



Facility Name & ID Number The United Methodist Village

# 0014506 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 02/11/2008

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	4,618	3,934	1,598	10,150	8	
9	SNF/PED					9	
10	ICF	12,731	10,049	1	22,781	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	17,349	13,983	1,599	32,931	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.35%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 01/01/1925

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 70 and days of care provided 1,599

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number      The United Methodist Village      #      0014506      Report Period Beginning:      01/01/2009      Ending:      12/31/2009

**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
	<b>A. General Services</b>										
1	Dietary	321,381	23,861	21,163	366,405		366,405		366,405		1
2	Food Purchase		247,143		247,143		247,143	(74,269)	172,874		2
3	Housekeeping	234,920	29,119	88	264,127		264,127	(35,040)	229,087		3
4	Laundry	137,042	23,589		160,631		160,631		160,631		4
5	Heat and Other Utilities			381,700	381,700		381,700	(202,641)	179,059		5
6	Maintenance	182,691	33,295	106,373	322,359		322,359	(28,508)	293,851		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>876,034</b>	<b>357,007</b>	<b>509,324</b>	<b>1,742,365</b>		<b>1,742,365</b>	<b>(340,458)</b>	<b>1,401,907</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,846,806	6,966	16,044	1,869,816		1,869,816	(8,605)	1,861,211		10
10a	Therapy			236,139	236,139		236,139		236,139		10a
11	Activities	103,325	2,333	1,871	107,529		107,529		107,529		11
12	Social Services	65,204	8	3,828	69,040		69,040	(1,799)	67,241		12
13	CNA Training										13
14	Program Transportation	17,504			17,504		17,504		17,504		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,032,839</b>	<b>9,307</b>	<b>267,482</b>	<b>2,309,628</b>		<b>2,309,628</b>	<b>(10,404)</b>	<b>2,299,224</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	130,949		27,799	158,748		158,748	(30,909)	127,839		17
18	Directors Fees										18
19	Professional Services			15,870	15,870		15,870		15,870		19
20	Dues, Fees, Subscriptions & Promotions			20,685	20,685		20,685	(13,789)	6,896		20
21	Clerical & General Office Expenses	177,608	31,773	92,016	301,397		301,397	(21,160)	280,237		21
22	Employee Benefits & Payroll Taxes			565,776	565,776		565,776	(10,595)	555,181		22
23	Inservice Training & Education										23
24	Travel and Seminar			23,139	23,139		23,139	(121)	23,018		24
25	Other Admin. Staff Transportation			8,509	8,509		8,509	(8,246)	263		25
26	Insurance-Prop.Liab.Malpractice			163,099	163,099		163,099	(3,872)	159,227		26
27	Other (specify):*	144,480	1,341	5,358	151,179		151,179	(145,821)	5,358		27
28	<b>TOTAL General Administration</b>	<b>453,037</b>	<b>33,114</b>	<b>922,251</b>	<b>1,408,402</b>		<b>1,408,402</b>	<b>(234,513)</b>	<b>1,173,889</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,361,910</b>	<b>399,428</b>	<b>1,699,057</b>	<b>5,460,395</b>		<b>5,460,395</b>	<b>(585,375)</b>	<b>4,875,020</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The United Methodist Village

#0014506

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			528,253	528,253		528,253	(156,488)	371,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,611	25,611		25,611	(25,611)				32
33	Real Estate Taxes			3,883	3,883		3,883	(3,883)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			557,747	557,747		557,747	(185,982)	371,765			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		204,961	11,866	216,827		216,827		216,827			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			89,273	89,273		89,273		89,273			42
43	Other (specify):* <b>Chaplin Expense</b>			1,557	1,557		1,557	(1,116)	441			43
44	<b>TOTAL Special Cost Centers</b>		204,961	102,696	307,657		307,657	(1,116)	306,541			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,361,910	604,389	2,359,500	6,325,799		6,325,799	(772,473)	5,553,326			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(43,619)	2		4
5	Telephone, TV & Radio in Resident Rooms	(23,229)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,689)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(666,325)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (772,473)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (772,473)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

The United Methodist VillageID# 0014506Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Utility Income	\$ (111,050)	5	1
2	Transportation Reimbursement	(8,246)	25	2
3	Child Care Salaries	(135,336)	27	3
4				4
5	Child Care - Education	(121)	24	5
6	Child Care Supplies	(1,341)	27	6
7	Child Care Meals	(1,229)	2	7
8	McKiou Food Expense	(17,741)	2	8
9	Bank Charges	(4,271)	21	9
10	Late Fees	(266)	21	10
11	Resident Services	(799)	12	11
12	Doctor Expense	(2,917)	10	12
13	Hospital Expense	(5,688)	10	13
14				14
15	Misc. Income	(10,348)	21	15
16	Depreciation	(15,971)	30	16
17	Marketing Salaries	(14,540)	17	17
18	Chaplin Expense	(1,116)	43	18
19	Chaplin Salary	(9,144)	27	19
20	Real Estate Taxes	(3,883)	33	20
21				21
22	Independent Living Allocation:			22
23	Maintenance	(28,508)	6	23
24	Housekeeping	(35,040)	3	24
25	Dietary	(11,680)	2	25
26	Utilities	(68,362)	5	26
27	Social Services	(1,000)	12	27
28	Administrative	(16,369)	17	28
29	Dues	(100)	20	29
30	Office	(6,275)	21	30
31	Employee Benefits	(10,595)	22	31
32	Insurance	(3,872)	26	32
33	Depreciation	(140,517)	30	33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(666,325)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The United Methodist Village# 0014506

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(74,269)	0	0	0	0	0	0	0	0	0	0	(74,269)	2
3	Housekeeping	(35,040)	0	0	0	0	0	0	0	0	0	0	(35,040)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(202,641)	0	0	0	0	0	0	0	0	0	0	(202,641)	5
6	Maintenance	(28,508)	0	0	0	0	0	0	0	0	0	0	(28,508)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(340,458)</b>	<b>0</b>	<b>(340,458)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,605)	0	0	0	0	0	0	0	0	0	0	(8,605)	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	(1,799)	0	0	0	0	0	0	0	0	0	0	(1,799)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(10,404)</b>	<b>0</b>	<b>(10,404)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	(30,909)	0	0	0	0	0	0	0	0	0	0	(30,909)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,789)	0	0	0	0	0	0	0	0	0	0	(13,789)	20
21	Clerical & General Office Expenses	(21,160)	0	0	0	0	0	0	0	0	0	0	(21,160)	21
22	Employee Benefits & Payroll Taxes	(10,595)	0	0	0	0	0	0	0	0	0	0	(10,595)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(121)	0	0	0	0	0	0	0	0	0	0	(121)	24
25	Other Admin. Staff Transportation	(8,246)	0	0	0	0	0	0	0	0	0	0	(8,246)	25
26	Insurance-Prop.Liab.Malpractice	(3,872)	0	0	0	0	0	0	0	0	0	0	(3,872)	26
27	Other (specify):*	(145,821)	0	0	0	0	0	0	0	0	0	0	(145,821)	27
28	<b>TOTAL General Administration</b>	<b>(234,513)</b>	<b>0</b>	<b>(234,513)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(585,375)</b>	<b>0</b>	<b>(585,375)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number The United Methodist Village# 0014506

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(156,488)	0	0	0	0	0	0	0	0	0	0	(156,488)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,611)	0	0	0	0	0	0	0	0	0	0	(25,611)	32
33	Real Estate Taxes	(3,883)	0	0	0	0	0	0	0	0	0	0	(3,883)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(185,982)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(185,982)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	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):*	(1,116)	0	0	0	0	0	0	0	0	0	0	(1,116)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,116)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,116)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(772,473)	0	0	0	0	0	0	0	0	0	0	(772,473)	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
The United Methodist Village, Inc.	100%	The United Methodist Village North Campus	Lawrenceville			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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:

01/01/2009

Ending: 2/31/2009

**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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Citizens National Bank		X	Mortgage	\$4,026.00	06/23/09	\$ 650,000	\$ 639,602	06/23/2029	4.2500	\$ 13,759	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Citizens National Bank		X	Operating Cash		08/24/06	500,000	317,122	11/09/2010	6.0000	11,853	6							
7	Citizens National Bank		X	Operating Cash for HVAC		07/22/08	125,000		01/22/2009	6.0000		7							
8												8							
9	<b>TOTAL Facility Related</b>				<b>\$4,026.00</b>		<b>\$ 1,275,000</b>	<b>\$ 956,724</b>			<b>\$ 25,612</b>	<b>9</b>							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>							
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 1,275,000</b>	<b>\$ 956,724</b>			<b>\$ 25,612</b>	<b>15</b>							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)





Facility Name & ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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).

N/A

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>Facility</u>	<u>631,620</u>	<u>1924</u>	<u>\$ 96,018</u>	<u>1</u>
2		<u>572,380</u>	<u>1987 &amp; 1989</u>	<u>63,690</u>	<u>2</u>
3	<b>TOTALS</b>	<b>1,204,000</b>		<b>\$ 159,708</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$	\$ 1,188,000	4
5			1974	1974	916,911	18,338	50	18,338		650,726	5
6			1979	1979	1,228,695	24,574	50	24,574		1,035,636	6
7			1925	1925	601,097	15,027	40	15,027		427,737	7
8											8
	<b>Improvement Type**</b>										
9	Various Fully Depreciated Assets Thru 2009				2,236,479					2,236,479	9
10	Various		1979		117,791	2,612	50	2,612		95,844	10
11	Various		1980		17,695	354	50	354		10,440	11
12	Various		1989		96,708	3,887	20	3,887		79,707	12
13	Various		1990		610,945	24,341	20	24,341		474,824	13
14	Various		1991		132,029	5,327	20	5,327		106,696	14
15	Various		1992		313,917	12,778	20	12,778		223,610	15
16	Various		1993		119,112	6,175	20	6,175		101,891	16
17	Various		1994		67,500	3,816	20	3,816		62,251	17
18	Various		1995		157,262	9,462	20	9,462		137,203	18
19	Various		1996		315,753	17,476	20	17,476		281,454	19
20	Various		1997		97,589	5,201	20	5,201		97,589	20
21	Various		1998		43,649	1,818	20	1,818		43,649	21
22	Various		1999		13,455	1,021	20	1,021		10,659	22
23	Various		2000		1,637	109	15	109		1,080	23
24	Various		2002		73,057	7,305	10	7,305		55,154	24
25	Various		2002		21,530	1,436	15	1,436		10,594	25
26	HVAC System		2002		14,126	831	17	831		5,886	26
27	Wiring and Circuit Panels		2002		9,048	452	20	452		3,354	27
28	Office Remodeling		2002		2,138	178	12	178		1,321	28
29	Office Remodeling		2002		4,664	334	7	334		4,664	29
30	Various		2003		3,323	134	25	134		916	30
31	Various		2003		56,659	3,778	15	3,778		26,204	31
32	Various		2003		46,484	4,649	10	4,649		30,448	32
33	Dycus Auto Door		2003		1,073	153	7	153		1,059	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 &amp; ID Number The United Methodist Village

# 0014506

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## 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	Building Supplies	2004	\$ 3,115	\$ 208	15	\$ 208	\$	\$ 1,109	37
38	Smoke Detectors	2004	2,114	302	7	302		1,560	38
39	Elevator Floor Lockout	2004	550	101	5	101		550	39
40	Various	2005	9,744	649	15	649		3,266	40
41	Various	2005	96,745	9,675	10	9,675		44,486	41
42	Sidewalk & Ramp	2005	6,000	667	9	667		3,057	42
43	Therapy Remodel Project	2005	272	54	5	54		244	43
44	Water Furnace	2006	1,944	130	15	130		520	44
45	Carpet	2006	841	168	5	168		658	45
46	Hallway Tile	2006	3,399	340	10	340		1,332	46
47	Handrails	2006	553	31	15	31		130	47
48	Geothermal System	2006	1,686	169	10	169		633	48
49	Water Meter	2006	2,194	110	20	110		403	49
50	Locks for Outside Entrance	2006	10,377	1,038	10	1,038		3,806	50
51	Smoke Detectors	2006	17,751	1,775	10	1,775		6,508	51
52	Mig Welder	2006	530	53	10	53		190	52
53	T-1 Computer Line & Equipment	2006	7,752	1,550	5	1,550		5,554	53
54	Boiler Repair	2006	11,590	773	15	773		2,685	54
55	Tile Floor in Dietary	2006	9,952	995	10	995		3,400	55
56	4 Water Furnaces	2006	7,331	733	10	733		2,504	56
57	Air Conditioner	2006	633	63	10	63		210	57
58	Washer for Laundry Department	2006	9,379	625	15	625		2,031	58
59	Pellet Heater for Dietary	2006	2,659	266	10	266		864	59
60	Water Softner	2006	2,925	293	10	293		903	60
61	Carbon Monoxide Detectors	2006	2,139	214	10	214		660	61
62	Dycus Remodel	2006	12,514	1,251	10	1,251		4,066	62
63	Sidewalk	2007	560	37	15	37		102	63
64	Railing on Dycus Ramp	2008	683	46	15	46		84	64
65	Room Remodel Wesley 1	2008	2,039	408	5	408		748	65
66	Breaker Box	2008	495	71	7	71		112	66
67	Shower Installation	2008	5,000	500	10	500		708	67
68	Sprinkler Installation	2008	145,567	7,278	20	7,278		9,098	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,049,359	\$ 229,139		\$ 229,139	\$	\$ 7,507,256	70

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 12A, Carried Forward		\$ 9,049,359	\$ 229,139		\$ 229,139	\$	\$ 7,507,256	1
2	Sprinkler System	2009	154,780	7,739	20	7,739		7,739	2
3	Dycus Room Remodel	2009	11,245	1,339	7	1,339		1,339	3
4	Elevator Upgrade	2009	39,165	837	39	837		837	4
5	Holden Center Roof Repair	2009	650	25	15	25		25	5
6	Facilities Maintenance	2009	259	26	5	26		26	6
7	Paint & Supplies	2009	479	48	5	48		48	7
8	Flooring & Supplies	2009	1,363	136	5	136		136	8
9	Office Upgrade	2009	3,023	50	5	50		50	9
10	Office Remodel	2009	363	12	5	12		12	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	TOTAL (lines 1 thru 33)		\$ 9,260,686	\$ 239,351		\$ 239,351	\$	\$ 7,517,468	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:

01/01/2009

Ending:

12/31/2009

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	\$ 1,622,935	\$ 104,467	\$ 104,467	\$		\$ 1,326,693	71
72	Current Year Purchases	71,335	3,680	3,680			3,680	72
73	Fully Depreciated Assets	2,874,155					2,874,155	73
74								74
75	TOTALS	\$ 4,568,425	\$ 108,147	\$ 108,147	\$		\$ 4,204,528	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	\$ 63,726	\$	\$			\$ 63,726	76
77		See Attached		178,967	24,267	24,267			114,829	77
78										78
79										79
80	TOTALS			\$ 242,693	\$ 24,267	\$ 24,267	\$		\$ 178,555	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)	\$ 14,231,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 371,765	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 371,765	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)	\$ 11,900,551	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	\$ 5,017,564	\$ 140,517	\$ 2,334,555	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 5,017,564	\$ 140,517	\$ 2,334,555	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	\$	675	\$ 80,252	\$	675	\$ 80,252	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		171	34,871		171	34,871	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-03	hrs		709	121,017		709	121,017	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				51,288		51,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Oxygen &amp; Chr. Sup</u>	39-02					153,673		153,673	13
14	TOTAL			\$	1,555	\$ 236,140	\$ 204,961	1,555	\$ 441,101	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: 01/01/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 250,018	\$	1
2	Cash-Patient Deposits	105,239		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,846</u> )	1,132,784		3
4	Supply Inventory (priced at )	43,472		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	268		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,531,781	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,262,175		12
13	Land	508,747		13
14	Buildings, at Historical Cost	18,891,586		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,495,951		16
17	Accumulated Depreciation (book methods)	(15,089,523)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Covenant Not to Compete</u>	416,667		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 14,485,603	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 16,017,384	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 294,789	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	105,239		28
29	Short-Term Notes Payable	317,122		29
30	Accrued Salaries Payable	63,871		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,424		32
33	Accrued Interest Payable			33
34	Deferred Compensation	117,434		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Other Payables</u>	335,097		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,328,976	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	5,581,585		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Refundable Deposits &amp; Fees</u>	230,575		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,812,160	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,141,136	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 8,876,248	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 16,017,384	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,166,824</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>9,166,824</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(290,578)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	2	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (290,576)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>8,876,248</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village# 0014506Report Period Beginning: 01/01/2009Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,278,912	1
2	Discounts and Allowances for all Levels	(2,878,761)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,400,151</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care	141,154	4
5	Other Care for Outpatients		5
6	Therapy	1,953,447	6
7	Oxygen	104,184	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,198,785</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,475	13
14	Non-Patient Meals	48,382	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,872	19
20	Radiology and X-Ray		20
21	Other Medical Services	485,339	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 748,801</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	115,812	24
25	Interest and Other Investment Income***	719,687	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 835,499</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	153,392	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 153,392</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 10,336,628</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,742,365	31
32	Health Care	2,309,628	32
33	General Administration	1,408,402	33
<b>B. Capital Expense</b>			
34	Ownership	557,747	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	218,384	35
36	Provider Participation Fee	89,273	36
<b>D. Other Expenses (specify):</b>			
37	<u>Expenses Reported on Related Party Cost Report</u>	4,301,407	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 10,627,206</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(290,578)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (290,578)</b>	<b>43</b>

\* 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: 01/01/2009

Ending: 12/31/2009

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	11,165	12,384	\$ 222,308	\$ 17.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,994	9,368	173,751	18.55	3
4	Licensed Practical Nurses	25,838	27,797	448,118	16.12	4
5	CNAs & Orderlies	87,071	93,490	871,473	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,674	11,902	103,325	8.68	10
11	Social Service Workers	8,135	6,467	65,204	10.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,501	37,866	321,381	8.49	15
16	Dishwashers					16
17	Maintenance Workers	20,673	22,574	234,972	10.41	17
18	Housekeepers	22,479	24,324	200,143	8.23	18
19	Laundry	13,687	15,463	137,042	8.86	19
20	Administrator	1,892	2,160	83,077	38.46	20
21	Assistant Administrator					21
22	Other Administrative	14,556	16,116	175,283	10.88	22
23	Office Manager					23
24	Clerical	5,517	5,881	50,197	8.54	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	13,939	15,056	131,155	8.71	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Child/Chaplin</u>	16,467	17,763	144,481	8.13	33
34	TOTAL (lines 1 - 33)	296,588	318,611	\$ 3,361,910 *	\$ 10.55	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	228	\$ 12,765	1-3	35
36	Medical Director	Monthly	9,600	9-3	36
37	Medical Records Consultant	Monthly	2,955	10-3	37
38	Nurse Consultant	Monthly	3,600	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,569	11-3	44
45	Social Service Consultant	24	1,749	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 32,238		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village# 0014506Report Period Beginning: 01/01/2009Ending: 12/31/2009**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. \$ 14,980 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. \$ 89,273  
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
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

Breakout of Other General Administrative Expenses

Column 1

Chaplain and Childcare Salaries	<u>144,480</u>
---------------------------------	----------------

Column 2

Child Care Supplies	<u>1,341</u>
---------------------	--------------

Column 3

Advertising/Marketing Materials	871
Auxillary Purchases	3,689
Resident Services Purchases	<u>798</u>
	<u>5,358</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

**Page 12 - 13 - Schedle XI Ownership Cost**

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building &amp; Improvements</u>	<u>Equipment and Vehciles</u>	<u>Total</u>
Schedule XI Ownership Cost	\$ 159,708	\$ 9,260,686	\$ 4,811,118	\$ 14,231,512
Non-care Assets	-	5,017,564	-	5,017,564
Related Facility	349,039	4,352,420	915,264	5,616,723
Non-care Assets of Related Facility	-	29,645	-	29,645
Reclassification for reporting of Ownership Cost	-	231,271	(230,431)	840
Schedule XV Balance Sheet	<u>\$ 508,747</u>	<u>\$ 18,891,586</u>	<u>\$ 5,495,951</u>	<u>\$ 24,896,284</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.

SEE ACCOUNTANTS' COMPILATION REPORT.

**Page 13 - Schedule XI Ownership Cost, Item D Vehicle Depreciation, Line 77**

<u>Model, Make</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Depreciation</u>	<u>Accumulated Depreciation</u>
Van	2003	\$ 26,685	\$ 3,812	\$ 24,143
John Deer Tractor	2004	36,884	5,269	31,176
Oldsmobile Silhouette Van	2004	26,143	3,735	21,475
Truck	2005	11,782	1,683	6,733
Wheelchair Van	2005	35,943	5,135	21,418
2006 Chevy Siverado	2006	4,673	1,168	4,575
2008 Ford E250 WC Van	2008	17,219	2,460	4,305
2008 Chevy Van	2009	14,087	939	939
2000 Ford Taurus	2009	5,551	66	65
Total to line 79 Page 13		<u>\$ 178,967</u>	<u>\$ 24,267</u>	<u>\$ 114,829</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

**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	798,975
Apts & Cottage Bldgs	1988	168,658	6,746	138,299
Apts & Cottage Bldgs	1989	93,293	3,787	73,853
McKiou Center	1994	3,177,429	79,436	1,152,356
Apts & Cottage Bldgs	1997	11,707	780	8,975
Apts & Cottage Bldgs	1998	50,680	2,533	50,680
McKiou Center	2000	9,211	614	5,168
Apts & Cottage Bldgs	2001	58,609	5,387	44,578
Apts & Cottage Bldgs	2002	64,155	4,401	28,337
Apts & Cottage Bldgs	2004	12,940	863	3,667
McKiou Center & Apts	2006	19,174	1,724	5,172
Removed house on 16th st	2003	4,499	300	4,499
Day Care	2005	22,743	1,516	5,433
Southern Meadows A/C Upgrade	2008	133,235	6,662	8,346
Roofing for Bldgs #18 & 24	2008	14,000	1,400	1,750
Day Care Remodel	2008	3,287	470	508
Reporting Reclassification	2008			3,372
Southern Meadows A/C Upgrade	2009	4,207	210	210
Carpet Cottage #3	2009	1,148	230	230
Cabinets for McKiou	2009	1,725	103	103
Repairs for 1720 17th Street	2009	1,321	44	44
TOTAL - To Page 13		<u>5,017,564</u>	<u>140,517</u>	<u>2,334,555</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT.