



Facility Name & ID Number THE METHODIST HOME

# 0005439 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 \_\_\_\_\_

	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	126	Skilled (SNF)	126	45,990	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	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	16,647	8,542	6,582	31,771	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,647	8,542	6,582	31,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.08%

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)  
N/A

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 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 5,600

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number **THE METHODIST HOME** # **0005439** Report Period Beginning: **01/01/10** Ending: **12/31/10**

**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	325,698	33,788	111,652	471,138		471,138		471,138		1
2	Food Purchase		269,977		269,977		269,977	(9,083)	260,894		2
3	Housekeeping	134,753	41,209		175,962		175,962		175,962		3
4	Laundry	35,600	10,453		46,053		46,053		46,053		4
5	Heat and Other Utilities			163,736	163,736		163,736		163,736		5
6	Maintenance	120,834	25,526	100,368	246,728		246,728		246,728		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>616,885</b>	<b>380,953</b>	<b>375,756</b>	<b>1,373,594</b>		<b>1,373,594</b>	<b>(9,083)</b>	<b>1,364,511</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			49,870	49,870		49,870		49,870		9
10	Nursing and Medical Records	2,104,260	241,675	90,257	2,436,192		2,436,192	(1,307)	2,434,885		10
10a	Therapy	39,787	1,076		40,863		40,863		40,863		10a
11	Activities	84,034	6,664	7,370	98,068		98,068		98,068		11
12	Social Services	103,140	1,452	3,680	108,272		108,272		108,272		12
13	CNA Training										13
14	Program Transportation			28,357	28,357		28,357	(8,149)	20,208		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,331,221</b>	<b>250,867</b>	<b>179,534</b>	<b>2,761,622</b>		<b>2,761,622</b>	<b>(9,456)</b>	<b>2,752,166</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	160,750			160,750		160,750		160,750		17
18	Directors Fees										18
19	Professional Services			132,319	132,319		132,319		132,319		19
20	Dues, Fees, Subscriptions & Promotions			61,399	61,399		61,399	(28,533)	32,866		20
21	Clerical & General Office Expenses	459,625	51,042	289,654	800,321		800,321	(199,083)	601,238		21
22	Employee Benefits & Payroll Taxes			809,606	809,606		809,606		809,606		22
23	Inservice Training & Education			637	637		637		637		23
24	Travel and Seminar			6,818	6,818		6,818		6,818		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			161,696	161,696		161,696		161,696		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>620,375</b>	<b>51,042</b>	<b>1,462,129</b>	<b>2,133,546</b>		<b>2,133,546</b>	<b>(227,616)</b>	<b>1,905,930</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,568,481</b>	<b>682,862</b>	<b>2,017,419</b>	<b>6,268,762</b>		<b>6,268,762</b>	<b>(246,155)</b>	<b>6,022,607</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.

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 METHODIST HOME**

#0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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			271,005	271,005		271,005		271,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,085	28,085		28,085	(3,669)	24,416			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,190	12,190		12,190		12,190			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			311,280	311,280		311,280	(3,669)	307,611			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		420,831	831,019	1,251,850		1,251,850		1,251,850			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):* <b>Non Nursing Home</b>	25,900		3,102,136	3,128,036		3,128,036	(3,128,036)				43
44	<b>TOTAL Special Cost Centers</b>	25,900	420,831	4,002,140	4,448,871		4,448,871	(3,128,036)	1,320,835			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,594,381	1,103,693	6,330,839	11,028,913		11,028,913	(3,377,860)	7,651,053			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		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	(9,083)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,823)	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	(3,669)	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	(183,209)	21		24
25	Fund Raising, Advertising and Promotional	(18,156)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,377)	20		28
29	Other-Attach Schedule	(3,148,543)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (3,377,860)</b>		<b>\$</b>	<b>30</b>

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<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>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (3,377,860)</b>		<b>37</b>

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>							
48		49		50		51	52

THE METHODIST HOME

ID# 0005439

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Marketing Salaries	\$ (25,900)	43	1
2	Marketing Travel	(594)	43	2
3	Marketing Seminar	(128)	43	3
4	Resident Transportation Revenue	(8,149)	14	4
5	Miscellaneous Resident Revenue	(1,307)	10	5
6	Misc Income - Purchasing Rebates	(10,789)	21	6
7	Misc Income - Other	(262)	21	7
8	Non-Nursing Home Expenses	(3,100,454)	43	8
9	Marketing Consulting	(960)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(3,148,543)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE METHODIST HOME# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	(9,083)	0	0	0	0	0	0	0	0	0	0	(9,083)	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	<b>TOTAL General Services</b>	<b>(9,083)</b>	<b>0</b>	<b>(9,083)</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	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	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	(8,149)	0	0	0	0	0	0	0	0	0	0	(8,149)	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>(9,456)</b>	<b>0</b>	<b>(9,456)</b>	<b>16</b>									
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(28,533)	0	0	0	0	0	0	0	0	0	0	(28,533)	20
21	Clerical & General Office Expenses	(199,083)	0	0	0	0	0	0	0	0	0	0	(199,083)	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	<b>TOTAL General Administration</b>	<b>(227,616)</b>	<b>0</b>	<b>(227,616)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(246,155)</b>	<b>0</b>	<b>(246,155)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE METHODIST HOME# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	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	(3,669)	0	0	0	0	0	0	0	0	0	0	(3,669)	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	<b>TOTAL Ownership</b>	<b>(3,669)</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>(3,669)</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):*	(3,128,036)	0	0	0	0	0	0	0	0	0	0	(3,128,036)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,128,036)</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>(3,128,036)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(3,377,860)	0	0	0	0	0	0	0	0	0	0	(3,377,860)	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 & SERVICE	100%			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
				UNITED NURSING S	CHICAGO	NURSE RECRUTE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

THE METHODIST HOME

#

0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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 THE METHODIST HOME

# 0005439 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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

Facility Name & ID Number

THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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	Axis Capital Inc	X	DIRECTV Satellite Dish -	\$415.00	05/01/07	\$ 20,604	\$ 6,278	05/01/2012	0.0800	\$ 691	1								
2			for resident televison service								2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	Harris Bank	X	Line of Credit	Interest Only	06/30/09			N/A	Variable	27,394	6								
7											7								
8						Interest Income Offset				(3,669)	8								
9	<b>TOTAL Facility Related</b>			\$415.00		\$ 20,604	\$ 6,278			\$ 24,416	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 20,604	\$ 6,278			\$ 24,416	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**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12
<b>N/A - Facility is not subject to real estate taxes</b>			
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2009 \$	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.**

# 2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE 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 2009 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 2009.

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

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

**C. Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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, UMH&S Foundation, and Home Care.

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>	<u>1</u>
2	<u>HEALTH CARE - Market Value Write Up</u>		<u>2010</u>	<u>1,975,000</u>	<u>2</u>
3	<u>TOTALS</u>	<u>39,375</u>		<u>\$ 2,000,000</u>	<u>3</u>

Facility Name &amp; ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	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	Additions - 1975		1975	898,240						898,240	9
10	Additions - 1976		1976	1,203						1,203	10
11	Additions - 1980		1980	1,300						1,306	11
12	Additions - 1983		1983	215						215	12
13	Additions - 1984		1984	1,188						1,188	13
14	Additions - 1985		1985	7,958						7,958	14
15	Additions - 1986		1986	31,965						31,965	15
16	Additions - 1987		1987	3,680						3,680	16
17	Additions - 1988		1988	41,556						41,556	17
18	Additions - 1989		1989	123,634						123,634	18
19	Additions - 1990		1990	81,482						81,555	19
20	Additions - 1991		1991	155,195						154,296	20
21	Additions - 1992		1992	276,411						271,528	21
22	Additions - 1993		1993	226,117						219,587	22
23	Additions - 1994		1994	261,289	312			312		256,382	23
24	Additions - 1995		1995	162,755	14			14		162,622	24
25	Additions - 1996		1996	281,475	7,177			7,177		206,109	25
26	Additions - 1997		1997	55,643	716			716		61,907	26
27	Additions - 1998		1998	110,213	15			15		110,036	27
28	Additions - 1999		1999	34,124	240			240		30,875	28
29	Additions - 2000		2000	136,254	6,178			6,178		117,408	29
30	Additions - 2001		2001	101,321	8,701			8,701		88,780	30
31	Additions - 2002		2002	245,777	24,064			24,064		207,200	31
32	Additions - 2003		2003	230,162	21,417			21,417		161,976	32
33	Additions - 2004		2004	84,046	5,642			5,642		61,867	33
34	Additions - 2005		2005	244,694	24,125			24,125		132,687	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 &amp; ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	Resident Room - Painting, Sinks, Toilets, Grab Bars, Window Cov	2006	\$ 40,854	\$ 4,085	10	\$ 4,085	\$	\$ 18,383	37
38	Lobby/Entrance/Utility Room - Vinyl Flooring, Intallation of new	2006	91,208	9,121	10	9,121		41,044	38
39	Roofing for The Methodist Home	2006	2,000	200	10	200		900	39
40	Lower Level - Rehab Areas, Painting, Flooring, Electrical, Gym In	2006	44,794	4,479	10	4,479		20,157	40
41	2nd Floor - Swift Corridor - New Doors & Frames, Painting	2006	3,565	357	10	357		1,605	41
42	4th Floor Dining Room - Wall Protection, Handrails, Windows Co	2006	2,588	259	10	259		1,165	42
43	Fire Alarm Smoke Detector/Sprinkler System	2006	70,839	7,084	10	7,084		31,878	43
44	Building Water Cooler	2006	860	43	20	43		193	44
45	Carpeting - Resident Rooms #281, #282, #283, Lower Level-Bush I	2006	16,209	3,242	5	3,242		14,589	45
46	Lawn Sprinkler System	2006	10,200	1,020	10	1,020		4,590	46
47	Perimeter Fence Upgrade Installed	2006	5,500	550	10	550		2,475	47
48	Landscaping -Trees & Shrubs for The Methodist Home	2006	6,300	630	10	630		2,835	48
49									49
50	1st Floor Nursing Station/Utility Room - Plumbing, Carpentry, De	2007	56,005	5,600	10	5,600		19,600	50
51	Chimney Replacement - The Methodist Home Roof	2007	53,190	5,319	10	5,319		18,617	51
52	Bathrooms - 2nd Floor/LL - Replaced Walls, Tubs, Toilets, Showe	2007	28,572	2,857	10	2,857		10,000	52
53	Resident Room - Painting - Rms 79, 459, 461, 466, 477, 268, 457, 26	2007	18,377	1,838	10	1,838		6,432	53
54	Painting - 2nd Floor - Bush Hall & 4th Floor Dayroom/Hallway/D	2007	5,440	544	10	544		1,904	54
55	Fire Alarm System Sprinklers - 1st Floor - Miller & Swift Hallway	2007	5,240	524	10	524		1,834	55
56	Smoke Dampers & Co2 Exhaust- 2nd Floor Resident Dining Room	2007	7,519	376	20	376		1,316	56
57	New Feed Pump Assembly - Boiler Room - The Methodist Home	2007	15,990	640	25	640		2,240	57
58	Carpeting/Flooring - 2nd Floor - Bush Hall - Common Areas and I	2007	28,509	5,702	5	5,702		19,957	58
59	Repaving of Parking Lot - The Methodist Home	2007	2,471	247	10	247		865	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,787,551	\$ 153,318		\$ 153,318	\$	\$ 6,131,763	70

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

Facility Name &amp; ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,787,551	\$ 153,318		\$ 153,318	\$	\$ 6,131,763	1
2									2
3	Resident Room Painting - #'s 66, 72, 79	2008	6,704	671	10	671		1,678	3
4	Painting - Ground Floor - Dining Room/Common Areas/Bathroom	2008	7,815	782	10	782		1,954	4
5	Installed Fire Sprinkler Pumps and Wiring - Utility Room	2008	3,143	314	10	314		785	5
6	Painting and Interior Design - 1st Floor - Foyer/Common Hallway	2008	16,403	1,640	10	1,640		4,100	6
7	Design and Schematics for Day Room and Foyer/Hallways	2008	2,800	280	10	280		700	7
8	Construction/Countertop Installation - 3rd Floor Nursing Station	2008	5,272	527	10	527		1,318	8
9	Emergency Power/Lighting Upgrade - North Entrance/2nd Floor	2008	11,552	577	20	577		1,444	9
10	Hot and Cold Circulating Pumps and Bearing Assemblies	2008	2,112	106	20	106		264	10
11	Boiler Room - Steam Trap/Condensate Pump/Control Switch Inst	2008	6,640	265	25	265		663	11
12	Resident Room - HVAC Fan Motor Replacement	2008	2,503	100	25	100		250	12
13	Chiller/Boiler Room - New Feed Pump, Thermostat & Flush Gun	2008	3,668	147	25	147		367	13
14	Boiler - Retube - Complete	2008	17,282	691	25	691		1,728	14
15	Cooling Tower Replacement	2008	17,644	706	25	706		1,765	15
16	Carpeting/Flooring - 2nd Floor - Bush Hall - 1st Floor Hallways/A	2008	46,410	9,282	5	9,282		23,205	16
17									17
18	Fifth Floor - Masonry/Brick Replacement	2009	9,175	917	10	917		1,375	18
19	Construction of New Nursing Stations - 1st/3rd Floors - Laminate	2009	5,054	505	10	505		758	19
20	Third Floor Hallways - Installed ADA Door Closers and Painted H	2009	7,550	755	10	755		1,133	20
21	Fire Smoke Dampers/Sprinkler Heads installed on 1st, 4th Floors,	2009	12,585	1,259	10	1,259		1,888	21
22	Fourth Floor Hallway/Day Room - Installed New Vinyl Flooring a	2009	12,831	1,283	10	1,283		1,925	22
23	Resident Rooms - New Plank and Amtico Flooring - Rooms #55,56	2009	21,055	2,106	10	2,106		3,159	23
24	Front & Rear Elevators - New Power Supply, Transformer, and S	2009	4,242	424	10	424		636	24
25	Hydraulic Freight Lift - Receiving Dock	2009	3,820	191	20	191		287	25
26	New Fire Stop Actuators and Ductwork	2009	6,600	264	25	264		396	26
27	Resident Rooms - New Ceiling Fan Coil Motors	2009	2,503	100	25	100		150	27
28	Boiler Room - Replacement of Pneumatic Control System, Gas Va	2009	6,737	269	25	269		404	28
29	Chiller Room - HVAC - Replacement of Main Control Board, Col	2009	23,092	924	25	924		1,386	29
30	Carpeting - Resident Rooms #75, #77, #80; 3rd & 4th Floor Hallwa	2009	24,602	4,920	5	4,920		7,379	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,077,345	\$ 183,323		\$ 183,323	\$	\$ 6,192,860	34

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

Facility Name & ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,077,345	\$ 183,323		\$ 183,323	\$	\$ 6,192,860	1
2									2
3	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	83	25	83		83	3
4	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	90	25	90		90	4
5	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	89	25	89		89	5
6	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	418	10	418		418	6
7	Refinish Fire Escape Stairways	2010	7,800	390	10	390		390	7
8	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	199	10	199		199	8
9	Construction of Built-In Laminate Counter Tops, Door - Med Rec	2010	2,960	148	10	148		148	9
10	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	267	10	267		267	10
11	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	524	10	524		524	11
12	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	173	10	173		173	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)		\$ 7,132,837	\$ 185,704		\$ 185,704	\$	\$ 6,195,241	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,223,657	\$ 82,723	\$ 82,723	\$		\$ 817,530	71
72	Current Year Purchases	13,163	658	658			658	72
73	Fully Depreciated Assets	986,353					986,353	73
74								74
75	TOTALS	\$ 2,223,173	\$ 83,381	\$ 83,381	\$		\$ 1,804,541	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			6,720	77
78										78
79										79
80	TOTALS			\$ 62,080	\$ 1,920	\$ 1,920	\$		\$ 61,119	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)	\$ 11,418,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 271,005	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,005	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)	\$ 8,060,901	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/2006-2010	\$ 58,724	\$ 4,451	\$ 9,181	86
87	2010 TMH Bldg Mkt Value Write Up	3,000,000			87
88					88
89					89
90					90
91	TOTALS	\$ 3,058,724	\$ 4,451	\$ 9,181	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: 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	<b>TOTAL</b>				\$ _____			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: \$ 12,190 Description: Copiers - Leased - \$10,871; Dishwasher - Leased - \$1,319

(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	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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**

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

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

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

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

	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	\$	5,051	\$ 322,321	\$	5,051	\$ 322,321	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,930	100,432		1,930	100,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		6,510	361,657		6,510	361,657	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 prescripts				346,479		346,479	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, C3				46,609	74,352		120,961	13
14	<b>TOTAL</b>			\$	13,491	\$ 831,019	\$ 420,831	13,491	\$ 1,251,850	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 **THE METHODIST HOME**# **0005439**Report Period Beginning: **01/01/10**Ending: **12/31/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/10**

(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	\$ 277,028	\$	1
2	Cash-Patient Deposits	22,961		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>428,959</u> )	584,350		3
4	Supply Inventory (priced at )	22,704		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	550		7
8	Accounts Receivable (owners or related parties)	69,956		8
9	Other(specify): <u>Misc A/R</u>	1,358		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 978,907	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	2,000,000		13
14	Buildings, at Historical Cost	10,132,837		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,343,977		16
17	Accumulated Depreciation (book methods)	(8,070,082)		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 (spe <u>Goodwill</u> )	1,000,000		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,441,732	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,420,639	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 160,846	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,687		28
29	Short-Term Notes Payable	4,646		29
30	Accrued Salaries Payable	498,217		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Unexpended Testricted Gifts</u>	35,041		36
37	<u>Due to Third-Party Payor</u>	30,705		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 834,142	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,633		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,633	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 835,775	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,584,864	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,420,639	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,533,222</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>1,533,222</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(505,446)	<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>TMH Mkt Value Adj Required by the</b>	<b>5,975,000</b>	<b>15</b>
<b>16</b>	Other (describe) <b>50% Parent Co. Exit from Strategic Alliance</b>		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>5,469,554</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Equity Transfer from Parent Corporation</b>	<b>582,088</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>582,088</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,584,864</b>	<b>24</b> *

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

Facility Name &amp; ID Number THE METHODIST HOME

# 0005439

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	\$ 7,082,523	1
2	Discounts and Allowances for all Levels	(1,788,130)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,294,393	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,420,853	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,420,853	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,083	14
15	Telephone, Television and Radio	4,823	15
16	Rental of Facility Space		16
17	Sale of Drugs	345,660	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,472	19
20	Radiology and X-Ray	8,953	20
21	Other Medical Services	199,784	21
22	Laundry	10,059	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 609,834	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Other - See attached schedule</u>	3,198,387	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,198,387	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,523,467	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,373,594	31
32	Health Care	2,761,622	32
33	General Administration	2,133,546	33
<b>B. Capital Expense</b>			
34	Ownership	311,280	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,379,886	35
36	Provider Participation Fee	68,985	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,028,913	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(505,446)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (505,446)	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 **THE METHODIST HOME**

# **0005439**

Report Period Beginning:

**01/01/10**

Ending:

**12/31/10**

**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	1,864	2,034	\$ 82,168	\$ 40.40	1
2	Assistant Director of Nursing	224	346	11,727	33.89	2
3	Registered Nurses	16,753	17,739	500,162	28.20	3
4	Licensed Practical Nurses	22,987	24,885	610,319	24.53	4
5	CNAs & Orderlies	72,704	77,330	817,274	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,659	2,796	39,787	14.23	8
9	Activity Director	1,640	1,807	31,822	17.61	9
10	Activity Assistants	4,496	4,769	52,212	10.95	10
11	Social Service Workers	3,966	4,589	103,140	22.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,456	3,864	57,309	14.83	14
15	Cook Helpers/Assistants	18,040	19,626	201,923	10.29	15
16	Dishwashers	6,780	7,485	66,466	8.88	16
17	Maintenance Workers	4,501	4,975	120,834	24.29	17
18	Housekeepers	12,494	13,429	134,753	10.03	18
19	Laundry	3,240	3,452	35,600	10.31	19
20	Administrator	2,328	2,620	160,750	61.35	20
21	Assistant Administrator					21
22	Other Administrative	1,736	1,969	41,928	21.29	22
23	Office Manager					23
24	Clerical	17,800	18,717	417,697	22.32	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	1,864	2,036	28,593	14.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Non Nursing Hom</u>	4,702	5,183	79,917	15.42	33
34	TOTAL (lines 1 - 33)	204,234	219,651	\$ 3,594,381 *	\$ 16.36	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	49,870	L9, C3	36
37	Medical Records Consultant	96	4,416	L10, C3	37
38	Nurse Consultant	377	16,353	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	8	440	L11, C3	44
45	Social Service Consultant	16	1,040	L12, C3	45
46	Other(specify)				46
47	<u>Dietary Management Fees</u>	Monthly	109,341	L1, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,017	\$ 181,460		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	632	\$ 35,790	L10, C3	50
51	Licensed Practical Nurses	12	577	L10, C3	51
52	Certified Nurse Assistants/Aides	41	697	L10, C3	52
53	TOTAL (lines 50 - 52)	685	\$ 37,064		53



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Nelson	Administrator		65,068	Workers' Compensation Insurance	\$ 83,323	IDPH License Fee	\$	
William Lowe	CEO		95,682	Unemployment Compensation Insurance	41,215	Advertising: Employee Recruitment	9,310	
				FICA Taxes	266,266	Health Care Worker Background Check	610	
				Employee Health Insurance	415,886	(Indicate # of checks performed 61)		
				Employee Meals		Patient Background Checks	266	
				Illinois Municipal Retirement Fund (IMRF)*		Books & Subscriptions	9,746	
				Employee Recognition	2,916	Membership Fees	10,012	
						Resident Relations	528	
						Advertising	28,533	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,750			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(18,156)	
Description			Amount			Yellow page advertising	(10,377)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost Ruttenberg & Rothblatt	Audit		\$ 19,550			\$	Out-of-State Travel	\$
FR&R Consulting	Accounting/Counseling		3,875					
Medifax	Data Processing		93					
KPMG	Data Processing		475				In-State Travel	1,421
IVANS	Data Processing		2,737					
James McParland	Legal		2,415					
Landon & Wickersty	Legal		262				Seminar Expense	5,397
Corporate Allocation -	Data Processing		55,817					
Corporate Allocation -	Consulting		47,095				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 132,319	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 6,818

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number THE METHODIST HOME

# 0005439

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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 Services Network of IL - \$6,488
- (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. \$ 54,333 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. \$ 68,985  
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. \$ 9,083
- (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% of L14.  
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? 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: FROST, RUTTENBERG & ROTHBLATT, P.C.
- (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.