

Facility Name & ID Number The United Methodist Village

0014506 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	165	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,859	9,138	3,537	27,534	8
9	SNF/PED					9
10	ICF	4,541	7,380		11,921	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,400	16,518	3,537	39,455	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.51%

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 3,537

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	311,282	25,812	19,668	356,762		356,762		356,762		1
2	Food Purchase		260,289		260,289		260,289	(77,371)	182,918		2
3	Housekeeping	196,340	30,019		226,359		226,359	(32,850)	193,509		3
4	Laundry	127,472	35,852	21	163,345		163,345		163,345		4
5	Heat and Other Utilities			397,313	397,313		397,313	(184,776)	212,537		5
6	Maintenance	186,925	81,714	46,921	315,560		315,560	(25,556)	290,004		6
7	Other (specify):*										7
8	TOTAL General Services	822,019	433,686	463,923	1,719,628		1,719,628	(320,553)	1,399,075		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,011,376	2,920	24,522	2,038,818		2,038,818	(25,733)	2,013,085		10
10a	Therapy			445,897	445,897		445,897		445,897		10a
11	Activities	97,575	4,301	1,922	103,798		103,798		103,798		11
12	Social Services	74,430		3,460	77,890		77,890	(1,349)	76,541		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,183,381	7,221	475,801	2,666,403		2,666,403	(27,082)	2,639,321		16
	C. General Administration										
17	Administrative	109,834	116	19,493	129,443		129,443	(33,167)	96,276		17
18	Directors Fees										18
19	Professional Services			27,756	27,756		27,756		27,756		19
20	Dues, Fees, Subscriptions & Promotions			29,201	29,201		29,201	(14,831)	14,370		20
21	Clerical & General Office Expenses	177,299	29,826	111,408	318,533		318,533	(12,663)	305,870		21
22	Employee Benefits & Payroll Taxes			559,341	559,341		559,341	(9,883)	549,458		22
23	Inservice Training & Education			23,859	23,859		23,859	(1,989)	21,870		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,648	7,648		7,648	(900)	6,748		25
26	Insurance-Prop.Liab.Malpractice			168,988	168,988		168,988	(3,546)	165,442		26
27	Other (specify):* See Attachment	175,433	6,269	2,235	183,937		183,937	(181,703)	2,234		27
28	TOTAL General Administration	462,566	36,211	949,929	1,448,706		1,448,706	(258,682)	1,190,024		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,467,966	477,118	1,889,653	5,834,737		5,834,737	(606,317)	5,228,420		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The United Methodist Village

#0014506

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			544,336	544,336		544,336	(155,770)	388,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,447	7,447		7,447	(7,447)				32
33	Real Estate Taxes			4,824	4,824		4,824	(4,824)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			556,607	556,607		556,607	(168,041)	388,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,087	26,421	297,508		297,508		297,508			39
40	Barber and Beauty Shops	19,208	10	987	20,205		20,205	(19,218)	987			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,846	97,846		97,846		97,846			42
43	Other (specify):* Chaplain Expense			4,510	4,510		4,510	(4,510)				43
44	TOTAL Special Cost Centers	19,208	271,097	129,764	420,069		420,069	(23,728)	396,341			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,487,174	748,215	2,576,024	6,811,413		6,811,413	(798,086)	6,013,327			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(43,217)	02		4
5	Telephone, TV & Radio in Resident Rooms	(23,814)	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	(7,447)	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	(14,731)	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 <u>Miscellaneous</u>	(708,877)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (798,086)		\$	30

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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (798,086)		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	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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

The United Methodist Village

ID# 0014506

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Utility Income	\$ (100,662)	5	1
2	Transportation Reimbursement	(900)	25	2
3	Child Care Salaries	(166,525)	27	3
4				4
5	Bank Charges	(27)	21	5
6	Child Care Supplies	(6,269)	27	6
7	Child Care Meals	(5,525)	2	7
8	McKiou Food Expense	(17,679)	2	8
9	Bank Charges	(5,172)	21	9
10	Child Care - Education	(1,989)	23	10
11	Resident Services	(349)	12	11
12	Doctor Expense	(6,528)	10	12
13	Hospital Expense	(19,205)	10	13
14	Barber and Beauty	(19,218)	40	14
15	Misc. Income	(794)	21	15
16				16
17	Marketing Salaries	(15,982)	17	17
18	Chaplin Expenses	(4,510)	43	18
19	Chaplin Salary	(8,909)	27	19
20	Real Estate Taxes	(4,824)	33	20
21	Independent Living Allocation:			21
22	Maintenance	(25,556)	6	22
23	Housekeeping	(32,850)	3	23
24	Dietary	(10,950)	2	24
25	Utilities	(60,300)	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	(9,883)	22	30
31	Insurance	(3,546)	26	31
32	Depreciation	(155,770)	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	Total	(708,877)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(77,371)	0	0	0	0	0	0	0	0	0	0	(77,371)	2
3	Housekeeping	(32,850)	0	0	0	0	0	0	0	0	0	0	(32,850)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(184,776)	0	0	0	0	0	0	0	0	0	0	(184,776)	5
6	Maintenance	(25,556)	0	0	0	0	0	0	0	0	0	0	(25,556)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(320,553)	0	0	0	0	0	0	0	0	0	0	(320,553)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(25,733)	0	0	0	0	0	0	0	0	0	0	(25,733)	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	(1,349)	0	0	0	0	0	0	0	0	0	0	(1,349)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(27,082)	0	0	0	0	0	0	0	0	0	0	(27,082)	16
	C. General Administration													
17	Administrative	(33,167)	0	0	0	0	0	0	0	0	0	0	(33,167)	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	(14,831)	0	0	0	0	0	0	0	0	0	0	(14,831)	20
21	Clerical & General Office Expenses	(12,663)	0	0	0	0	0	0	0	0	0	0	(12,663)	21
22	Employee Benefits & Payroll Taxes	(9,883)	0	0	0	0	0	0	0	0	0	0	(9,883)	22
23	Inservice Training & Education	(1,989)	0	0	0	0	0	0	0	0	0	0	(1,989)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(900)	0	0	0	0	0	0	0	0	0	0	(900)	25
26	Insurance-Prop.Liab.Malpractice	(3,546)	0	0	0	0	0	0	0	0	0	0	(3,546)	26
27	Other (specify):*	(181,703)	0	0	0	0	0	0	0	0	0	0	(181,703)	27
28	TOTAL General Administration	(258,682)	0	0	0	0	0	0	0	0	0	0	(258,682)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(606,317)	0	0	0	0	0	0	0	0	0	0	(606,317)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The United Methodist Village# 0014506

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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)
	D. Ownership												
30	Depreciation	(155,770)	0	0	0	0	0	0	0	0	0	0	(155,770) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(7,447)	0	0	0	0	0	0	0	0	0	0	(7,447) 32
33	Real Estate Taxes	(4,824)	0	0	0	0	0	0	0	0	0	0	(4,824) 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(168,041)	0	0	0	0	0	0	0	0	0	0	(168,041) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	(19,218)	0	0	0	0	0	0	0	0	0	0	(19,218) 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):*	(4,510)	0	0	0	0	0	0	0	0	0	0	(4,510) 43
44	TOTAL Special Cost Centers	(23,728)	0	0	0	0	0	0	0	0	0	0	(23,728) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(798,086)	0	0	0	0	0	0	0	0	0	0	(798,086) 45

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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
The United Methodist Village, Inc.	100%	United Methodist Village North Campus	Lawrenceville, IL			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007 Ending: 2/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Citizens National Bank of Albion		X	Operating Cash		08/24/06	500,000	100,000	08/24/2008	7.2500	8,346	6
7												7
8												8
9	TOTAL Facility Related						\$ 500,000	\$ 100,000			\$ 8,346	9
	B. Non-Facility Related*											
10	Citizens National Bank of Albion		X	Administrator Housing		08/07/06	150,000		08/07/2007	8.5000	322	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 150,000	\$			\$ 322	14
15	TOTALS (line 9+line14)						\$ 650,000	\$ 100,000			\$ 8,668	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 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 Cos

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2006

(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 Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2007

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 Brick Frame _____ Number of Stories 3

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>631,620</u>	<u>1924</u>	<u>\$ 96,018</u>	<u>1</u>
2		<u>572,380</u>	<u>1987, 1989</u>	<u>63,690</u>	<u>2</u>
3	TOTALS	1,204,000		\$ 159,708	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$	\$ 1,134,000	4
5			1974	1974	916,911	18,338	50	18,338		614,050	5
6			1979	1979	1,228,695	24,574	50	24,574		986,488	6
7			1925	1925	601,097	15,027	40	15,027		397,683	7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets thru 2007				2,184,114		20			2,184,114	9
10	Various		1979		117,791	2,612	50	2,612		90,620	10
11	Various		1980		17,695	354	50	354		9,732	11
12	Various		1988		1,669	83	20	83		1,627	12
13	Various		1989		96,708	3,887	20	3,887		71,933	13
14	Various		1990		610,945	24,341	20	24,341		426,142	14
15	Various		1991		132,029	5,327	20	5,327		96,042	15
16	Various		1992		313,917	12,778	20	12,778		198,054	16
17	Various		1993		119,112	6,175	20	6,175		89,541	17
18	Various		1994		67,500	3,816	20	3,816		54,619	18
19	Various		1995		157,262	9,462	20	9,462		118,279	19
20	Various		1996		315,753	17,476	20	17,476		246,502	20
21	Various		1997		97,589	8,034	20	8,034		84,354	21
22	Various		1998		43,649	4,018	20	4,018		37,813	22
23	Various		1999		13,455	1,021	20	1,021		8,617	23
24	Various		2000		1,637	109	15	109		862	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	Wood Flooring	2002	2,279	228	10	228	1,349	38
39	Electrical Work	2002	4,432	222	5	222	4,432	39
40	Electrical Work	2002	1,558	78	5	78	1,558	40
41	Air Conditioners	2002	8,279	828	10	828	4,692	41
42	Air Conditioners	2002	10,292	1,029	10	1,029	5,832	42
43	Concrete Ramp	2002	2,500	167	15	167	931	43
44	Air Conditioners	2002	28,584	2,858	10	2,858	15,959	44
45	Office Remodeling	2002	4,664	666	7	666	3,664	45
46	Air Conditioner Duct Work	2002	6,840	684	10	684	3,762	46
47	Wood and Ceiling Tiles	2002	709	71	5	71	709	47
48	Office Remodeling	2002	2,247	150	15	150	824	48
49	Wiring and Circuit Panels	2002	9,048	452	20	452	2,450	49
50	Office Remodeling	2002	2,138	178	12	178	965	50
51	Phone System	2002	16,783	1,678	10	1,678	8,950	51
52	Phone System	2002	16,783	1,119	15	1,119	5,967	52
53	Air Conditioner	2002	5,835	778	5	778	5,835	53
54	Office Remodeling	2002	2,378	357	5	357	2,378	54
55	Boiler Removal	2002	14,144	2,357	5	2,357	14,144	55
56	Hvac System	2002	14,126	831	17	831	4,224	56
57	Nurse Call System	2003	43,045	2,870	15	2,870	14,110	57
58	Labor Hrs for Wes Resident Room Remodel	2003	1,638	66	25	66	323	58
59	Labor Hrs for W4S 1 Room Remodel	2003	1,171	47	25	47	227	59
60	Labor Hrs for Break Room Hvac Upg	2003	514	21	25	21	98	60
61	Labor Hours For We Remodel	2003	632	126	5	126	589	61
62	New A/C Installed in McKiou Bldg	2003	2,847	285	10	285	1,329	62
63	Labor Hours For WI Remodel	2003	1,381	276	5	276	1,266	63
64	Phone System	2003	37,015	3,702	10	3,702	16,966	64
65	Labor Hours For WI Remodel	2003	430	86	5	86	380	65
66	Labor Hours For WI Remodel	2003	1,003	201	5	201	870	66
67	Labor Hours For WI Remodel	2003	1,047	209	5	209	889	67
68	Labor Hours For WI Remodel	2003	394	79	5	79	322	68
69								69
70	TOTAL (lines 4 thru 69)		\$ 8,632,264	\$ 207,131		\$ 207,131	\$ 6,977,066	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 8,632,264	\$ 207,131		\$ 207,131	\$	\$ 6,977,066	1
2	Computer System For Phone System	2003	12,500	2,500	5	2,500		12,500	2
3	Phone System	2003	13,614	908	15	908		4,538	3
4	Dycus Auto Door	2003	215	21	10	21		107	4
5	Dycus Auto Door	2003	1,073	153	7	153		753	5
6	Carpet	2003	2,205	441	5	441		2,021	6
7	Flooring for Remodel	2003	2,959	296	10	296		1,282	7
8	Flooring for Dycus Center	2003	3,448	345	10	345		1,466	8
9	Corner Guard For Dycus Rooms	2003	505	101	5	101		421	9
10	Building Supplies	2004	3,115	208	15	208		693	10
11	Smoke Detectors	2004	2,114	302	7	302		956	11
12	Elevator Floor Lockout	2004	550	110	5	110		339	12
13	Smoke Detectors	2005	807	81	10	81		168	13
14	Handrails	2005	483	32	15	32		75	14
15	Water Heater	2005	4,389	439	10	439		988	15
16	Door Replacement	2005	2,499	250	10	250		750	16
17	Heating and Cooling Unit	2005	1,930	129	15	129		386	17
18	Compressor	2005	2,331	155	15	155		618	18
19	Alarm Keypad	2005	1,661	166	10	166		346	19
20	Ceramic Tile Work	2005	4,903	490	10	490		1,430	20
21	Fire Alarm	2005	2,351	235	10	235		666	21
22	Wall Cabinets	2005	1,320	132	10	132		396	22
23	Entrance Door	2005	1,865	187	10	187		513	23
24	Therapy Remodel Project	2005	272	54	5	54		136	24
25	Sidewalk and Ramp	2005	5,000	333	15	333		889	25
26	Sidewalk and Ramp	2005	6,000	667	9	667		1,723	26
27	Roof and Installation Work	2005	76,950	7,695	10	7,695		19,879	27
28	Water Furnace	2006	1,944	130	15	130		260	28
29	Carpet	2006	841	168	5	168		322	29
30	Hallway Tile	2006	3,399	340	10	340		652	30
31	Handrails	2006	553	31	15	31		68	31
32	Geothermal System	2006	1,686	169	10	169		295	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,795,746	\$ 224,399		\$ 224,399	\$	\$ 7,032,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 8,795,746	\$ 224,399		\$ 224,399	\$	\$ 7,032,702	1
2	Water Meter	2006	2,194	110	20	110		183	2
3	Locks for outside entrance	2006	10,377	1,038	10	1,038		1,730	3
4	Smoke Detectors	2006	17,751	1,775	10	1,775		2,958	4
5	Mig Welder	2006	530	53	10	53		84	5
6	T-1 Computer Line and Equipment	2006	7,752	1,550	5	1,550		2,454	6
7	Boiler Repair	2006	11,590	773	15	773		1,139	7
8	Tile floor in Dietary	2006	9,952	995	10	995		1,410	8
9	4 Water Furnaces	2006	7,331	733	10	733		1,038	9
10	Air Conditioner	2006	633	63	10	63		84	10
11	Washer for Laundry Department	2006	9,379	625	15	625		781	11
12	Pellet Heater for Dietary	2006	2,659	266	10	266		332	12
13	Water Softner	2006	2,925	293	10	293		317	13
14	Carbon Monoxide Detector	2006	2,139	214	10	214		232	14
15	Dycus Remodel	2006	12,514	1,251	10	1,251		1,564	15
16	Sidewalk	2007	560	28	15	28		28	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)		\$ 8,894,032	\$ 234,166		\$ 234,166	\$	\$ 7,047,036	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 1,551,219	\$ 136,346	\$ 136,346			\$ 1,119,879	71
72	Current Year Purchases	150,896	10,714	10,714			10,714	72
73	Fully Depreciated Assets	2,686,030					2,686,030	73
74								74
75	TOTALS	\$ 4,388,145	\$ 147,060	\$ 147,060	\$		\$ 3,816,623	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	20,894	20,894			68,605	77
78										78
79										79
80	TOTALS			\$ 205,836	\$ 20,894	\$ 20,894	\$		\$ 131,641	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,647,721	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 402,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 402,120	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)	\$ 10,995,300	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	\$ 5,022,488	\$ 142,216	\$ 2,199,020	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 5,022,488	\$ 142,216	\$ 2,199,020	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	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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The United Methodist Village # 0014506 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$	1,831	\$ 165,259	\$	1,831	\$ 165,259	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		411	51,354		411	51,354	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		2,348	229,283		2,348	229,283	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				79,108		79,108	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 and Chr. Supp</u>	39-02					148,524		148,524	13
14	TOTAL			\$	4,590	\$ 445,896	\$ 227,632	4,590	\$ 673,528	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

Facility Name & ID Number The United Methodist Village# 0014506Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007 (last day of reporting year)

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	\$ 211,897	\$	1
2	Cash-Patient Deposits	57,245		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 40,000)	1,600,955		3
4	Supply Inventory (priced at)	42,427		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,747		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)	\$ 1,922,271	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,327,172		12
13	Land	509,708		13
14	Buildings, at Historical Cost	18,252,863		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,208,939		16
17	Accumulated Depreciation (book methods)	(13,760,220)		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):	616,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,155,129	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,077,400	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 700,361	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,245		28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	229,563		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation	120,757		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Payables</u>	372,662		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,681,588	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,355,438		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Refundable deposits and entrance fee</u>	249,694		43
44	<u>Other Long-Term Payables</u>	113,038		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,718,170	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,399,758	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 11,677,642	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,077,400	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,315,598	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 12,315,598	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(637,956)	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)	\$ (637,956)	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)	\$ 11,677,642	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village# 0014506Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,522,032	1
2	Discounts and Allowances for all Levels	(3,287,197)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,234,835	3
B. Ancillary Revenue			
4	Day Care	89,142	4
5	Other Care for Outpatients		5
6	Therapy	2,214,735	6
7	Oxygen	118,436	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,422,313	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	22,947	13
14	Non-Patient Meals	49,981	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	183,422	17
18	Sale of Supplies to Non-Patients	38,856	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	409,033	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 704,239	23
D. Non-Operating Revenue			
24	Contributions	148,756	24
25	Interest and Other Investment Income***	353,552	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 502,308	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	111,288	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 111,288	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,974,983	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,719,628	31
32	Health Care	2,666,403	32
33	General Administration	1,448,706	33
B. Capital Expense			
34	Ownership	556,607	34
C. Ancillary Expense			
35	Special Cost Centers	322,224	35
36	Provider Participation Fee	97,846	36
D. Other Expenses (specify):			
37	<u>Expenses reported on related party cost report (see pg. 26)</u>	3,801,525	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,612,939	40
41	Income before Income Taxes (line 30 minus line 40)**	(637,956)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (637,956)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete 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:

01/01/2007

Ending:

12/31/2007

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	8,624	9,640	\$ 190,972	\$ 19.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,930	12,567	229,099	18.23	3
4	Licensed Practical Nurses	30,501	32,521	525,620	16.16	4
5	CNAs & Orderlies	91,999	98,526	932,207	9.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,715	11,598	97,575	8.41	10
11	Social Service Workers	6,659	7,136	74,430	10.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,254	37,622	311,282	8.27	15
16	Dishwashers					16
17	Maintenance Workers	17,647	18,939	186,925	9.87	17
18	Housekeepers	23,656	25,227	196,340	7.78	18
19	Laundry	13,095	14,743	127,472	8.65	19
20	Administrator	2,080	2,080	72,500	34.86	20
21	Assistant Administrator					21
22	Other Administrative	10,156	10,980	174,995	15.94	22
23	Office Manager					23
24	Clerical	4,582	4,897	39,638	8.09	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	14,547	15,711	133,478	8.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beauty & Child Ca</u>	22,286	24,119	194,641	8.07	33
34	TOTAL (lines 1 - 33)	303,731	326,306	\$ 3,487,174 *	\$ 10.69	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	240	\$ 12,588	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	3,060	10-03	37
38	Nurse Consultant	Monthly	12,100	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	17	1,166	11-03	44
45	Social Service Consultant	23	1,608	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	\$ 30,522		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

Facility Name & ID Number The United Methodist Village

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,368 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. \$ 97,846
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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? Yes If no, please explain. _____
- (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 - Schedule XI Ownership Cost, Item D Vehicle Depreciation, Line 79

<u>Model, Make</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Depreciation</u>	<u>Accumulated Depreciation</u>
2002 Pickup	2002	690	92	690
Van	2003	26,685	3,812	16,519
John Deer Tractor	2004	36,884	5,269	20,637
Oldsmobile Silhouette Van	2004	26,143	3,735	14,005
Truck	2005	11,782	1,683	3,366
Wheelchair Van	2005	35,943	5,135	11,149
2006 Chevy Siverado	2006	4,673	1,168	2,239
Total to line 79 Page 13		<u>142,800</u>	<u>20,894</u>	<u>68,605</u>

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

Description of Non Care Assets and Depreciation

<u>Description</u>	<u>Year</u>	<u>Cost</u>	<u>Depreciation</u>	<u>Accumulated Depreciation</u>	
Apts & Cottage Bldgs	1987	1,165,543	23,311	775,664	
Apts & Cottage Bldgs	1988	168,658	6,746	131,553	
Apts & Cottage Bldgs	1989	93,293	3,787	70,066	
Apts & Cottage Bldgs	1992	14,492	386	8,792	Disposed
McKiou Center	1994	3,177,429	79,436	1,072,920	
Apts & Cottage Bldgs	1997	11,707	780	8,195	
Apts & Cottage Bldgs	1998	50,680	5,068	48,147	
McKiou Center	2000	9,211	614	4,554	
Apts & Cottage Bldgs	2001	58,609	5,387	39,191	
Apts & Cottage Bldgs	2002	64,155	4,401	23,936	
Apts & Cottage Bldgs	2004	12,940	863	2,804	
1 Locust Lane	2006	150,205	3,129	6,258	
McKiou Center & Apts	2006	19,174	1,724	3,448	
Removed house on 16th st	2003	4,499	900	4,199	
Day Care	2005	22,743	1,516	3,917	
Roofing for 1 Locust Lane	2007	13,642	796	796	
Reporting Reclassification			3,372	3,372	
Subtotal		<u>5,036,980</u>	<u>142,216</u>	<u>2,207,812</u>	
1 Disposal		(14,492)	-	(8,792)	
Total to Page 13		<u><u>5,022,488</u></u>	<u><u>142,216</u></u>	<u><u>2,199,020</u></u>	

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.

Page 12 - 13 - Schedle XI Ownership Cost

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment and Vehciles</u>	<u>Total</u>
Schedule XI Ownership Cost	\$ 159,708	\$ 8,894,032	\$ 4,593,981	\$ 13,647,721
Related Facility	350,000	4,105,072	845,389	5,300,461
Non-care Assets	-	5,022,488	-	5,022,488
Reclassification for reporting of Ownership Cost	-	231,271	(230,431)	840
Schedule XV Balance Sheet	<u>\$ 509,708</u>	<u>\$ 18,252,863</u>	<u>\$ 5,208,939</u>	<u>\$ 23,971,510</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.

Page 15, XIII. Expenses Relating to Certified Nurse AIDE Training Programs

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

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

Breakout of Other General Administrative Expenses

Column 1

Chaplain and Childcare Salaries	175,433
---------------------------------	---------

Column 2

Child Care Supplies	6,269
---------------------	-------

Column 3

Child Care Repairs and Maintenance	312
------------------------------------	-----

Auxillary Purchases	1,575
---------------------	-------

Resident Services Purchases	349
-----------------------------	-----

<u>2,235</u>
