



Facility Name & ID Number The United Methodist Village

# 0014506 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 N/A

	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	165	Skilled (SNF)	165	60,225	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	80	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	245	TOTALS	165	60,225	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					
		2 Medicaid Recipient		3 Private Pay	4 Other		5 Total
8	SNF	15,326	8,852	3,370	27,548	8	
9	SNF/PED					9	
10	ICF	5,978	6,152		12,130	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	21,304	15,004	3,370	39,678	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.88%

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 20 and days of care provided 3,370

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number      The United Methodist Village      #      0014506      Report Period Beginning:      01/01/2006      Ending:      12/31/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	269,110	25,114	15,405	309,629		309,629		309,629		1
2	Food Purchase		232,564		232,564		232,564	(76,466)	156,098		2
3	Housekeeping	176,383	33,354	310	210,047		210,047	(28,470)	181,577		3
4	Laundry	64,661	32,809	226	97,696		97,696		97,696		4
5	Heat and Other Utilities			290,090	290,090		290,090	(204,012)	86,078		5
6	Maintenance	137,984	34,621	60,756	233,361		233,361	(23,683)	209,678		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>648,138</b>	<b>358,462</b>	<b>366,787</b>	<b>1,373,387</b>		<b>1,373,387</b>	<b>(332,631)</b>	<b>1,040,756</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,796,021	1,421	22,914	1,820,356		1,820,356	(12,665)	1,807,691		10
10a	Therapy	73,988		430,539	504,527		504,527		504,527		10a
11	Activities	88,416	7,453	1,428	97,297		97,297		97,297		11
12	Social Services	80,622		2,560	83,182		83,182	(2,664)	80,518		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,039,047</b>	<b>8,874</b>	<b>457,441</b>	<b>2,505,362</b>		<b>2,505,362</b>	<b>(15,329)</b>	<b>2,490,033</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	137,480	96	24,111	161,687		161,687	(34,163)	127,524		17
18	Directors Fees										18
19	Professional Services			64,076	64,076		64,076		64,076		19
20	Dues, Fees, Subscriptions & Promotions			23,675	23,675		23,675	(13,749)	9,926		20
21	Clerical & General Office Expenses	53,363	25,382	148,936	227,681		227,681	(34,595)	193,086		21
22	Employee Benefits & Payroll Taxes			510,223	510,223		510,223	(41,039)	469,184		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,442	12,442		12,442	(134)	12,308		24
25	Other Admin. Staff Transportation			12,790	12,790		12,790	(678)	12,112		25
26	Insurance-Prop.Liab.Malpractice			255,769	255,769		255,769	(19,639)	236,130		26
27	Other (specify):*	146,260	7,949	1,366	155,575		155,575	(155,575)			27
28	<b>TOTAL General Administration</b>	<b>337,103</b>	<b>33,427</b>	<b>1,053,388</b>	<b>1,423,918</b>		<b>1,423,918</b>	<b>(299,572)</b>	<b>1,124,346</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,024,288</b>	<b>400,763</b>	<b>1,877,616</b>	<b>5,302,667</b>		<b>5,302,667</b>	<b>(647,532)</b>	<b>4,655,135</b>		<b>29</b>

\*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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			531,846	531,846		531,846	(137,611)	394,235			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,323	15,323		15,323	(15,323)				32
33	Real Estate Taxes			6,957	6,957		6,957	(6,957)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			554,126	554,126		554,126	(159,891)	394,235			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,911	13,624	248,535		248,535		248,535			39
40	Barber and Beauty Shops	17,989	77	1,018	19,084		19,084	(18,066)	1,018			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,471	84,471		84,471		84,471			42
43	Other (specify):*			4,889	4,889		4,889	(4,889)				43
44	<b>TOTAL Special Cost Centers</b>	17,989	234,988	104,002	356,979		356,979	(22,955)	334,024			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,042,277	635,751	2,535,744	6,213,772		6,213,772	(830,378)	5,383,394			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 The United Methodist Village

# 0014506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(42,521)	02		4
5	Telephone, TV & Radio in Resident Rooms	(22,483)	05		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	(15,323)	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	(13,649)	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 Attached	(736,402)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (830,378)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (830,378)</b>		<b>37</b>

\*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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

## The United Methodist Village

ID# 0014506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

## Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Utility Income	\$ (102,716)	5	1
2	Transportation Reimbursement	(678)	25	2
3	Child Care Salaries	(144,720)	27	3
4	Employee Benefits - Child Care	(26,422)	22	4
5	McKiou	(33)	10	5
6	Child Care Supplies	(7,949)	27	6
7	Child Care Meals	(7,482)	2	7
8	McKiou Food Expense	(16,973)	2	8
9	Bank Charges	(4,331)	21	9
10	Child Care - Education	(134)	24	10
11	Resident Services	(1,664)	12	11
12	Doctor Expense	(1,915)	10	12
13	Hospital Expense	(10,717)	10	13
14	Barber and Beauty	(18,066)	40	14
15	Misc. Income	(23,594)	21	15
16	Insurance Reimbursement	(157)	26	16
17	Marketing Salaries	(16,978)	17	17
18	Chaplin Expenses	(4,889)	43	18
19	Chaplin Salary	(2,906)	27	19
20	Real Estate Taxes	(6,957)	33	20
21	Independent Living Allocation:			21
22	Maintenance	(23,683)	6	22
23	Housekeeping	(28,470)	3	23
24	Dietary	(9,490)	2	24
25	Utilities	(78,813)	5	25
26	Social Services	(1,000)	12	26
27	Administrative	(17,185)	17	27
28	Dues	(100)	20	28
29	Office	(6,670)	21	29
30	Employee Benefits	(14,617)	22	30
31	Insurance	(19,482)	26	31
32	Depreciation	(137,611)	30	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	<b>Total</b>	(736,402)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The United Methodist Village# 0014506 Report Period Beginning:01/01/2006Ending: 12/31/2006**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(76,466)	0	0	0	0	0	0	0	0	0	0	(76,466)	2
3	Housekeeping	(28,470)	0	0	0	0	0	0	0	0	0	0	(28,470)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(204,012)	0	0	0	0	0	0	0	0	0	0	(204,012)	5
6	Maintenance	(23,683)	0	0	0	0	0	0	0	0	0	0	(23,683)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(332,631)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(332,631)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,665)	0	0	0	0	0	0	0	0	0	0	(12,665)	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	(2,664)	0	0	0	0	0	0	0	0	0	0	(2,664)	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	<b>TOTAL Health Care and Programs</b>	<b>(15,329)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15,329)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(34,163)	0	0	0	0	0	0	0	0	0	0	(34,163)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,749)	0	0	0	0	0	0	0	0	0	0	(13,749)	20
21	Clerical & General Office Expenses	(34,595)	0	0	0	0	0	0	0	0	0	0	(34,595)	21
22	Employee Benefits & Payroll Taxes	(41,039)	0	0	0	0	0	0	0	0	0	0	(41,039)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(134)	0	0	0	0	0	0	0	0	0	0	(134)	24
25	Other Admin. Staff Transportation	(678)	0	0	0	0	0	0	0	0	0	0	(678)	25
26	Insurance-Prop.Liab.Malpractice	(19,639)	0	0	0	0	0	0	0	0	0	0	(19,639)	26
27	Other (specify):*	(155,575)	0	0	0	0	0	0	0	0	0	0	(155,575)	27
28	<b>TOTAL General Administration</b>	<b>(299,572)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(299,572)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(647,532)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(647,532)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	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)
	<b>D. Ownership</b>												
30	Depreciation	(137,611)	0	0	0	0	0	0	0	0	0	0	(137,611) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(15,323)	0	0	0	0	0	0	0	0	0	0	(15,323) 32
33	Real Estate Taxes	(6,957)	0	0	0	0	0	0	0	0	0	0	(6,957) 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	<b>TOTAL Ownership</b>	<b>(159,891)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(159,891) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	(18,066)	0	0	0	0	0	0	0	0	0	0	(18,066) 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):*	(4,889)	0	0	0	0	0	0	0	0	0	0	(4,889) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(22,955)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(22,955) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(830,378)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(830,378) 45</b>

Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Village Healthcare Management	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number      The United Methodist Village      #      0014506      Report Period Beginning:      01/01/2006      Ending:      12/31/2006

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	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 The United Methodist Village # 0014506 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

**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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village# 0014506

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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
						Amount of Note	Reporting Period Interest Expense				
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)			
YES	NO										
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
<b>Working Capital</b>											
6	Citizens National Bank	X	Operating Cash		8/4/00	500,000	450,000	8/24/07	7.2500	12,720	6
7	of Albion										7
8											8
9	TOTAL Facility Related					\$ 500,000	\$ 450,000			\$ 12,720	9
<b>B. Non-Facility Related*</b>											
10	Citizens National Bank										10
11	of Albion	X			8/7/06	150,000	43,254	8/7/07	8.5000	2,603	11
12											12
13											13
14	TOTAL Non-Facility Related					\$ 150,000	\$ 43,254			\$ 2,603	14
15	TOTALS (line 9+line14)					\$ 650,000	\$ 493,254			\$ 15,323	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 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 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
<b>FOR BHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The United Methodist Village COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0014506

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

**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 The United Methodist Village# 0014506 Report Period Beginning:01/01/2006 Ending: 12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 66,538 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 3C. 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 ground (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)

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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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		1965	1965	\$ 1,350,000	\$ 27,000	50	\$ 27,000		\$ 1,107,000
5		1974	1974	916,911	18,338	50	18,338		595,712
6		1979	1979	1,228,695	24,574	50	24,574		961,914
7		1925	1925	601,097	15,027	40	15,027		382,656
8									
<b>Improvement Type**</b>									
9	Various Fully Depreciated Assets thru 2006			2,177,240		20			2,177,240
10	Various		1979	117,791	2,612	50	2,612		88,008
11	Various		1980	17,695	354	50	354		9,378
12	Various		1988	1,669	83	20	83		1,544
13	Various		1989	96,708	3,887	20	3,887		68,046
14	Various		1990	610,945	24,341	20	24,341		401,801
15	Various		1991	132,029	5,327	20	5,327		90,715
16	Various		1992	313,917	12,778	20	12,778		185,276
17	Various		1993	119,112	6,175	20	6,175		83,366
18	Various		1994	67,500	3,816	20	3,816		50,803
19	Various		1995	157,262	9,462	20	9,462		108,817
20	Various		1996	315,753	17,476	20	17,476		229,026
21	Various		1997	97,589	8,034	20	8,034		76,320
22	Various		1998	43,649	4,018	20	4,018		33,795
23	Various		1999	13,455	1,021	20	1,021		7,596
24	Various		2000	1,637	109	15	109		753
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	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			\$	\$		\$	\$	\$	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)		\$ 8,380,654	\$ 184,432		\$ 184,432	\$	\$ 6,659,766	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-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	\$ 8,380,654	\$ 184,432		\$ 184,432	\$	\$ 6,659,766		1
2	Electrical Work	2002 1,333	267	5	267		1,333		2
3	Electrical Work	2002 4,410	882	5	882		4,410		3
4	Electrical Work	2002 1,131	226	5	226		1,112		4
5	Wood Flooring	2002 2,279	228	10	228		1,121		5
6	Electrical Work	2002 4,432	886	5	886		4,210		6
7	Electrical Work	2002 1,558	312	5	312		1,480		7
8	Air Conditioners	2002 8,279	828	10	828		3,864		8
9	Air Conditioners	2002 10,292	1,029	10	1,029		4,803		9
10	Concrete Ramp	2002 2,500	167	15	167		764		10
11	Air Conditioners	2002 28,584	2,858	10	2,858		13,101		11
12	Office Remodeling	2002 4,664	666	7	666		2,998		12
13	Air Conditioner Duct Work	2002 6,840	684	10	684		3,078		13
14	Wood and Ceiling Tiles	2002 709	142	5	142		638		14
15	Office Remodeling	2002 2,247	150	15	150		674		15
16	Wiring and Circuit Panels	2002 9,048	452	20	452		1,998		16
17	Office Remodeling	2002 2,138	178	12	178		787		17
18	Phone System	2002 16,783	1,678	10	1,678		7,272		18
19	Phone System	2002 16,783	1,119	15	1,119		4,848		19
20	Air Conditioner	2002 5,835	1,167	5	1,167		5,057		20
21	Office Remodeling	2002 2,378	476	5	476		2,021		21
22	Boiler Removal	2002 14,144	2,829	5	2,829		11,787		22
23	Hvac System	2002 14,126	831	17	831		3,393		23
24	Nurse Call System	2003 43,045	2,870	15	2,870		11,240		24
25	Labor Hrs for Wes Resident Room Remodel	2003 1,638	66	25	66		257		25
26	Labor Hrs for W4S 1 Room Remodel	2003 1,171	47	25	47		180		26
27	Labor Hrs for Break Room Hvac Upg	2003 514	21	25	21		77		27
28	Labor Hours For We Remodel	2003 632	126	5	126		463		28
29	New A/C Installed in McKiou Bldg	2003 2,847	285	10	285		1,044		29
30	Labor Hours For WI Remodel	2003 1,381	276	5	276		990		30
31	Phone System	2003 37,015	3,702	10	3,702		13,264		31
32	Labor Hours For WI Remodel	2003 430	86	5	86		294		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,629,820	\$ 209,966		\$ 209,966	\$	\$ 6,768,324		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12B, Carried Forward	\$ 8,629,820	\$ 209,966		\$ 209,966		\$ 6,768,324		1
2	Labor Hours For WI Remodel	2003 1,003	201	5	201		669		2
3	Labor Hours For WI Remodel	2003 1,047	209	5	209		680		3
4	Labor Hours For WI Remodel	2003 394	79	5	79		243		4
5	Computer System For Phone System	2003 12,500	2,500	5	2,500		10,000		5
6	Phone System	2003 13,614	908	15	908		3,630		6
7	Dycus Auto Door	2003 215	21	10	21		86		7
8	Dycus Auto Door	2003 1,073	153	7	153		600		8
9	Carpet	2003 2,205	441	5	441		1,580		9
10	Flooring for Remodel	2003 2,959	296	10	296		986		10
11	Flooring for Dycus Center	2003 3,448	345	10	345		1,121		11
12	Corner Guard For Dycus Rooms	2003 505	101	5	101		320		12
13	Building Supplies	2004 3,115	208	15	208		485		13
14	Smoke Detectors	2004 2,114	302	7	302		654		14
15	Elevator Floor Lockout	2004 550	110	5	110		229		15
16	Smoke Detectors	2005 807	81	10	81		87		16
17	Handrails	2005 483	32	15	32		43		17
18	Water Heater	2005 4,389	439	10	439		549		18
19	Door Replacement	2005 2,499	250	10	250		500		19
20	Heating and Cooling Unit	2005 1,930	129	15	129		257		20
21	Compressor	2005 2,331	155	15	155		463		21
22	Alarm Keypad	2005 1,661	166	10	166		180		22
23	Ceramic Tile Work	2005 4,903	490	10	490		940		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)	\$ 8,693,565	\$ 217,582		\$ 217,582		\$ 6,792,626		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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 12C, Carried Forward		\$ 8,693,565	\$ 217,582		\$ 217,582	\$	\$ 6,792,626	1
2	Fire Alarm	2005	2,351	235	10	235		431	2
3	Wall Cabinets	2005	1,320	132	10	132		264	3
4	Entrance Door	2005	1,865	187	10	187		326	4
5	Therapy Remodel Project	2005	272	54	5	54		82	5
6	Sidewalk and Ramp	2005	5,000	333	15	333		556	6
7	Sidewalk and Ramp	2005	6,000	667	9	667		1,056	7
8	Roof and Installation Work	2005	76,950	7,695	10	7,695		12,184	8
9	Water Furnace	2006	1,944	130	15	130		130	9
10	Carpet	2006	841	154	5	154		154	10
11	Hallway Tile	2006	3,399	312	10	312		312	11
12	Handrails	2006	553	31	15	31		31	12
13	Geothermal System	2006	1,686	126	10	126		126	13
14	Water Meter	2006	2,194	73	20	73		73	14
15	Locks for outside entrance	2006	10,377	692	10	692		692	15
16	Smoke Detectors	2006	17,751	1,183	10	1,183		1,183	16
17	Mig Welder	2006	530	31	10	31		31	17
18	T-1 Computer Line and Equipment	2006	7,752	904	5	904		904	18
19	Boiler Repair	2006	11,590	366	15	366		366	19
20	Tile floor in Dietary	2006	9,952	415	10	415		415	20
21	4 Water Furnaces	2006	7,331	305	10	305		305	21
22	Air Conditioner	2006	633	21	10	21		21	22
23	Washer for Laundry Department	2006	9,379	156	15	156		156	23
24	Pellet Heater for Dietary	2006	2,659	66	10	66		66	24
25	Water Softner	2006	2,925	24	10	24		24	25
26	Carbon Monoxide Detector	2006	2,139	18	10	18		18	26
27	Dycus Remodel	2006	12,514	313	10	313		313	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,893,472	\$ 232,205		\$ 232,205	\$	\$ 6,812,845	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,548,592	\$ 134,142	\$ 134,142	\$		\$ 1,082,874	71
72	Current Year Purchases	106,149	5,320	5,320			5,320	72
73	Fully Depreciated Assets	2,581,394					2,581,394	73
74								74
75	TOTALS	\$ 4,236,135	\$ 139,462	\$ 139,462	\$		\$ 3,669,588	75

D. Vehicle Depreciation (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	\$ 63,036	\$	\$			\$ 63,036	76
77		See Attached	Various	142,800	20,842	20,842			47,711	77
78		Current Year Disposed	Various		1,726	1,726				78
79										79
80	TOTALS			\$ 205,836	\$ 22,568	\$ 22,568	\$		\$ 110,747	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)	\$ 13,495,151 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 394,235 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 394,235 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)	\$ 10,593,180 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	\$ 4,996,096	\$ 135,826	\$ 2,059,896	86
87	Removed House on 16th Street	4,499	900	3,299	87
88	Day Care - 2005	22,743	885	2,401	88
89					89
90					90
91	TOTALS	\$ 5,023,338	\$ 137,611	\$ 2,065,596	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95			95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

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.	_____/2007	\$ _____
13.	_____/2008	\$ _____
14.	_____/2009	\$ _____

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)

\* 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.

**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	<b>TOTAL</b>		\$	\$	21

**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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a-03	8905	hrs	\$ 133,595					8,905	\$ 133,595	1
2	Licensed Speech and Language Development Therapist	10a-03	4335	hrs	73,966					4,335	73,966	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a-03	8654	hrs	222,979					8,654	222,979	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 prescripts				95,772			95,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify): <u>Oxygen &amp; Chr. Supplies</u>							127,222			127,222	13
14	<b>TOTAL</b>				\$ 430,540		\$	\$ 222,994		21,894	\$ 653,534	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

Page 17

Facility Name &amp; ID Number The United Methodist Village

# 0014506

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,693	\$	1
2	Cash-Patient Deposits	44,053		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,850,432		3
4	Supply Inventory (priced at )	38,168		4
5	Short-Term Investments	22,098		5
6	Prepaid Insurance	32,712		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,989,156	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,780,582		12
13	Land	509,708		13
14	Buildings, at Historical Cost	18,243,786		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,977,305		16
17	Accumulated Depreciation (book methods)	(13,067,951)		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>	716,667		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 18,160,097	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 20,149,253	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 367,574	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120,765		28
29	Short-Term Notes Payable	493,254		29
30	Accrued Salaries Payable	201,352		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,744		32
33	Accrued Interest Payable			33
34	Deferred Compensation	121,237		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Payables</u>	373,352		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,780,278	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,578,714		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Refundable deposits and entrance fee</u>	349,901		43
44	<u>Other Long-Term Payables</u>	124,762		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,053,377	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,833,655	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 12,315,598	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 20,149,253	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,861,896	1
2	Restatements (describe):		2
3	Equity Restatement: See Pg. 26	173,359	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,035,255	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	280,343	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)	\$ 280,343	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 12,315,598	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number The United Methodist Village

# 0014506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,295,870	1
2	Discounts and Allowances for all Levels	(3,339,514)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,956,356	3
<b>B. Ancillary Revenue</b>			
4	Day Care	101,565	4
5	Other Care for Outpatients		5
6	Therapy	1,952,682	6
7	Oxygen	120,037	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,174,284	8
<b>C. Other Operating Revenue</b>			
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	40,527	13
14	Non-Patient Meals	51,538	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	564,000	16
17	Sale of Drugs	156,440	17
18	Sale of Supplies to Non-Patients	36,580	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	401,442	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,250,527	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	94,172	24
25	Interest and Other Investment Income***	994,832	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,089,004	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	213,667	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 213,667	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,683,838	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,373,387	31
32	Health Care	2,492,162	32
33	General Administration	1,437,118	33
<b>B. Capital Expense</b>			
34	Ownership	554,126	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	272,508	35
36	Provider Participation Fee	84,471	36
<b>D. Other Expenses (specify):</b>			
37	Expenses reported on related party cost report (see pg. 26)	4,189,723	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,403,495	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	280,343	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 280,343	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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	2,893	2,997	\$ 75,089	\$ 25.05	1
2	Assistant Director of Nursing	1,920	1,984	43,523	21.94	2
3	Registered Nurses	21,505	19,950	363,825	18.24	3
4	Licensed Practical Nurses	24,310	24,878	390,953	15.71	4
5	CNAs & Orderlies	86,859	88,912	808,485	9.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,139	7,290	74,028	10.15	8
9	Activity Director					9
10	Activity Assistants	10,894	11,237	88,938	7.91	10
11	Social Service Workers	7,828	8,050	81,327	10.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,467	35,199	269,635	7.66	15
16	Dishwashers					16
17	Maintenance Workers	14,994	15,482	138,984	8.98	17
18	Housekeepers	23,373	23,889	176,568	7.39	18
19	Laundry	7,764	8,020	63,685	7.94	19
20	Administrator	8,439	8,663	136,666	15.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,041	5,229	52,425	10.03	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	14,151	14,552	116,171	7.98	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty & Child Care	20,737	21,311	161,975	7.60	33
34	TOTAL (lines 1 - 33)	292,314	297,643	\$ 3,042,277 *	\$ 10.22	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	232	\$ 11,929	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	2,785	10-03	37
38	Nurse Consultant	Monthly	13,200	10-03	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	27	1,390	11-03	44
45	Social Service Consultant	25	1,238	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	\$ 30,542		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

SEE ACCOUNTANTS' COMPILATION REPORT



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010	14 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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 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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,405 Line 39-2
- (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. \$ 84,471  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 13 Line 79 Vehicles  
12/31/2006

<u>Model, Make</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Depreciation</u>	<u>Accumulated Depreciation</u>
2002 Pickup	2002	690	138	598
Van	2003	26,685	3,812	12,707
John Deer Tractor	2004	36,884	5,269	15,368
Oldsmobile Silhouette Van	2004	26,143	3,734	10,270
Truck	2005	11,782	1,683	1,683
Wheelchair Van	2005	35,943	5,135	6,014
2006 Chevy Siverado	2006	4,673	1,071	1,071
Total to line 79 Page 13		<u>142,800</u>	<u>20,842</u>	<u>47,711</u>

Description of Non Care Assets and Depreciation

Description	<u>Year</u>	<u>Cost</u>	<u>Depreciation</u>	<u>Accumulated Depreciation</u>
Apts & Cottage Bldgs	1987	1,165,543	23,311	752,353
Apts & Cottage Bldgs	1988	168,658	6,746	124,807
Apts & Cottage Bldgs	1989	93,293	3,787	66,279
Apts & Cottage Bldgs	1992	14,492	580	8,406
McKiou Center	1994	3,177,429	79,436	993,484
Apts & Cottage Bldgs	1997	11,707	780	7,415
Apts & Cottage Bldgs	1998	50,680	5,068	43,079
McKiou Center	2000	9,211	614	3,940
Apts & Cottage Bldgs	2001	58,609	5,387	33,804
Apts & Cottage Bldgs	2002	64,155	4,401	19,535
Apts & Cottage Bldgs	2004	12,940	863	1,941
1 Locust Lane	2006	150,205	3,129	3,129
McKiou Center & Apts	2006	19,174	1,724	1,724
Total to Page 13		<u>4,996,096</u>	<u>135,826</u>	<u>2,059,896</u>

**Equity Restatement pg. 18**

In previous years The United Methodist Villiage and a related facility, which files a separate cost report, had kept separate balance sheet accounts. This is no longer the case. Therefore we have to show an Equity Restatement of \$11,759,048 to properly report financial information.

**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 must report revenue and expenses of a related party to present balanced financial statements.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building &amp; Improvements</u>	<u>Equipment and Vehciles</u>	<u>Total</u>
Schedule XI Ownership Cost	\$ 159,708	\$ 8,893,472	\$ 4,441,971	\$ 13,495,151
Related Facility	350,000	4,049,874	811,596	5,211,470
Non-care Assets	-	5,023,338	-	5,023,338
Reclassification for reporting of Ownership Cost	<u>-</u>	<u>277,102</u>	<u>(276,262)</u>	<u>840</u>
Schedule XV Balance Sheet	<u><u>\$ 509,708</u></u>	<u><u>\$ 18,243,786</u></u>	<u><u>\$ 4,977,305</u></u>	<u><u>\$ 23,730,799</u></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 Village Health Management, LLC, IDPH # 0046656.

Note: The assets, accumulated depreciation, and depreciaiton expense have been adjusted from prior year to properly report ownership cost based on depreciation schedules maintained by the United Methodist Village, Inc.