	$ 3,442	$ 21,153

SEE ACCOUNTANTS' COMPILATION REPORT.

Expenses of related facility presented on separate cost report: pg. 19

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

SEE ACCOUNTANTS' COMPILATION REPORT.

No training expenses is reported since the Village only hires certified nurses.

SEE ACCOUNTANTS' COMPILATION REPORT.

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

Description	Who Attended	Date	Amount
Sanitation Recertification	Dietary Staff	4/22/2014	200
Restoritive Certification	Sarah Clark RN	7/11/2014	447
Pathway MDS In house training	MDS Staff	10/7/2014	1,000
Relias Learning In house education	All staff	2/11/2014	7,825
Relias Learning In house education	All staff	12/17/2014	7,421
MDS Book	Education Materials	10/6/2014	242
Total Inservice			$ 17,135

SEE ACCOUNTANTS' COMPILATION REPORT.

Meeting Attended	Dates	Who Attended	Department Charged	Cost
None				
			Total Out of State:	-
In State				
SIATA Workshop	3/5/2014	Cindy Hillyard ACT	Olney, IL	40
Health Services Consultants	8/20/2014	Teri Stangle		236
AANAC	8/1/2014	Jennifer Vowels RN, Penny Eckel LPN		330
IHCA Conference	8/24/2014	Paula McKnight CEO, Meranda Snider	Peoria, IL	2,065
Restoritive Training	12/31/2014	May Piper RN	Mt. Vernon, IL	899
Outcome Services Training	1/28/2014	Social Services		180
			Total In-State:	3,750
			TOTAL Travel	$ 3,750

SEE ACCOUNTANTS' COMPILATION REPORT.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT.

Name	Provided Services (Y or N)	Type of Service (if applicable)	Ownership of Business That Provided Services	Type of Business (if applicable)
Sarah Brian	N	N/A	N/A	N/A
Ed Davis	N	N/A	N/A	N/A
Keith Chelsvig	N	N/A	N/A	N/A
Rev. Mark Canada	N	N/A	N/A	N/A
Diane Goff	N	N/A	N/A	N/A
Nancy Myers	N	N/A	N/A	N/A
Luanne Negley	N	N/A	N/A	N/A
Rev. Gary Pearce	N	N/A	N/A	N/A
Duane Ambrose	N	N/A	N/A	N/A
Clyde Putnam	N	N/A	N/A	N/A
Jack Vayhinger	N	N/A	N/A	N/A
Paula Stoltz	N	N/A	N/A	N/A
Morgan Newell, South Campus Administrator	N	N/A	N/A	N/A
Paula McKnight, North Campus Administrator	N	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT.

Program Services. Page 21, Part C - Detail of Legal Services.

Vendor/Payee	Invoice Date	Description of Services	Allowable
Duane Morris LLP	2/7/2014	Draft of new ALF contract re North Campus, releases of liability; Review Assisted Living act regulations, review and analyze background checks	13,630.00
Duane Morris LLP	2/28/2014	Regulatory Counsel; conference re POA for Resident, review outstanding matters, Al Establishment Contract	3,445.50
Duane Morris LLP	3/11/2014	For professional services recorded through 2/28/2014; Review IDPH notice of prehearing conference re NH 13-C494; correspondence	982.00
Duane Morris LLP	3/11/2014	Regulatory Counsel; research statute and verification of background check, review results of criminal code, meetings	-
Duane Morris LLP	4/16/2014	NH 13-C0494 ; Complete analysis of IDPH investigation file, correspondence, prep for prehearing conference, Settlement analysis	4,325.50
Duane Morris LLP	5/15/2014	NH 13-C0494 ; Complete analysis of IDPH investigation file, correspondence, prep for prehearing conference, Settlement analysis	4,153.50
Duane Morris LLP	5/15/2014	NH 13-C0494 ; Complete analysis of IDPH investigation file, correspondence, prep for prehearing conference, Settlement analysis	2,505.50
Duane Morris LLP	6/9/2014	Employment Law Advice	-
Duane Morris LLP	6/9/2014	Regulatory Counsel	-
Duane Morris LLP	6/9/2014	Legal Services Related To IDPH Case - NH 13-C0494	786.00
Duane Morris LLP	7/15/2014	Employment Law Advice	-
Duane Morris LLP	7/18/2014	Regulatory Counsel	-
Duane Morris LLP	7/18/2014	UMV for professional services recorded through 6/30/14	-
Duane Morris LLP	8/14/2014	Employment Law Advice	-
Duane Morris LLP	8/14/2014	Employment Matter	-
Duane Morris LLP	8/14/2014	For professional services in connection with the the UMV Logo	-
Duane Morris LLP	7/18/2014	Legal Services Related To IDPH Case - NH 13-C0494	458.50
Duane Morris LLP	8/14/2014	Regulatory Counsel	-
Duane Morris LLP	9/15/2014	For professional services in connection with the the UMV Logo	-
Duane Morris LLP	9/15/2014	Employment Law Advice	-
Duane Morris LLP	9/15/2014	Regulatory Counsel	-
Duane Morris LLP	9/15/2014	Legal Services Related To IDPH Case - NH 13-C0494	720.50
Duane Morris LLP	9/15/2014	Employment Law Advice	-
Duane Morris LLP	8/14/2014	For professional services in connection with the the UMV Logo and Trademark	-
Duane Morris LLP	10/13/2014	Employment Law Advice	-
Duane Morris LLP	10/13/2014	Regulatory Counsel	-
Duane Morris LLP	10/13/2014	Legal Services Related To IDPH Case - NH 13-C0494	2,227.00
Duane Morris LLP	10/13/2014	For professional services recorded through 09/30/14 in connection with the the UMV Logo	-
Duane Morris LLP	10/13/2014	Employement Matter - 9/11/14 Incident	-
Duane Morris LLP	11/10/2014	Employment Law Advice	-
Duane Morris LLP	11/10/2014	Regulatory Counsel	-
Duane Morris LLP	11/10/2014	Legal Services Related To IDPH Case - NH 13-C0494	65.50
Duane Morris LLP	11/10/2014	Employement Matter - 9/11/14 Incident	-
Duane Morris LLP	11/10/2014	Employement Matter - 9/11/14 Incident	-
Duane Morris LLP	11/14/2014	Employement Matter - 9/11/14 Incident	-
Duane Morris LLP	12/11/2014	Employment Law Advice	-

Duane Morris LLP	12/11/2014	Regulatory Counsel	-
Duane Morris LLP	12/11/2014	Employment Law	-
			$ 33,300

SEE ACCOUNTANTS' COMPILATION REPORT.

Non-Allowable	Total
-	13,630.00
-	3,445.50
-	982.00
4,448.50	4,448.50
-	4,325.50
-	4,153.50
-	2,505.50
5,893.00	5,893.00
10,099.00	10,099.00
-	786.00
2,121.50	2,121.50
16,985.00	16,985.00
2,521.00	2,521.00
673.50	673.50
3,267.50	3,267.50
675.00	675.00
-	458.50
20,173.18	20,173.18
95.00	95.00
710.50	710.50
9,961.00	9,961.00
-	720.50
1,002.37	1,002.37
897.00	897.00
6,155.00	6,155.00
6,052.50	6,052.50
-	2,227.00
724.50	724.50
5,764.00	5,764.00
2,573.50	2,573.50
10,906.00	10,906.00
-	65.50
131.00	131.00
2,737.00	2,737.00
3,678.40	3,678.40
1,864.50	1,864.50

14,170.50	14,170.50
1,765.50	1,765.50
$ 136,045	$ 169,345

Schedule V. Cost Center Expenses - Reclassifications

Cost Center	Line	Increase	Decrease
In-Service Training & Education	23	$ 17,135	
Travel and Seminar	24		$ 17,135

(Reclassify in-service training and education expenses)

SEE ACCOUNTANTS' COMPILATION REPORT.