

Facility Name & ID Number The United Methodist Village

0014506 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 3/22/2012

	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	143	Skilled (SNF)	143	52,195	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	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,565	1,508	2,692	5,765	8
9	SNF/PED					9
10	ICF	11,473	8,510		19,983	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,038	10,018	2,692	25,748	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.33%

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 143 and days of care provided 2,692

Medicare Intermediary Wisconsin Physicans Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	240,869	16,290	17,868	275,027		275,027	275,027		1	
2	Food Purchase		233,447		233,447		233,447	(16,603)	216,844	2	
3	Housekeeping	115,589	18,207	227	134,023		134,023	(8,656)	125,367	3	
4	Laundry	59,183	22,287	519	81,989		81,989		81,989	4	
5	Heat and Other Utilities			315,936	315,936		315,936	(150,296)	165,640	5	
6	Maintenance	65,201	11,918	65,410	142,529	364	142,893	(39,468)	103,425	6	
7	Other (specify):*									7	
8	TOTAL General Services	480,842	302,149	399,960	1,182,951	364	1,183,315	(215,023)	968,292	8	
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600	9	
10	Nursing and Medical Records	1,430,508	35,140	2,126	1,467,774		1,467,774	(14,232)	1,453,542	10	
10a	Therapy			501,581	501,581		501,581		501,581	10a	
11	Activities	63,528	610	1,785	65,923		65,923		65,923	11	
12	Social Services	50,106		1,516	51,622		51,622		51,622	12	
13	CNA Training									13	
14	Program Transportation	21,181			21,181		21,181		21,181	14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,565,323	35,750	516,608	2,117,681		2,117,681	(14,232)	2,103,449	16	
	C. General Administration										
17	Administrative	47,903	71	21,499	69,473		69,473	(19,441)	50,032	17	
18	Directors Fees									18	
19	Professional Services			28,358	28,358		28,358	(20,504)	7,854	19	
20	Dues, Fees, Subscriptions & Promotions			21,805	21,805		21,805	(21,043)	762	20	
21	Clerical & General Office Expenses	234,877	26,295	147,110	408,282		408,282	(68,466)	339,816	21	
22	Employee Benefits & Payroll Taxes			432,132	432,132		432,132	(11,880)	420,252	22	
23	Inservice Training & Education					16,060	16,060		16,060	23	
24	Travel and Seminar			26,548	26,548	(16,484)	10,064		10,064	24	
25	Other Admin. Staff Transportation			3,208	3,208	60	3,268		3,268	25	
26	Insurance-Prop.Liab.Malpractice			126,505	126,505		126,505	(11,000)	115,505	26	
27	Other (specify):* See PG24	881			881		881	(881)		27	
28	TOTAL General Administration	283,661	26,366	807,165	1,117,192	(364)	1,116,828	(153,215)	963,613	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,329,826	364,265	1,723,733	4,417,824		4,417,824	(382,470)	4,035,354	29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The United Methodist Village

#0014506

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			402,345	402,345	402,345	(138,370)	263,975				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,692	22,692	22,692	(22,692)					32
33	Real Estate Taxes			3,744	3,744	3,744	(3,744)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			428,781	428,781	428,781	(164,806)	263,975				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,357	15,364	172,721	172,721		172,721				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,243	225,243	225,243		225,243				42
43	Other (specify):*			333	333	333	(333)					43
44	TOTAL Special Cost Centers		157,357	240,940	398,297	398,297	(333)	397,964				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,329,826	521,622	2,393,454	5,244,902	5,244,902	(547,609)	4,697,293				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,054)	2		4
5	Telephone, TV & Radio in Resident Rooms	(28,982)	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	(22,692)	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	(8,135)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,348)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(460,398)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (547,609)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (547,609)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

The United Methodist VillageID# 0014506Report Period Beginning: 01/01/2014Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Doctor Expense	\$ (3,502)	10	1
2	Hospital Expense	(10,730)	10	2
3	Marketing Salaries	(19,195)	17	3
4	Transportation Reimbursement	(14,289)	21	4
5	Bank Charges	(839)	21	5
6	Late Fees	(19,886)	21	6
7	Resident Services	(196)	21	7
8	Miscellaneous Income	(6,605)	21	8
9	Chaplin Salary	(881)	27	9
10	Real Estate Taxes	(359)	33	10
11	Chaplin Expenses	(333)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18	INDEPENDENT LIVING ALLOCATION:			18
19	Maintenance Salary	(24,737)	6	19
20	Housekeeping Salary	(8,656)	3	20
21	Office/Billing Salary	(26,651)	21	21
22	Repairs, Maintenance & Supplies	(14,731)	6	22
23	Meal Costs	(8,549)	2	23
24	Utilities	(121,314)	5	24
25	Professional Fees	(12,369)	19	25
26	Dues, Fees, Subs, Promotions	(1,695)	20	26
27	Employee Benefits	(11,880)	22	27
28	Insurance	(11,000)	26	28
29	Miscellaneous	(246)	17	29
30	Depreciation	(138,370)	30	30
31	Real Estate Taxes	(3,385)	33	31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(460,398)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The United Methodist Village# 0014506

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	(16,603)	0	0	0	0	0	0	0	0	0	0	(16,603)	2
3	Housekeeping	(8,656)	0	0	0	0	0	0	0	0	0	0	(8,656)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(150,296)	0	0	0	0	0	0	0	0	0	0	(150,296)	5
6	Maintenance	(39,468)	0	0	0	0	0	0	0	0	0	0	(39,468)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(215,023)	0	(215,023)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(14,232)	0	0	0	0	0	0	0	0	0	0	(14,232)	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(14,232)	0	(14,232)	16									
	C. General Administration													
17	Administrative	(19,441)	0	0	0	0	0	0	0	0	0	0	(19,441)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,504)	0	0	0	0	0	0	0	0	0	0	(20,504)	19
20	Fees, Subscriptions & Promotions	(21,043)	0	0	0	0	0	0	0	0	0	0	(21,043)	20
21	Clerical & General Office Expenses	(68,466)	0	0	0	0	0	0	0	0	0	0	(68,466)	21
22	Employee Benefits & Payroll Taxes	(11,880)	0	0	0	0	0	0	0	0	0	0	(11,880)	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	(11,000)	0	0	0	0	0	0	0	0	0	0	(11,000)	26
27	Other (specify):*	(881)	0	0	0	0	0	0	0	0	0	0	(881)	27
28	TOTAL General Administration	(153,215)	0	(153,215)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(382,470)	0	(382,470)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(138,370)	0	0	0	0	0	0	0	0	0	0	(138,370)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,692)	0	0	0	0	0	0	0	0	0	0	(22,692)	32
33	Real Estate Taxes	(3,744)	0	0	0	0	0	0	0	0	0	0	(3,744)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(164,806)	0	(164,806)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(333)	0	0	0	0	0	0	0	0	0	0	(333)	43
44	TOTAL Special Cost Centers	(333)	0	(333)	44									
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(547,609)	0	(547,609)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The United Methodist Village, Inc.	100%	United Methodist Village North Campus	Lawrenceville			

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	See Page 30 for Board of Directors								\$	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: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The United Methodist Village

0014506

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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			
	A. Directly Facility Related																
	Long-Term																
1	Citizens National Bank		X	Mortgage	\$4,026.00	06/23/09	\$ 650,000	\$ 525,770	06/23/29	4.2500	\$ 22,692						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related				\$4,026.00		\$ 650,000	\$ 525,770			\$ 22,692						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 650,000	\$ 525,770			\$ 22,692						

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.)

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 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	_____	8	
		2010	_____	9	
		2011	_____	10	
		2012	_____	11	
		2013	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2013 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The United Methodist Village COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0014506

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,538 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	143	1965	1965	\$ 1,350,000	\$ 27,000	50	\$ 27,000	\$	\$ 1,323,000	4
5		1974	1974	916,911	18,338	50	18,338		742,417	5
6		1979	1979	1,228,695	24,574	50	24,574		1,158,506	6
7		1925	1925	601,097	15,027	40	15,027		502,874	7
8										8
Improvement Type**										
9	Various Fully Depreciated Assets Thru 2014			3,516,997					3,516,997	9
10	Various		1979	117,791	2,356	50	2,356		108,392	10
11	Various		1989	17,695	354	50	354		12,210	11
12	Various		1989	96,708	505	20	505		96,708	12
13	Various		1990	610,945	30,547	20	30,547		608,941	13
14	Various		1991	132,029	2,751	20	2,751		132,029	14
15	Various		1992	313,917	15,696	20	15,696		293,336	15
16	Various		2000	1,637	109	15	109		1,625	16
17	Various		2002	21,530	1,436	15	1,436		17,774	17
18	HVAC System		2002	14,126	831	17	831		10,041	18
19	Wiring & Circuit Panels		2002	9,048	452	20	452		5,614	19
20	Office Remodeling		2002	2,138	105	12	105		2,138	20
21	Various		2003	3,323	134	25	134		1,586	21
22	Various		2003	56,659	3,778	15	3,778		45,094	22
23	Building Supplies		2004	3,115	208	15	208		2,149	23
24	Various		2005	9,744	649	15	649		6,511	24
25	Various		2005	96,745	9,675	10	9,675		92,861	25
26	Sidewalk & Ramps		2005	6,000	272	9	272		6,000	26
27	Water Furnace		2006	1,944	130	15	130		1,040	27
28	Hallway Tile		2006	3,399	340	10	340		2,692	28
29	Handrails		2006	553	37	15	37		260	29
30	Geothermal System		2006	1,686	169	10	169		1,309	30
31	Water Meter		2006	2,194	110	20	110		843	31
32	Locks for Outside Entrance		2006	10,377	1,038	10	1,038		7,958	32
33	Smoke Detectors		2006	17,751	1,775	10	1,775		13,068	33
34	Mig Welder		2006	530	53	10	53		402	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Boiler Repair	2006	\$ 11,590	\$ 773	15	\$ 773	\$	\$ 6,550	37
38	Tile Floor in Dietary	2006	9,952	995	10	995		8,375	38
39	4 Water Furnaces	2006	7,331	733	10	733		6,169	39
40	Air Conditioner	2006	633	63	10	63		525	40
41	Washer for Laundry Department	2006	9,379	625	15	625		8,156	41
42	Pellet Heater for Dietary	2006	2,659	266	10	266		2,194	42
43	Water Softner	2006	2,925	293	10	293		2,368	43
44	Carbon Monoxide Detectors	2006	2,139	214	10	214		1,730	44
45	Dycus - Replaced Carpet with Tile	2006	12,514	1,251	10	1,251		10,321	45
46	Sidewalk	2007	560	37	15	37		287	46
47	Railing on Dycus Ramp	2007	683	46	15	46		314	47
48	Breaker Box	2007	495	71	7	71		467	48
49	Shower Installation	2007	5,000	500	10	500		3,208	49
50	Sprinkler Installation	2007	145,567	7,278	20	7,278		45,488	50
51	Sprinkler System	2008	154,780	7,739	20	7,739		46,434	51
52	Dycus Room - Install Drop Ceiling for Sprinkler System	2009	11,245	1,606	7	1,606		9,369	52
53	Elevator Upgrade	2009	39,165	1,004	39	1,004		5,857	53
54	Holden Center Roof Repair	2009	650	43	15	43		240	54
55	Electrical Maintenance	2009	259	25	5	25		259	55
56	Paint & Supplies	2009	479	47	5	47		479	56
57	Flooring & Supplies	2009	1,363	135	5	135		1,363	57
58	Added Cabinets	2009	3,023	605	5	605		1,998	58
59	Replaced Floor Coverings & Carpet in Office	2010	363	59	5	59		363	59
60	Various Supplies	2010	399	57	7	57		285	60
61	Mechanical Door Resistor for Elevator	2010	1,683	84	20	84		399	61
62	Screen & Windows	2010	2,539	169	15	169		747	62
63	Flooring	2010	1,260	252	5	252		1,092	63
64	Wesley 1 - Flooring	2010	21,532	3,076	7	3,076		13,073	64
65	Tile Flooring	2010	10,080	1,008	10	1,008		4,200	65
66	Tile for Wesley 1	2011	35,951	3,595	10	3,595		14,110	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,661,482	\$ 191,098		\$ 191,098	\$	\$ 8,910,795	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 and Improvement Costs-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		\$ 9,661,482	\$ 191,098		\$ 191,098	\$	\$ 8,910,795	1
2	Vinyl Flooring	2012	6,966	697	10	697		2,033	2
3	Air Conditioner - P Tac Unit	2012	2,294	459	5	459		1,150	3
4	Push Bars & Sirens	2012	2,628	263	10	263		723	4
5	Cabinets for Nursing Station	2012	442	88	5	88		220	5
6	Hote Water Heater	2013	726	73	10	73		146	6
7	Keypad Entry System	2013	1,014	101	10	101		169	7
8	Water Heaters	2013	7,713	771	10	771		1,028	8
9	Drink Station Dietary	2013	589	59	10	59		74	9
10	Water Heaters	2014	7,859	458	10	458		458	10
11	Dycus Laminate Floor	2014	1,848	123	5	123		123	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)		\$ 9,693,561	\$ 194,190		\$ 194,190	\$	\$ 8,916,919	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 823,387	\$ 60,438	\$ 60,438	\$		\$ 424,432	71
72	Current Year Purchases	15,318	1,596	1,596			1,596	72
73	Fully Depreciated Assets	3,602,516					3,602,516	73
74								74
75	TOTALS	\$ 4,441,221	\$ 62,034	\$ 62,034	\$		\$ 4,028,544	75

D. Vehicle Costs. (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		See Attached Schedule - Page 26		\$ 227,813	\$ 7,751	\$ 7,751	\$	Various	\$ 213,512	76
77										77
78										78
79										79
80	TOTALS			\$ 227,813	\$ 7,751	\$ 7,751	\$		\$ 213,512	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)	\$ 14,522,303	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,975	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)	\$ 13,158,975	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 Schedule - Page 27	\$ 5,136,068	\$ 138,703	\$ 3,159,300	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 5,136,068	\$ 138,703	\$ 3,159,300	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A-03	hrs	\$	13,034	\$	262,400	\$	13,034	\$	262,400	1
2	Licensed Speech and Language Development Therapist	10A-03	hrs		1,252		41,506		1,252		41,506	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A-03	hrs		5,401		197,675		5,401		197,675	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 prescrpts					96,292			96,292	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 & Supplies</u>	39-02						61,065			61,065	13
14	TOTAL			\$	19,687	\$	501,581	\$	157,357	\$	658,938	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: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 311,177	\$	1
2	Cash-Patient Deposits	49,606		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>214,765</u>)	3,008,651		3
4	Supply Inventory (priced at)	27,420		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd-party payors</u>	4,176		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,401,030	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	117,752		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,213,175		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,868,187		16
17	Accumulated Depreciation (book methods)	(18,039,901)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,667,960	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,068,990	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,621,788	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,606		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,525		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,912		32
33	Accrued Interest Payable			33
34	Deferred Compensation	89,833		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other Payables</u>	455,447		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,435,111	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,182,520		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Refundable Deposits and Fees</u>	91,605		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,274,125	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,709,236	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,359,754	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,068,990	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,656,159	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,656,159	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(296,407)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (296,405)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,359,754	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,080,226	1
2	Discounts and Allowances for all Levels	(2,201,729)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,878,497	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,977,251	6
7	Oxygen	49,878	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,027,129	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	700	13
14	Non-Patient Meals	48,784	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	189,300	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,479	19
20	Radiology and X-Ray		20
21	Other Medical Services	161,738	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 418,001	23
D. Non-Operating Revenue			
24	Contributions	292,201	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 292,201	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	121,957	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,957	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,737,785	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,182,951	31
32	Health Care	2,117,681	32
33	General Administration	1,117,192	33
B. Capital Expense			
34	Ownership	428,781	34
C. Ancillary Expense			
35	Special Cost Centers	173,054	35
36	Provider Participation Fee	225,243	36
D. Other Expenses (specify):			
37	<u>Expenses Reported on Related Party Cost Report</u>	4,789,290	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,034,192	40
41	Income before Income Taxes (line 30 minus line 40)**	(296,407)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (296,407)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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	7,664	8,416	\$ 179,615	\$ 21.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,014	9,792	184,989	18.89	3
4	Licensed Practical Nurses	21,322	22,734	408,695	17.98	4
5	CNAs & Orderlies	62,062	65,595	629,490	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,689	6,255	63,529	10.16	10
11	Social Service Workers	3,186	3,521	50,105	14.23	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,000	15.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,192	22,581	208,868	9.25	15
16	Dishwashers					16
17	Maintenance Workers	10,703	11,970	127,588	10.66	17
18	Housekeepers	11,213	12,099	107,060	8.85	18
19	Laundry	4,979	5,441	59,183	10.88	19
20	Administrator	1,581	2,080	47,903	23.03	20
21	Assistant Administrator					21
22	Other Administrative	13,773	15,000	195,227	13.02	22
23	Office Manager					23
24	Clerical	531	594	7,255	12.21	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	2,594	2,833	27,438	9.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplin</u>	100	100	881	8.81	33
34	TOTAL (lines 1 - 33)	177,683	191,091	\$ 2,329,826 *	\$ 12.19	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	192	\$ 11,050	1-3	35
36	Medical Director	Monthly	9,600	9-3	36
37	Medical Records Consultant	13	1,013	10-3	37
38	Nurse Consultant	As Needed		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	41	1,516	11-3	44
45	Social Service Consultant	41	1,516	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	287	\$ 24,695		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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The United Methodist Village

0014506

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,955 Line 10-2
- (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. \$ 225,243
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Breakout of Other General Administrative Expenses

Column 1

Chaplain Salaries

\$ 881

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment and Vehciles</u>	<u>Total</u>
Schedule XI Ownership Cost	\$ 159,708	\$ 9,693,561	\$ 4,669,034	\$ 14,522,303
Non-care Assets	-	5,136,068	-	5,136,068
Related Facility	349,039	4,344,077	1,168,937	5,862,053
Non-care Assets of Related Facility	-	68,846	-	68,846
Reconciliation variance	<u>-</u>	<u>(29,377)</u>	<u>30,216</u>	<u>839</u>
Schedule XV Balance Sheet	<u><u>\$ 508,747</u></u>	<u><u>\$ 19,213,175</u></u>	<u><u>\$ 5,868,187</u></u>	<u><u>\$ 25,590,109</u></u>

Note: The related facility is required to file a separate cost report with the Department of Healthcare and Family Services.
The related facility is The United Methodist Village North Campus, IDPH # 0046656.

SEE ACCOUNTANTS' COMPILATION REPORT.

<u>Vehicle Description</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Depreciation</u>	<u>Accumulated Depreciation</u>
Fully Depreciated Assets	Various	\$ 169,893	\$ -	\$ 169,893
2008 Ford E250 WC Van	2008	36,878	5,268	30,645
2008 Chevy Van	2009	14,087	1,409	7,983
2000 Ford Taurus	2009	5,551	793	4,031
Transmission Repair	2011	1,404	281	960
Total to Page 13, Line 79		<u>\$ 227,813</u>	<u>\$ 7,751</u>	<u>\$ 213,512</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Description of Non Care Assets and Depreciation

Description	Year	Cost	Current Year Depreciation	Accumulated Depreciation
Apts & Cottage Bldgs	1987	\$ 1,165,544	\$ 23,311	\$ 938,840
Cottage Buildings	1988	133,505	-	133,505
Apts & Cottage Bldgs	1989	90,982	1,820	90,982
Bathroom, plumbing and other upgrades	1990	7,275	-	7,275
Carports	1992	14,781	-	14,781
Apartment upgrades, Master Key	1993	7,513	-	7,513
McKiou Center	1994	3,177,429	79,436	1,628,970
Apts & Cottage Bldgs	1997	11,707	-	11,707
Appliances and Upgrades	1998	50,680	-	50,680
Roofing, Carpet, Tile, Heat Pumps, Guttering	2001	70,478	248	70,231
Apts & Cottage Bldgs	2002	64,155	1,185	46,970
A/C Unit and House Removal	2003	7,346	-	7,346
Carport Door, A/C Units	2005	3,624	250	3,624
Flooring, Carpet, Tile, and Heat/Air Units	2006	20,881	391	20,328
Appliances and Flooring for Cottages	2007	4,406	441	3,315
Garage Door, Carpet, Shower, Roofing, and A/C Upgrades	2008	155,415	8,837	56,628
Appliances, Carpet, and A/C Upgrade for Cottages	2009	13,545	1,419	7,875
Appliances for cottages	2010	9,278	843	3,862
Appliances, AC Units and Laminate Flooring for Cottages & Apts	2011	32,973	6,595	23,546
New flooring for cottages and upgrade units	2012	61,643	9,720	25,132
Flooring, Appliances, Awning, Water Heater, Paint	2013	32,192	4,171	6,154
Carpet for Cottage	2014	716	36	36
TOTAL - To Page 13		<u>\$ 5,136,068</u>	<u>\$ 138,703</u>	<u>\$ 3,159,300</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

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

PAGE 28

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

SEE ACCOUNTANTS' COMPILATION REPORT.

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

PAGE 29

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.

Name	Provided Services (Y or N)	Type of Service (if applicable)	Ownership of Business That Provided Services	Type of Business (if applicable)
Sarah Brian	N	N/A	N/A	N/A
Ed Davis	N	N/A	N/A	N/A
Keith Chelsvig	N	N/A	N/A	N/A
Rev. Mark Canada	N	N/A	N/A	N/A
Diane Goff	N	N/A	N/A	N/A
Nancy Myers	N	N/A	N/A	N/A
Luanne Negley	N	N/A	N/A	N/A
Rev. Gary Pearce	N	N/A	N/A	N/A
Duane Ambrose	N	N/A	N/A	N/A
Clyde Putnam	N	N/A	N/A	N/A
Jack Vayhinger	N	N/A	N/A	N/A
Paula Stoltz	N	N/A	N/A	N/A
Morgan Newell, South Campus Administrator	N	N/A	N/A	N/A
Paula McKnight, North Campus Administrator	N	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT.

<u>Description</u>	<u>Who Attended</u>	<u>Date</u>	<u>Amount</u>
Sanitation Recertification		4/22/2014	100
Sanitation Recertification	Susan Munson	7/22/2014	100
Sanitation Recertification	Jackie Phegley	11/18/2014	70
Relias Learning In house education	All staff	2/11/2014	7,825
Relias Learning In house education	All staff	12/17/2014	7,421
C N A Recertification	C N A Staff	6/23/2014	120
MDS Book	Education Materials	10/6/2014	242
Optuminsight (Nursing Training)	Education Materials	10/28/2014	182
			<u>16,060</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Meeting Attended	Dates	Who Attended	Location	Cost
Nursing Home Administrator Licensure	1/1/2014	Pam Ryan	Evansville, IN	441
			Total Out of State:	<u>441</u>
SIATA Workshop	3/5/2014	Pam Hipsher ACT, Barbara Barker, Judy Lea	Olney, IL	120
SIATA Workshop	9/26/2014	Pam Hipsher ACT, Barbara Barker, Judy Lea	Olney, IL	136
Nursing Home Administrator Licensure Review course	1/22/2014	Morgan Newell	Springfield, IL	400
Illinois Great Rivers Annual Conference	7/4/2014	Morgan Newell	Peoria, IL	478
Administrator Seminar	10/3/2014	Morgan Newell	Peoria, IL	488
IHCA Conference	8/24/2014	Morgan Newell, Ed Lancaster, Nanette Dunn	Peoria, IL	5,491
Human Resources	11/5/2014	Teri Stangle	Springfield, IL	230
SIATA Workshop	10/23/2014	Carol Wood SS, Vicki Lewis SS	Springfield, IL	223
LTC Certification	5/22/2014	Ed Lancaster DON	Naperville, IL	1,857
SIATA Workshop	9/23/2014	Social Services Staff	Springfield, IL	200
			Total In-State:	<u>9,623</u>
			TOTAL Travel	<u>\$ 10,064</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Program Services. Page 21, Part C.

<u>Vendor/Payee</u>	<u>Invoice Date</u>	<u>Description of Services</u>	<u>Allowable</u>	<u>Non-Allowable</u>
Duane Morris LLP	1/17/2014	Professional Services for Employment Issue, IDPH Notice	\$ -	\$ 875
Duane Morris LLP	12/17/2013	Professional Services for Employment Issue, HIPAA Notice	-	4,101
Duane Morris LLP	1/17/2014	Regulatory Counsel	-	3,159
			<u>\$ -</u>	<u>\$ 8,135</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Total

\$	875
	4,101
	3,159
<hr/>	
\$	8,135
<hr/> <hr/>	

Schedule V. Cost Center Expenses - Reclassifications

<u>Cost Center</u>	<u>Line</u>	<u>Increase</u>	<u>Decrease</u>
In-Service Training & Education	23	\$ 16,060	
Travel and Seminar	24		\$ 16,060
(Reclassify in-service training and education expenses)			
Maintenance	6	\$ 364	
Other Admin. Staff Transportation	25	\$ 60	
Travel and Seminar	24		\$ 424
(Relcassify fuel and supply expenses)			

SEE ACCOUNTANTS' COMPILATION REPORT.