

Facility Name & ID Number METHODIST HOME# 0005439 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 02/05/08

	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	<u>111</u>	Skilled (SNF)	<u>126</u>	<u>45,591</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>10</u>	Intermediate (ICF)	<u>0</u>	<u>350</u>	3
4		Intermediate/DD			4
5	<u>12</u>	Sheltered Care (SC)	<u>0</u>	<u>420</u>	5
6		ICF/DD 16 or Less			6
7	<u>133</u>	TOTALS	<u>126</u>	<u>46,361</u>	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	<u>17,615</u>	<u>11,794</u>	<u>6,943</u>	<u>36,352</u>	8
9	SNF/PED					9
10	ICF	<u>206</u>	<u>35</u>		<u>241</u>	10
11	ICF/DD					11
12	SC	<u>4</u>	<u>159</u>		<u>163</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,825</u>	<u>11,988</u>	<u>6,943</u>	<u>36,756</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.28%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

Senior FitnessF. 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 1898

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 126 and days of care provided 6,663Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	339,166	33,720	122,794	495,680		495,680		495,680			1
2	Food Purchase		271,378		271,378		271,378	(7,444)	263,934			2
3	Housekeeping	181,785	39,173		220,958		220,958		220,958			3
4	Laundry	41,750	13,143		54,893		54,893		54,893			4
5	Heat and Other Utilities			231,280	231,280		231,280		231,280			5
6	Maintenance	121,733	25,772	100,344	247,849		247,849		247,849			6
7	Other (specify):*											7
8	TOTAL General Services	684,434	383,186	454,418	1,522,038		1,522,038	(7,444)	1,514,594			8
	B. Health Care and Programs											
9	Medical Director			45,420	45,420		45,420		45,420			9
10	Nursing and Medical Records	2,440,058	263,445	56,468	2,759,971		2,759,971	(25,886)	2,734,085			10
10a	Therapy	77,605	2,565	230	80,400		80,400		80,400			10a
11	Activities	85,938	7,399	7,246	100,583		100,583		100,583			11
12	Social Services	86,156	1,947	17,923	106,026		106,026		106,026			12
13	CNA Training											13
14	Program Transportation			40,501	40,501		40,501	(21,071)	19,430			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,689,757	275,356	167,788	3,132,901		3,132,901	(46,957)	3,085,944			16
	C. General Administration											
17	Administrative	142,837		20,655	163,492		163,492		163,492			17
18	Directors Fees											18
19	Professional Services			210,530	210,530		210,530	(901)	209,629			19
20	Dues, Fees, Subscriptions & Promotions			130,688	130,688		130,688	(91,572)	39,116			20
21	Clerical & General Office Expenses	486,875	57,204	243,414	787,493		787,493	(157,779)	629,714			21
22	Employee Benefits & Payroll Taxes			818,319	818,319		818,319		818,319			22
23	Inservice Training & Education			1,272	1,272		1,272		1,272			23
24	Travel and Seminar			12,682	12,682		12,682		12,682			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			178,059	178,059		178,059		178,059			26
27	Other (specify):*											27
28	TOTAL General Administration	629,712	57,204	1,615,619	2,302,535		2,302,535	(250,252)	2,052,283			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,003,903	715,746	2,237,825	6,957,474		6,957,474	(304,653)	6,652,821			29

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

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

Facility Name & ID Number METHODIST HOME

#0005439

Report Period Beginning:

01/01/08

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12/31/08

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			268,984	268,984	268,984		268,984				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,393	54,393	54,393	(6,701)	47,692				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,088	13,088	13,088		13,088				35
36	Other (specify):*											36
37	TOTAL Ownership			336,465	336,465	336,465	(6,701)	329,764				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		451,683	756,454	1,208,137	1,208,137		1,208,137				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,912	68,912	68,912		68,912				42
43	Other (specify):* Non-Nursing Home	10,390	11,518	2,859,428	2,881,336	2,881,336	(2,881,336)					43
44	TOTAL Special Cost Centers	10,390	463,201	3,684,794	4,158,385	4,158,385	(2,881,336)	1,277,049				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,014,293	1,178,947	6,259,084	11,452,324	11,452,324	(3,192,690)	8,259,634				45

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

Facility Name & ID Number METHODIST HOME

0005439

Report Period Beginning: 01/01/08

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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	(7,444)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,963)	21		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	(1,050)	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	(132,558)	21		24
25	Fund Raising, Advertising and Promotional	(53,465)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(38,107)	20		28
29	Other-Attach Schedule	(2,953,103)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,192,690)		\$	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)	20,655	17,22	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,655		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,172,035)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	51
					52

METHODIST HOME

ID# 0005439

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Consulting	\$ (47,439)	43	1
2	Collection Fees	(901)	19	2
3	Resident Transportation Fees	(21,071)	14	3
4	Miscellaneous Resident Revenue	(16,082)	10	4
5	Contract Nursing Revenue	(9,804)	10	5
6	Misc Income - Purchasing Rebates	(8,053)	21	6
7	Misc Income - P.A. Interest Income	(5,651)	32	7
8	Misc Income - Other	(10,205)	21	8
9	Marketing Salaries	(10,390)	43	9
10	Non Nursing Home Expenses	(2,823,507)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(2,953,103)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number METHODIST HOME# 0005439

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(7,444)	0	0	0	0	0	0	0	0	0	0	(7,444)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,444)	0	0	0	0	0	0	0	0	0	0	(7,444)	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	(25,886)	0	0	0	0	0	0	0	0	0	0	(25,886)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(21,071)	0	0	0	0	0	0	0	0	0	0	(21,071)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(46,957)	0	0	0	0	0	0	0	0	0	0	(46,957)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(901)	0	0	0	0	0	0	0	0	0	0	(901)	19
20	Fees, Subscriptions & Promotions	(91,572)	0	0	0	0	0	0	0	0	0	0	(91,572)	20
21	Clerical & General Office Expenses	(157,779)	0	0	0	0	0	0	0	0	0	0	(157,779)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(250,252)	0	0	0	0	0	0	0	0	0	0	(250,252)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(304,653)	0	0	0	0	0	0	0	0	0	0	(304,653)	29

STATE OF ILLINOIS

Facility Name & ID Number METHODIST HOME

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Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,701)	0	0	0	0	0	0	0	0	0	0	(6,701)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,701)	0	(6,701)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,881,336)	0	0	0	0	0	0	0	0	0	0	(2,881,336)	43
44	TOTAL Special Cost Centers	(2,881,336)	0	(2,881,336)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,192,690)	0	(3,192,690)	45									

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
UNITED METHODIST HOMES & SERVICES FOUNDATION	50%			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATION	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
COVENANT RETIREMENT COMMUNITII	50%			COVENANT HOME	CHICAGO	ASSISTED LIVING

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		\$			\$	\$
2	V	17 Administrator - Contracted Salary Exp	17,212	UNITED METHODIST HOME & SERVICES FOUNDATION	50.00%	17,212	
3	V	22 Administrator - Contracted FICA Exp	1,317	UNITED METHODIST HOME & SERVICES FOUNDATION	50.00%	1,317	
4	V	22 Administrator - Contracted Other Ben	2,126	UNITED METHODIST HOME & SERVICES FOUNDATION	50.00%	2,126	
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 20,655			\$ 20,655	\$ *

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

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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.

Facility Name & ID Number METHODIST HOME

0005439

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 UMH&S FOUNDATION
 Street Address 1415 W. FOSTER AVE.
 City / State / Zip Code CHICAGO, IL 60640
 Phone Number (773) -769-5500
 Fax Number (773) 769-6287

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	17	Administrator Salary Expense	# of Hours	2,080	2	\$ 137,696	\$ 137,696	260	\$ 17,212	1
2	22	Administrator FICA Expense	# of Hours	2,080	2	10,534	0	260	1,317	2
3	22	Administrator Other Benefits - In	# of Hours	2,080	2	17,008	0	260	2,126	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					\$ 165,238	\$ 137,696		\$ 20,655	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Axis Capital Inc		X	DIRECTV Satellite Dish -	\$415.00	05/01/07	\$ 20,604	\$ 14,529	05/01/2012	0.0800	\$ 1,364	1								
2				for resident television service								2								
3												3								
4												4								
5												5								
Working Capital																				
6	Harris Bank		X	Line of Credit	Interest Only	06/30/06		900,000	N/A	Variable	53,029	6								
7												7								
8							Interest Income Offset				(6,701)	8								
9	TOTAL Facility Related				\$415.00		\$ 20,604	\$ 914,529			\$ 47,692	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 20,604	\$ 914,529			\$ 47,692	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.)

** 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>Important, 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 2007 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2003</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2006</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2007</td> <td>_____</td> <td>12</td> </tr> </table> <p>N/A - Facility is not subject to real estate taxes.</p>				Real Estate Tax Bill for Calendar Year:	2003	_____	8		2004	_____	9		2005	_____	10		2006	_____	11		2007	_____	12
Real Estate Tax Bill for Calendar Year:	2003	_____	8																				
	2004	_____	9																				
	2005	_____	10																				
	2006	_____	11																				
	2007	_____	12																				
		FOR BHF USE ONLY																					
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME METHODIST HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005439

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>N/A - Facility is not subject to real estate taxes</u>	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 METHODIST HOME

0005439 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,281 B. General Construction Type: Exterior BRICK Frame CONCRETE BLOCK Number of Stories 5

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).

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to The Methodist Home are:

Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults.

Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults.

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation as well as rental space for White Crane Wellness Center.

The costs for these entities are segregated and not included as part of the financial information presented on this report for The Methodist Home.

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	<u>HEALTH CARE</u>	<u>39,375</u>	<u>1898-1950</u>	<u>\$ 25,000</u>	1
2					2
3	TOTALS	39,375		\$ 25,000	3

Facility Name & ID Number **METHODIST HOME**

0005439

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42			1922	\$ 214,000	\$		\$	\$	214,000	4
5	48			1951	297,000					297,000	5
6				1972	941,207					941,207	6
7	8			1973	541,942					541,942	7
8	28			1974	479,275					479,275	8
	Improvement Type**										
9	ELEVATOR; HEATING AND A/C SYSTEM			1975	898,240		25			898,240	9
10	BEAUTY SHOP AND SWIFT OFFICE			1976	1,203		20			1,203	10
11	NURSING OFFICE AND CONFERENCE ROOM PARTITION			1980	1,300		20			1,300	11
12	DINING AND BOILER ROOM			1983	215		20			215	12
13	DOOR ALARMS			1984	1,188		20			1,188	13
14	SIDEWALK; PAVEMENT			1985	7,958		20			7,958	14
15	FENCING			1986	31,965		20			31,965	15
16	SIDEWALK			1987	3,680		20			3,680	16
17	ROOF & LIGHTING			1988	41,556		10			41,556	17
18	PARKING LOT			1989	123,634		10			123,634	18
19	GROUND FLOOR BATHROOMS AND BEAUTY SHOP			1990	81,482		10			81,555	19
20	1ST FLOOR COMMON AREAS			1991	155,195		10			154,296	20
21	1ST FLOOR ROOM RENOVATIONS 7 2ND FLOOR NURSING STATI			1992	224,277		10			219,394	21
22	LIVING ROOM & 2ND FLOOR HALLWAYS			1993	211,680		10			205,150	22
23	3RD FLOOR RENOVATIONS & 4TH FLOOR NURSES STATION			1994	239,782	312	10	312		234,251	23
24	4TH FLOOR RENOVATIONS & ADMINISTRATIVE OFFICES			1995	143,955	14	10	14		143,794	24
25	REPLACE CHILLER (AIR CONDITIONING SYSTEM)			1996	264,240	7,177	10	7,177		174,520	25
26	3RD FLOOR RENOVATIONS & SEWER LINE			1997	50,445	716	10	716		55,277	26
27	NURSING STATION - 2ND FL, DOOR ALARM SYSTEM - 4TH FL, CE			1998	70,774	3,535	10	3,535		70,567	27
28	AUTOMATIC DOOR - LOBBY, 4TH FLOOR - TILE & RENOVATION,			1999	33,593	2,998	10	2,998		28,481	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **METHODIST HOME**# **0005439**

Report Period Beginning:

01/01/08

Ending:

12/31/08**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	
37			\$	\$		\$	\$	\$	37
38	<u>Carpeting 1988 - 1992</u>		52,134		5			52,134	38
39	<u>Carpeting</u>	1993	14,437		5			14,437	39
40	<u>Carpeting</u>	1994	21,507		5			21,507	40
41	<u>Carpeting</u>	1995	18,800		5			18,800	41
42	<u>Carpeting</u>	1996	17,235		5			17,235	42
43	<u>Carpeting</u>	1997	5,198		5			5,198	43
44	<u>Carpeting</u>	1998	39,439		5			39,439	44
45	<u>Carpeting</u>	1999	531		5			531	45
46									46
47	<u>Main Stairway Upgrade, Plumbing, Remodeling of Resident Rooms - Floor</u>	2000	76,700	7,670	10	7,670		65,195	47
48	<u>Main Elevator Upgrade</u>	2000	38,713	1,936	20	1,936		16,456	48
49	<u>Air Conditioner - Circulation Pump Replacement</u>	2000	787	31	25	31		264	49
50	<u>Carpeting - 4th Floor, Main Stairway, Rooms - 57, 70, 74</u>	2000	12,458		5			12,458	50
51	<u>Parking Lot Improvements - Concrete Replacement, Trees, Fence</u>	2000	7,596	760	10	760		6,460	51
52									52
53	<u>1st Floor Nursing Station Remodeling, Flooring - 2nd Fl Dining Room</u>	2001	81,554	8,155	10	8,155		61,163	53
54	<u>Heat & A/C - Multistack A/C Unit, Chiller Condensor Bypass Filter</u>	2001	13,647	546	25	546		4,095	54
55	<u>Carpeting - Rms. 55, 75, 79, LL Corridor, 1st Fl Conf. Room</u>	2001	6,120		5			6,120	55
56									56
57	<u>Fire Alarm System, 2nd Fl Nursing Station & Dining Room Remod</u>	2002	235,781	23,578	10	23,578		153,257	57
58	<u>Main Elevator Upgrade</u>	2002	4,965	248	20	248		1,612	58
59	<u>Carpeting - Resident Services Office, Rm 48, Front Entrance</u>	2002	2,656		5			2,656	59
60	<u>Parking Lot Improvements - Seal Coating</u>	2002	2,375	238	10	238		1,547	60
61									61
62	<u>Magnetic Door System, Renovation-Senior Fit Area, Resident Room</u>	2003	199,523	19,952	10	19,952		109,736	62
63	<u>Carpeting - Resident Rooms 64, 80, Res. Svc Office, Adm. Office</u>	2003	1,349	134	5	134		1,349	63
64	<u>Lighting Retro Fit, Sewage Ejector Pumps, Emergency Generator I</u>	2003	29,290	1,465	20	1,465		8,057	64
65									65
66	<u>Resident Room Remodeling, Magnetic Door System, 4th Fl Nursing</u>	2004	50,774	5,077	10	5,077		22,847	66
67	<u>Ejector Pump - Rehab Office, Fire Dampers, Drain for Wash Mach</u>	2004	4,854	243	20	243		1,093	67
68	<u>Stairway Ramp Renovation - Parking Lot</u>	2004	3,224	322	10	322		1,449	68
69	<u>Carpeting - Main Lobby, 1st Floor, 3rd Floor</u>	2004	25,194	5,039	5	5,039		22,675	69
70	TOTAL (lines 4 thru 69)		\$ 6,026,627	\$ 90,146		\$ 90,146	\$	\$ 5,619,424	70

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

Facility Name & ID Number METHODIST HOME

0005439

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 6,026,627	\$ 90,146		\$ 90,146	\$	\$ 5,619,424	1
2									2
3	Fire Alarm System & Smoke Detectors, Resident Room Remodeling	2005	233,482	23,348	10	23,348		81,718	3
4	Kitchen Sewage Pump, Boiler Feed and Ejector Pumps	2005	6,887	344	20	344		1,204	4
5	Trees/Grounds/Landscaping Work	2005	4,325	433	10	433		1,515	5
6									6
7	Fire Alarm System, Resident Room Remodeling, Lobby/Entrance/	2006	255,848	25,585	10	25,585		63,962	7
8	Building Water Cooler	2006	860	43	20	43		107	8
9	Carpeting - Resident Rooms #281, #282, #283, Lower Level-Bush H	2006	16,209	3,242	5	3,242		8,105	9
10	Lawn Sprinkler System, Fence Renovation, Landscaping -Trees & S	2006	22,000	2,200	10	2,200		5,500	10
11									11
12	1st Floor Nursing Station/Training/Utility Room Renovations; Chin	2007	166,824	16,682	10	16,682		25,023	12
13	Smoke Dampers - 2nd Floor Resident Dining Room; Installation of	2007	7,519	376	20	376		564	13
14	New Feed Pump Assembly - Boiler Room - The Methodist Home	2007	15,990	640	25	640		960	14
15	Carpeting/Flooring - 2nd Floor - Bush Hall - Common Areas and N	2007	28,509	5,702	5	5,702		8,553	15
16	Repaving of Parking Lot - The Methodist Home	2007	2,471	247	10	247		371	16
17									17
18	Building Renovations - 1st Floor Nursing Station, Foyer, Hallway a	2008	42,137	2,107	10	2,107		2,107	18
19	Lighting Upgrade - 2nd Floor & Entrances; Hot & Cold Circulating	2008	13,664	342	20	342		342	19
20	HVAC - Boiler Room/Cooling Tower - Pumps, Motor, Fan, Switch	2008	47,737	955	25	955		955	20
21	Carpeting/Flooring - 2nd Floor - Bush Hall - 1st Floor Hallways/At	2008	46,410	4,641	5	4,641		4,641	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)		\$ 6,937,499	\$ 177,033		\$ 177,033	\$	\$ 5,825,051	34

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

Facility Name & ID Number METHODIST HOME # 0005439 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 1,212,283	\$ 83,781	\$ 83,781	\$		\$ 845,454	71
72	Current Year Purchases	125,000	6,250	6,250			6,250	72
73	Fully Depreciated Assets	781,381					781,381	73
74								74
75	TOTALS	\$ 2,118,664	\$ 90,031	\$ 90,031	\$		\$ 1,633,085	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	PATIENT TRANSPORTATI	FORD BUS, 2002	2001	\$ 54,399	\$	\$	\$		\$ 54,399	76
77	PATIENT TRANSPORTATI	FORD ELDORADO PASSENGE	2007	7,681	1,920	1,920			2,880	77
78										78
79										79
80	TOTALS			\$ 62,080	\$ 1,920	\$ 1,920	\$		\$ 57,279	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)	\$ 9,143,243	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 268,984	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 268,984	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)	\$ 7,515,415	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	Non-Nursing Home Assets/2006-2008	\$ 494,319	\$ 1,433	\$ 2,053	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 494,319	\$ 1,433	\$ 2,053	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number METHODIST HOME

0005439

Report Period Beginning: 01/01/08

Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 13,088 Description: Copiers - Leased - \$12,208; Dishwasher - Leased - \$880

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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.

Facility Name & ID Number METHODIST HOME# 0005439

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	L39, C3	hrs	\$	4,411	\$ 289,242	\$	4,411	\$ 289,242	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,229	75,951		1,229	75,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		6,408	340,978		6,408	340,978	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				377,872		377,872	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Med. Suppl, Lab, X-Ra</u>	L39, C2				50,283	73,811		124,094	13
14	TOTAL			\$	12,048	\$ 756,454	\$ 451,683	12,048	\$ 1,208,137	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number METHODIST HOME# 0005439Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 436,514	\$	1
2	Cash-Patient Deposits	28,315		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>317,350</u>)	1,532,712		3
4	Supply Inventory (priced at)	26,020		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,225		6
7	Other Prepaid Expenses	1,150		7
8	Accounts Receivable (owners or related parties)	108,522		8
9	Other(specify): <u>Misc A/R</u>	118		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,150,576	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	496,080		13
14	Buildings, at Historical Cost	6,937,499		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,203,983		16
17	Accumulated Depreciation (book methods)	(7,517,468)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,155,094	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,305,670	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,042		28
29	Short-Term Notes Payable	972,912		29
30	Accrued Salaries Payable	526,261		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Unexpended Restricted Gifts</u>	33,833		36
37	<u>Due to Third-Party Payor</u>	11,740		37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,820,397	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	436,946		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 436,946	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,257,343	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,048,327	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,305,670	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,679,119	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,679,119	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(130,792)	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)	\$ (130,792)	17
B. Transfers (Itemize):			
18	Equity Transfers from Parent Corporations	500,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 500,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,048,327	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number METHODIST HOME# 0005439Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 7,258,771	1
2	Discounts and Allowances for all Levels	(974,564)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,284,207	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,282,904	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,282,904	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		13
14	Non-Patient Meals	7,444	14
15	Telephone, Television and Radio	6,963	15
16	Rental of Facility Space		16
17	Sale of Drugs	376,435	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,800	19
20	Radiology and X-Ray	10,834	20
21	Other Medical Services	218,108	21
22	Laundry	13,877	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 662,461	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,050	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,050	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Other - See attached Schedule</u>	3,090,910	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,090,910	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,321,532	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,522,038	31
32	Health Care	3,132,901	32
33	General Administration	2,302,535	33
B. Capital Expense			
34	Ownership	336,465	34
C. Ancillary Expense			
35	Special Cost Centers	4,089,473	35
36	Provider Participation Fee	68,912	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,452,324	40
41	Income before Income Taxes (line 30 minus line 40)**	(130,792)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (130,792)	43

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

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

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

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

Facility Name & ID Number **METHODIST HOME**

0005439

Report Period Beginning:

01/01/08

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,940	2,084	\$ 85,557	\$ 41.05	1
2	Assistant Director of Nursing	1,296	1,423	47,125	33.12	2
3	Registered Nurses	28,416	30,455	840,465	27.60	3
4	Licensed Practical Nurses	13,844	15,231	364,348	23.92	4
5	CNAs & Orderlies	91,212	98,401	1,002,350	10.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,423	5,891	77,605	13.17	8
9	Activity Director	1,651	1,860	27,812	14.95	9
10	Activity Assistants	5,005	5,314	58,126	10.94	10
11	Social Service Workers	4,452	4,877	86,156	17.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,819	4,298	62,021	14.43	14
15	Cook Helpers/Assistants	18,991	21,127	211,236	10.00	15
16	Dishwashers	7,103	7,549	65,909	8.73	16
17	Maintenance Workers	4,734	5,279	121,733	23.06	17
18	Housekeepers	17,463	19,052	181,785	9.54	18
19	Laundry	3,679	4,274	41,750	9.77	19
20	Administrator	2,124	2,413	142,837	59.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,877	25,587	486,874	19.03	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	1,745	2,089	48,991	23.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl Sched.</u>	4,158	4,484	61,613	13.74	33
34	TOTAL (lines 1 - 33)	238,932	261,688	\$ 4,014,293 *	\$ 15.34	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		\$		35
36	Medical Director	520	45,420	L9, C3	36
37	Medical Records Consultant	96	3,960	L10, C3	37
38	Nurse Consultant	1,050	29,524	L10, C3	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				44
45	Social Service Consultant	40	2,390	L12, C3	45
46	Other(specify) <u>Contract Chaplain</u>	430	12,833	L12, C3	46
47	<u>Dietary Management Fees</u>	Monthly	119,480	L1, C3	47
48	<u>Rehab Consulting</u>	5	230	L10a, C3	48
49	TOTAL (lines 35 - 48)	2,141	\$ 213,837		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 454	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 454		53

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? YES
If YES, give association name and amount. Life Service Network of IL - \$6,049
- (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. \$ 62,532 Line L10, C2
- (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. \$ 68,912
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 7,444
- (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? 100%
- d. Have vehicle usage logs been maintained? YES
- 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? YES
- 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: FROST, RUTTENBERG & ROTHBLATT, P.C. 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.