

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0014506

Facility Name: The United Methodist Village, Inc

Address: 1616 Cedar Street Lawrenceville 62439
Number City Zip Code

County: Lawrence

Telephone Number: (618)943-3347 Fax # (618) 943-3823

HFS ID Number:

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

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Rose Sepulveda Telephone Number: (618)943-3347 ext 1203
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Carol Hawkins-Brown
(Title) Administrator

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number	The United Methodist Village, Inc
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#	0014506	Report Period Beginning:	01/01/2011	Ending:	12/31/2011
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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

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 ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

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

Date started 01/01/1925

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 70 and days of care provided

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED CASH*	☐	CASH*	☐
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1	163	Skilled (SNF)	163	59,495	1		
2		Skilled Pediatric (SNF/PED)			2		
3		Intermediate (ICF)			3		
4		Intermediate/DD			4		
5		Sheltered Care (SC)			5		
6		ICF/DD 16 or Less			6		
7	163	TOTALS	163	59,495	7		

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,210	1,661	2,753	6,624	8
9	SNF/PED					9
10	ICF	12,240	7,321		19,561	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,450	8,982	2,753	26,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **44.01%**

Facility Name & ID Number The United Methodist Village, Inc # 0014506 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	304,294	27,845	20,393	352,532		352,532		352,532			1
2	Food Purchase		251,409		251,409		251,409	(44,192)	207,217			2
3	Housekeeping	205,439	27,984		233,423		233,423	(16,000)	217,423			3
4	Laundry	115,519	20,879		136,398		136,398		136,398			4
5	Heat and Other Utilities			332,894	332,894		332,894	(200,061)	132,833			5
6	Maintenance	245,252	30,186	133,821	409,259		409,259	(78,063)	331,196			6
7	Other (specify):*											7
8	TOTAL General Services	870,504	358,303	487,108	1,715,915		1,715,915	(338,316)	1,377,599			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,650,620	111,468	20,933	1,783,021		1,783,021	(14,405)	1,768,616			10
10a	Therapy			529,455	529,455		529,455		529,455			10a
11	Activities	108,459	3,400	1,062	112,921		112,921	(13,000)	99,921			11
12	Social Services	76,657		1,280	77,937		77,937	(1,152)	76,785			12
13	CNA Training											13
14	Program Transportation	15,625			15,625		15,625		15,625			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,851,361	114,868	562,330	2,528,559		2,528,559	(28,557)	2,500,002			16
	C. General Administration											
17	Administrative	135,682	190	10,911	146,783		146,783	(4,400)	142,383			17
18	Directors Fees											18
19	Professional Services			14,408	14,408		14,408	(219)	14,189			19
20	Dues, Fees, Subscriptions & Promotions			26,418	26,418		26,418	(25,472)	946			20
21	Clerical & General Office Expenses	182,613	35,212	89,851	307,676		307,676	(36,686)	270,990			21
22	Employee Benefits & Payroll Taxes			538,676	538,676		538,676	(12,000)	526,676			22
23	Inservice Training & Education					7,345	7,345		7,345			23
24	Travel and Seminar			19,136	19,136	(7,345)	11,791		11,791			24
25	Other Admin. Staff Transportation			11,378	11,378		11,378	(11,378)				25
26	Insurance-Prop.Liab.Malpractice			149,392	149,392		149,392	(12,000)	137,392			26
27	Other (specify):* Child care costs	127,520	2,014	730	130,264		130,264	(130,264)				27
28	TOTAL General Administration	445,815	37,416	860,900	1,344,131		1,344,131	(232,419)	1,111,712			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,167,680	510,587	1,910,338	5,588,605		5,588,605	(599,292)	4,989,313			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			437,026	437,026		437,026	(141,832)	295,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,910	61,910		61,910	(61,910)				32
33	Real Estate Taxes			3,202	3,202		3,202	(3,202)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Godfrey bond			262,127	262,127		262,127	(262,127)				36
37	TOTAL Ownership			764,265	764,265		764,265	(469,071)	295,194			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,144	1,498	96,642		96,642		96,642			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,368	90,368		90,368	(1,125)	89,243			42
43	Other (specify):* granny Tax			106,480	106,480		106,480		106,480			43
44	TOTAL Special Cost Centers		95,144	198,346	293,490		293,490	(1,125)	292,365			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,167,680	605,731	2,872,949	6,646,360		6,646,360	(1,069,488)	5,576,872			45

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

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	(29,118)	2		4
5	Telephone, TV & Radio in Resident Rooms	(46,561)	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	(61,910)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,472)	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	(906,427)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,069,488)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,069,488)		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

ID#

0014506

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Utility Income	\$ (68,835)	5	1
2	Transportation Reimbursement	(11,378)	25	2
3	Supplies and misc	(495)	21	3
4	Child Care Salaries	(127,520)	27	4
5	Child Care Supplies	(2,014)	27	5
6	Child Care Meals	(623)	27	6
7	Child Care Education	(107)	27	7
8	Godfrey Bond Expense	(262,127)	36	8
9	McKiou Food Expense	(14,074)	2	9
10	Bank Charges	(7,559)	21	10
11	Late Fees	(1,125)	42	11
12	Resident Services	(152)	12	12
13				13
14	Doctor Expense	(2,282)	10	14
15	Hospital Expense	(12,123)	10	15
16			30	16
17	Misc Income		21	17
18	Marketing Salaries	(17,914)	21	18
19	Chaplin Expenses	(590)	21	19
20	Chaplin Salary	(10,128)	21	20
21	Real Estate Taxes	(3,202)	33	21
22				22
23	Independent Living Allocation:			23
24	Maintenance	(78,063)	6	24
25	Housekeeping	(16,000)	3	25
26	Dietary	(1,000)	2	26
27	Utilities	(84,665)	5	27
28	Social Services	(1,000)	12	28
29	Administrative	(4,400)	17	29
30	Activities	(13,000)	11	30
31				31
32	Employee Benefits and workers com	-12000	22	32
33	Insurance	-12000	26	33
34	Depreciation	-141832	30	34
35				35
36	Legal	-219	19	36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(906,427)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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

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

Ending: 2/31/2011

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Citizens National Bank		X	Mortgage	\$4,026.00	6/23/09	\$ 650,000	\$ 597,462	6/23/2029	4.2500	\$ 23,779	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Citizens National Bank		X	Operating Cash		3/14/11	500,000	499,051	3/14/2012	5.5000	22,862	6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,026.00		\$ 1,150,000	\$ 1,096,513			\$ 46,641	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,150,000	\$ 1,096,513			\$ 46,641	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.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		8	
	2007		9	
	2008		10	
	2009		11	
	2010		12	

	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>The United Methodist Village, Inc</u>	COUNTY	<u>Lawrence</u>
---------------	--	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0014506

CONTACT PERSON REGARDING THIS REPORT Rose Sepulveda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,538

B. General Construction Type: Exterior BrickFrameNumber of Stories 1

C. Does the Operating Entity?

☒ (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?

☒ (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☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	631,620	1924	\$ 96,018	1
2		572,380	1987&1989	63,690	2
3	TOTALS	1,204,000		\$ 159,708	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	163		1965	1965	\$ 1,350,000	\$ 27,000	50	\$ 27,000	\$	\$ 1,242,000	4
5			1974	1974	916,911	18,338	50	18,338		687,402	5
6			1979	1979	1,228,695	24,574	50	24,574		1,084,784	6
7			1925	1925	601,097	15,027	40	15,027		457,791	7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets Thru 2010				2,710,283					2,710,283	9
10	Various			1979	117,791	2,612	50	2,612		101,068	10
11	Various			18980	17,695	354	50	354		11,148	11
12	Various			1989	96,708	3,887	20	3,887		87,481	12
13	Various			1990	610,945	24,341	20	24,341		523,506	13
14	Various			1991	132,029	5,327	20	5,327		117,350	14
15	Various			1992	313,917	12,778	20	12,778		249,166	15
16	Various			1993	119,112	6,175	20	6,175		114,241	16
17	Various			1994	67,500	3,816	20	3,816		69,883	17
18	Various			1995	157,262	9,462	20	9,462		156,127	18
19	Various			1996	315,753	17,476	20	17,476		316,406	19
20	Various			1999	13,455	1,021	20	1,021		12,701	20
21	Various			2000	1,637	109	15	109		1,298	21
22	Various			2002	73,057	7,305	10	7,305		69,764	22
23	Various			2002	21,530	1,436	15	1,436		13,466	23
24	HVAC System			2002	14,126	831	17	831		7,548	24
25	Wiring and Circuit Panels			2002	9,048	452	20	452		4,258	25
26	Office Remodeling			2002	2,138	178	12	178		1,677	26
27	Various			2003	3,323	134	25	134		1,184	27
28	Various			2003	56,659	3,778	15	3,778		33,760	28
29	Various			2003	46,484	4,649	10	4,649		39,746	29
30	Dycus Auto Door			2003	1,073		7			1,073	30
31	Building Supplies			2004	3,115	208	15	208		1,525	31
32	Smoke Detectors			5004	2,114	302	7	302		2,164	32
33	Various			2005	9,744	649	15	649		4,564	33
34	Various			2005	96,745	9,675	10	9,675		63,836	34
35	Sidewalk and Ramps			2005	6,000	667	9	667		4,394	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number The United Methodist Village, Inc

0014506

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Therapy Project	2005	\$ 272	\$	5	\$		\$ 272	37
38	Water Furnace	2006	1,944	130	15	130		780	38
39	Carpet	2006	841	168	5	168		994	39
40	Hallway Tile	2006	3,399	340	10	340		2,012	40
41	Handrails	2006	553	31	15	31		192	41
42	Geothermal System	2006	1,686	169	10	169		971	42
43	Water Meter	2006	2,194	110	20	110		623	43
44	Locks for Outside Entrance	2006	10,377	1,038	10	1,038		5,882	44
45	Smoke Detectors	2006	17,751	1,775	10	1,775		10,058	45
46	Mig Welder	2006	530	53	10	53		296	46
47	T-1 Computer Line & Equipment	2006	7,752	1,550	5	1,550		8,654	47
48	Boiler Repair	2006	11,590	773	15	773		4,231	48
49	Tile Floor in Dietary	2006	9,952	995	10	995		5,390	49
50	4 Water Furnaces	2006	7,331	733	10	733		3,970	50
51	Air Conditioner	2006	633	63	10	63		336	51
52	Washer for Laundry Department	2006	9,379	625	15	625		6,281	52
53	Pellet Heater for Dietary	2006	2,659	266	10	266		1,396	53
54	Water Softner	2006	2,925	293	10	293		1,489	54
55	Carbon Monoxide Detectors	2006	2,139	214	10	214		1,088	55
56	Dycus - Replaced Carpet with Tile	2006	12,514	1,251	10	1,251		6,568	56
57	Sidewalk	2007	560	37	15	37		176	57
58	Railing on Dycus ramp	2008	683	46	15	46		176	58
59	Wesley I - painted and added floor tile	2008	2,039	408	5	408		1,564	59
60	Breaker Box	2008	495	71	7	71		254	60
61	Shower Installation	2008	5,000	500	10	500		1,708	61
62	Sprinkler Installation	2008	145,567	7,278	20	7,278		23,654	62
63	Sprinkler System	2008	154,780	7,739	20	7,739		23,217	63
64	Dycus Room - install drop ceiling for sprinkler system	2009	11,245	1,606	7	1,606		4,551	64
65	Elevator Upgrade	2009	39,165	1,004	39	1,004		2,845	65
66	Holden Center Roof Repair	2009	650	43	15	43		111	66
67	Electrical Maintance	2009	259	52	5	52		130	67
68	Paint & Supplies	2009	479	96	5	96		240	68
69	Flooring and Supplies	2009	1,363	273	5	273		682	69
70	TOTAL (lines 4 thru 69)		\$ 9,584,652	\$ 232,291		\$ 232,291	\$	\$ 8,312,385	70

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

Facility Name & ID Number The United Methodist Village, Inc

0014506

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,584,652	\$ 232,291		\$ 232,291	\$	\$ 8,312,385	1
2	Added Cabinets	2009	3,023	246	5	246		542	2
3	Replaced floor coverings and carpet in office	2009	363	73	5	73		158	3
4	Various Supplies	2010	399	57	7	57		114	4
5	Mechanical Door Resistor for Elevator	2010	1,683	84	20	84		147	5
6	Screen and windows	2010	2,539	169	15	169		240	6
7	Flooring	2010	1,260	252	5	252		336	7
8	WesleyI Flooring	2010	21,532	3,076	7	3,076		3,845	8
9	80 boxes of tile flooring	2010	10,080	1,008	10	1,008		1,176	9
10	Tile for Wesley I	2011	35,951	3,460	10	3,460		3,460	10
11	TV, computers and printer	2011	4,747	549	5	549		549	11
12	2 Generators	2011	3,068	141	20	141		141	12
13	Hoyer Scale	2011	1,083	103	7	103		103	13
14	Manual Crank Tilt Table	2011	2,146	60	15	60		60	14
15	Commercial Dryer for Laundry	2011	3,678	102	15	102		102	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)		\$ 9,676,204	\$ 241,671		\$ 241,671	\$	\$ 8,323,358	34

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

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:
- *

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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.

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	\$979,613	\$40,077	\$40,077	\$		\$560,532	71
72	Current Year Purchases	28,208	2,803	2,803			2,803	72
73	Fully Depreciated Assets	2,973,448					2,973,448	73
74								74
75	TOTALS	\$3,981,269	\$42,880	\$42,880	\$		\$3,536,783	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 & Prior Fully depr	Various	\$63,726	\$	\$	\$		\$63,726	76
77		See attached - Page 26		164,087	10,643	10,643			124,850	77
78										78
79										79
80	TOTALS			\$227,813	\$10,643	\$10,643	\$		\$188,576	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$14,044,994	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$295,194	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$295,194	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$12,048,717	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	See Attached - Various Years	\$5,041,517	\$138,328	\$2,739,004	86
87					87
88					88
89					89
90					90
91	TOTALS	\$5,041,517	\$138,328	\$2,739,004	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.

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-03	hrs	\$	3,174	\$ 221,892	\$	3,174	\$ 221,892	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		1,973	214,046		1,973	214,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		565	93,517		565	93,517	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				51,130		51,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Oxygen & Char. Supp</u>	39-02					44,014		44,014	13
14	TOTAL			\$	5,712	\$ 529,455	\$ 95,144	5,712	\$ 624,599	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 111,187	\$	1
2	Cash-Patient Deposits	43,575		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,517,416		3
4	Supply Inventory (priced at)	48,176		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,827		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,735,181	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,481,162		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,066,579		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,579,673		16
17	Accumulated Depreciation (book methods)	(16,267,046)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>covenant not to compete</u>	275,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,644,115	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,379,296	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 725,579	\$	26
27	Officer's Accounts Payable	43,575		27
28	Accounts Payable-Patient Deposits	218,128		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,104		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	275,205		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other payables</u>	106,165		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,704,756	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,130,050		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Refundable deposits and fees</u>	145,310		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,275,360	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,980,116	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,399,180	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,379,296	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,438,187	1
2	Restatements (describe):	(3,626)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,434,561	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,035,381)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,035,381)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,399,180	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The United Methodist Village, Inc

0014506

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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

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

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,382,075	1
2	Discounts and Allowances for all Levels	(2,964,476)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,417,599	3
	B. Ancillary Revenue		
4	Day Care	115,999	4
5	Other Care for Outpatients		5
6	Therapy	2,380,666	6
7	Oxygen	135,847	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,632,512	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,700	13
14	Non-Patient Meals	35,964	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	223,756	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,660	19
20	Radiology and X-Ray		20
21	Other Medical Services	365,761	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 658,841	23
	D. Non-Operating Revenue		
24	Contributions	146,584	24
25	Interest and Other Investment Income***	135,986	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 282,570	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>independent living</u>	121,790	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,790	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,113,312	30

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

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,931	2,138	\$ 49,332	\$ 23.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,607	23,408	400,735	17.12	3
4	Licensed Practical Nurses	21,850	23,481	404,190	17.21	4
5	CNAs & Orderlies	66,775	71,413	707,617	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,036	9,964	108,459	10.89	10
11	Social Service Workers	6,096	6,734	76,657	11.38	11
12	Dietician					12
13	Food Service Supervisor	1,756	2,056	32,217	15.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,996	30,847	272,077	8.82	15
16	Dishwashers					16
17	Maintenance Workers	16,420	17,826	245,252	13.76	17
18	Housekeepers	20,066	21,557	205,439	9.53	18
19	Laundry	10,396	12,124	115,519	9.53	19
20	Administrator	1,829	2,080	80,000	38.46	20
21	Assistant Administrator					21
22	Other Administrative	17,430	19,053	183,201	9.62	22
23	Office Manager					23
24	Clerical	12,543	13,580	172,485	12.70	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	9,610	10,594	104,372	9.85	31
32	Other Health Care(specify)					32
33	Other(specify) Chaplin	858	943	10,128	10.74	33
34	TOTAL (lines 1 - 33)	247,199	267,798	\$ 3,167,680 *	\$ 11.83	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	\$ 11,325	1-3	35
36	Medical Director	monthly	9,600	9-3	36
37	Medical Records Consultant	monthly	1,785	10-3	37
38	Nurse Consultant	monthly	3,600	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	810	11-3	44
45	Social Service Consultant	12	810	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	\$ 27,930		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Carol Hawkins Brown	Administrator		\$ 80,000
Other administrative personnel			55,682
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,682
B. Administrative - Other			
Description			Amount
Admin maintenance		\$	0
Volunteer expenses			4,375
Gift Planning			1,230
Other			5,306
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 10,911
C. Professional Services			
Vendor/Payee	Type		Amount
Cox Phillips, Weber Tedford		\$	2,079
Winter Black & Livesay			1,172
Kemper CPA Group			11,157
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,408
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	139,602
Unemployment Compensation Insurance			5,970
FICA Taxes			208,521
Employee Health Insurance			42,259
Employee Meals			2,507
Illinois Municipal Retirement Fund (IMRF)*			
Life Insurance			1,220
401K			22,841
Miscellaneous employee benefits			102,757
TOTAL (agree to Schedule V, line 22, col.8)			\$ 525,677
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			165
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Advertising			25,472
Dues			
Subscriptions			781
Less: Public Relations Expense			(3,600)
Non-allowable advertising			(21,872)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 946
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	2,039
In-State Travel			9,621
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	11,660

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

No
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
12
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 12,739 Line 10-2
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (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.
This amount is to be recorded on line 42 of Schedule V.

\$ 89,243
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

Yes
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Kemper CPA Group LLP

(18)

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

Yes

(19)

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

Breakout of Other General Administrative Expenses

Column 1

Childcare Salaries	127,520
--------------------	---------

Column 2

Child Care Supplies	2,014
---------------------	-------

Column 3

Advertising /Marketing Materials	107
childcare meal cost	623

130,264

Fixed Assets Reconciliation

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

Note: The related facility is required to file a separate cost report with the Department of Healthcare and Family Services.
The related facility is The United Methodist Village North Campus, IDPH #0046656

Fixed Assets Reconciliation

Vehicle Description	Year Acquired	Cost	Current Depreciation	Accumulated Depreciation
Van	2003	\$26,685	\$0	\$26,685
John Deer Tractor	2004	36,884	439	36,884
Oldsmobile Silhouette Van	2004	26,143	933	26,143
Truck	2005	11,782	1,683	10,099
2006 Chevy Silverado	2006	4,673	0	4,673
2008 Ford E250 WC Van	2008	36,878	5,268	14,841
2008 Chevy Van	2009	14,087	1,409	3,757
2000 Ford Taurus	2009	5,551	793	1,652
transmission repair	2011	\$1,404	\$117	\$117
Total to line 79 Page 13		<u>\$164,087</u>	<u>\$10,642</u>	<u>\$124,851</u>

Description	Year	Cost	Current Depreciation	Accumulated Depreciation
Various Fully Depreciated Non-care Assets		\$36,881	\$0	\$36,881
Apts & Cottage Bldgs	1987	1,165,543	23,311	845,597
Apts & Cottage Bldgs	1988	168,658	6,746	296,722
Apts & Cottage Bldgs	1989	93,293	3,787	81,427
McKiou Center	1994	3,177,429	79,436	1,311,228
Apts & Cottage Bldgs	1997	11,707	780	10,535
McKiou Center	2000	9,211	614	6,396
Apts & Cottage Bldgs	2001	58,609	5,387	55,352
Apts & Cottage Bldgs	2002	64,155	4,401	37,139
Apts & Cottage Bldgs	2004	12,940	863	5,393
McKiou Center and Apts	2006	19,174	1,724	8,620
Day Care	2005	22,743	1,516	8,465
Southern Meadows AC upgrade	2008	133,235	2,339	21,670
Roofing for Bldings 18 & 24	2008	14,000	1,400	4,550
Day Care Remodel	2008	3,287	470	1,448
 Southernmeadows A/C Upgrade	 2009	 4,207	 210	 630
Carpet Cottage #3	2009	1,148	230	690
Cabinets for McKiou	2009	1,725	246	595
Upgrades for 1720 17th st	2009	1,321	264	572
appliances for cottages	2010	9,278	843	1,333
Laminate Flooring for cottages	2011	7,612	1,960	1,960
Carpeting for apartments	2011	1,835	122	122
Appliances for Cottages	2011	12,637	590	590
Airconditioning units and installation - So Meadows	2011	10,889	1,089	1,089
Total to 13		<u>\$5,041,517</u>	<u>\$138,328</u>	<u>\$2,739,004</u>

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

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

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

Description	Who Attended	Amount
Red cross Certifications	Nursing staff	1,351.00
Manuals	entire facility	329.00
Heartland Human Services	Social Services	233.00
HFMA	Accounting	137.00
Illinois Department of Public Health	Dietary	140.00
inservice	admissions	160.00
Leavex	entire facility	125.00
Med-Pass, Inc.	Nursing staff	77.00
Webinars	nursing/ administration	420.00
Certifications and license	Social Services	273.00
Certifications and license	Dietary	363.00
Seminar & Workshop Expenses		881.00
Silverchair inservices	Entire facility	2,856.00
		7,345.00

Who Attended	Job Title	Dates	Location	Title of Seminar	Sponsor	Cost
Out of State						
Rose Sepulveda	Finance Director	5/19/2011	St Louis MO	HFMA Education sessions	HFMA	339
Carol Brown/ Steve Blevins	Administrator/maintenance	11/16/2011	Evansville IN	workplace safety	Nat seminar	198
Eunice Glasser	Volunteer coordinator	2/26/2011	San Antonio TX	UMA conference	UMA	1502
Total out of state						2039
In State						
Carol Hawkins	adminsistrator	11/15/2012	books	OSHA	national seminars	796
Carol Brown	Administrator	3/2311/-3/25/11	Chicago IL	Annual conference	LSN	1451
Rose Sepulveda	Finance Director	3/24/11-3/25/11	Collinsville IL	RAC	HFMA	175
directors	directors	9/13/11-9/15/11	East Peoria IL	conference	IHA	2688
Carol wood	soc serv	4/12/2011	Effinham IL	workshop		62
Carol Wood/Vicki Lewis	S Services	11/7/2011	Effinham IL	changes in advanced directives	IHA	290
Rose Sepulveda	Finance Director	11/1/2011	Effinham IL	PPS Final Rule	IHCA	200
Sue Finley	ADON	4/27/2011	Effinham IL	pressure ulcer		21
Hattie Gottfriedt	nurse		Mattoon IL	Alzheimers conference	continuing ed	95
Eunice Glasser	Volunteer coordinator	6/1/11-6/4/11	Peoria IL	United Methodist Conference	UMA	472
Stacey ZellersStephanie Baker	MDS nurse	9/19/11-9/23/11	Schamburg IL	MDS training	Medicare	2,472
carolhawkins/ steve blevins	administrator/maintenance	11/10/2011	Springfield IL	meeting for construction	state of il	66
Ed Lancaster	DON	1/24/2011	Springfield IL			27
Eunice Glasser	Volunteer coordinator	3/11/2011	Springfield IL	golden cross	UMA	11
billing dept		7/8/2011	webinar	upgrades	AOD	99
billing dept		3/4/2011	webinar	upgrades	AOD	50
billing dept		9/8/2011	Webinar	upgrades	AOD	50
Carol Hawkins	administrator	3/15/2011	Webinar	infection control	LSNI	75
Jamie Tussey	Marketing Director	6/14/2011	Webinar	marketing	LSN	149
Rose Sepulveda	Finance Director	6/13/2011	Webinar	Medicare cost report	PPS	175
billing dept		3/4/2011	webinar	upgrades	AOD	99
Freedra Hughes	Admissions		books	Workers comp	Illinois	99
Total In-state						9621
Total Travel						11660