

Facility Name & ID Number United Methodist Vlg N Cam

0046656 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 2/11/2008

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,868	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	98	TOTALS	98	35,868	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6	291	3,370	3,667	8
9	SNF/PED					9
10	ICF	8,504	10,391		18,895	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,510	10,682	3,370	22,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.90%

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 03/01/2004

J. Was the facility purchased or leased after January 1, 1978?

YES Date 03/01/2004 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 98 and days of care provided 3,370

Medicare Intermediary Wisconsin Physicans Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	207,312	12,064	15,340	234,716		234,716	(5,196)	229,520		1
2	Food Purchase		154,173		154,173		154,173	(18,458)	135,715		2
3	Housekeeping	98,395	13,353		111,748		111,748	(2,474)	109,274		3
4	Laundry	54,038	15,590	1,746	71,374		71,374	(1,580)	69,794		4
5	Heat and Other Utilities			110,018	110,018		110,018	(14,939)	95,079		5
6	Maintenance	46,180	4,875	23,626	74,681		74,681	(1,738)	72,943		6
7	Other (specify):*										7
8	TOTAL General Services	405,925	200,055	150,730	756,710		756,710	(44,385)	712,325		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,575,638	41,316	3,174	1,620,128		1,620,128	(8,256)	1,611,872		10
10a	Therapy			380,758	380,758		380,758		380,758		10a
11	Activities	79,920	1,584	3,244	84,748		84,748		84,748		11
12	Social Services	29,731		3,154	32,885		32,885		32,885		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,685,289	42,900	399,930	2,128,119		2,128,119	(8,256)	2,119,863		16
	C. General Administration										
17	Administrative	130,633	6	4,010	134,649		134,649		134,649		17
18	Directors Fees										18
19	Professional Services			222,810	222,810		222,810	(188,317)	34,493		19
20	Dues, Fees, Subscriptions & Promotions			13,754	13,754	1,020	14,774	(10,684)	4,090		20
21	Clerical & General Office Expenses	130,791	8,968	237,988	377,747		377,747	(198,227)	179,520		21
22	Employee Benefits & Payroll Taxes			349,707	349,707		349,707		349,707		22
23	Inservice Training & Education					2,268	2,268		2,268		23
24	Travel and Seminar			6,885	6,885	(2,268)	4,617		4,617		24
25	Other Admin. Staff Transportation			3,665	3,665		3,665	(7,200)	(3,535)		25
26	Insurance-Prop.Liab.Malpractice			76,121	76,121		76,121		76,121		26
27	Other (specify):* See PG29			46,734	46,734	(1,020)	45,714	(45,000)	714		27
28	TOTAL General Administration	261,424	8,974	961,674	1,232,072		1,232,072	(449,428)	782,644		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,352,638	251,929	1,512,334	4,116,901		4,116,901	(502,069)	3,614,832		29

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

SEE ACCOUNTANTS' PREPARATION 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 United Methodist Vlg N Cam

#0046656

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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			177,991	177,991		177,991	(3,442)	174,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			112,416	112,416		112,416	(25)	112,391			32
33	Real Estate Taxes			97,247	97,247		97,247	(2,849)	94,398			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			387,654	387,654		387,654	(6,316)	381,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,752	27,008	178,760		178,760		178,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):* Chaplin Expenses			18	18		18	(18)				43
44	TOTAL Special Cost Centers		151,752	80,828	232,580		232,580	(18)	232,562			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,352,638	403,681	1,980,816	4,737,135		4,737,135	(508,403)	4,228,732			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,045)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,504)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25)	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	(2,849)	33		17
18	Fines and Penalties	(31,651)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(188,317)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(166,000)	21		24
25	Fund Raising, Advertising and Promotional	(10,684)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(81,328)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (508,403)		\$	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))	\$ (508,403)		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	

SEE ACCOUNTANTS' PREPARATION REPORT

United Methodist Vlg N Cam

ID# 0046656

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (109)	21	1
2	Transportation Reimbursement	(7,200)	25	2
3	Chaplin Expenses	(18)	43	3
4	Settlement Expenses	(45,000)	27	4
5				5
6				6
7				7
8				8
9	Assisted Living Expense Allocation:			9
10	Dietary	(5,196)	1	10
11	Food Purchase	(3,413)	2	11
12	Housekeeping	(2,474)	3	12
13	Laundry	(1,580)	4	13
14	Utilities	(2,435)	5	14
15	Maintenance	(1,738)	6	15
16	Depreciation	(3,442)	30	16
17	Nursing Salary	(936)	10	17
18	Cert. Nursing Assistant Salary	(7,320)	10	18
19	Billing Salary	(467)	21	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(81,328)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number United Methodist Vlg N Cam# 0046656 Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	(5,196)	0	0	0	0	0	0	0	0	0	0	(5,196)	1
2	Food Purchase	(18,458)	0	0	0	0	0	0	0	0	0	0	(18,458)	2
3	Housekeeping	(2,474)	0	0	0	0	0	0	0	0	0	0	(2,474)	3
4	Laundry	(1,580)	0	0	0	0	0	0	0	0	0	0	(1,580)	4
5	Heat and Other Utilities	(14,939)	0	0	0	0	0	0	0	0	0	0	(14,939)	5
6	Maintenance	(1,738)	0	0	0	0	0	0	0	0	0	0	(1,738)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(44,385)	0	(44,385)	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	(8,256)	0	0	0	0	0	0	0	0	0	0	(8,256)	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	(8,256)	0	(8,256)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(188,317)	0	0	0	0	0	0	0	0	0	0	(188,317)	19
20	Fees, Subscriptions & Promotions	(10,684)	0	0	0	0	0	0	0	0	0	0	(10,684)	20
21	Clerical & General Office Expenses	(198,227)	0	0	0	0	0	0	0	0	0	0	(198,227)	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	(7,200)	0	0	0	0	0	0	0	0	0	0	(7,200)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(45,000)	0	0	0	0	0	0	0	0	0	0	(45,000)	27
28	TOTAL General Administration	(449,428)	0	(449,428)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(502,069)	0	(502,069)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number United Methodist Vlg N Cam# 0046656

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,442)	0	0	0	0	0	0	0	0	0	0	(3,442)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	0	0	0	0	0	0	0	0	0	0	(25)	32
33	Real Estate Taxes	(2,849)	0	0	0	0	0	0	0	0	0	0	(2,849)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,316)	0	0	0	0	0	0	0	0	0	0	(6,316)	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):*	(18)	0	0	0	0	0	0	0	0	0	0	(18)	43
44	TOTAL Special Cost Centers	(18)	0	0	0	0	0	0	0	0	0	0	(18)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(508,403)	0	0	0	0	0	0	0	0	0	0	(508,403)	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	The United Methodist Village - South 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' PREPARATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam # 0046656 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 31 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' PREPARATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam

0046656

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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' PREPARATION REPORT

Facility Name & ID Number

United Methodist Vlg N Cam

0046656

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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		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			
A. Directly Facility Related																		
Long-Term																		
1	USDA		X	Mortgage	\$13,260.00	10/26/04	\$ 3,000,000	\$ 2,544,139	11/26/14	4.3750	\$ 112,416	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$13,260.00		\$ 3,000,000	\$ 2,544,139			\$ 112,416	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,544,139			\$ 112,416	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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' PREPARATION 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 2015 report.				\$	92,000	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.)				\$	94,623	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	2,398	3	
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	92,000	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.				\$	94,398	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2011	88,801	8	FOR BHF USE ONLY			
	2012	85,947	9	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	2013	83,093	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2014	90,404	11	15	LESS REFUND FROM LINE 6	\$	15
	2015	94,398	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Note: Accrual based on prior year tax bill.							

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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME United Methodist Vlg N Cam COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0046656

CONTACT PERSON REGARDING THIS REPORT Curt Benson, CPA

TELEPHONE (812) 882-7730 FAX #: (812) 882-7778

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-001-673-40</u>	<u>Long-Term Care Facility</u>	\$ <u>94,623.42</u>	\$ <u>94,623.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>94,623.42</u></u>	\$ <u><u>94,623.42</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 X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 39,415 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Assisted Living Units Located within the building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Facility, 2004, \$349,039, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), \$349,039, 3.

SEE ACCOUNTANTS' PREPARATION 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	98	2004	1991	\$ 3,982,381	\$ 102,224	39	\$ 102,224		\$ 1,307,493	4
5			2006	12,172	609	20	609		6,293	5
6			2008	198,160	4,954	40	4,954		40,458	6
7			2009	49,324	1,233	40	1,233		10,245	7
8										8
Improvement Type**										
9	Various Fully Depreciated Assets Thru 2016			3,434					3,434	9
10	Roof Improvements		2007	5,070	296	10	296		5,070	10
11	Upgrade for Fire System		2007	1,629	163	10	163		1,561	11
12	Handrails		2008	720	48	15	48		432	12
13	25 Cartons of Tile		2008	1,199	120	10	120		1,019	13
14	Keypad for Doors		2009	2,020	264	7	264		2,020	14
15	New Smoke Shack		2009	1,210	121	10	121		887	15
16	Kitchen Lighting		2010	1,017	68	15	68		424	16
17	Sprinklers Clean Out		2010	28,751	2,875	10	2,875		17,968	17
18	Locks for Facility		2010	1,253	179	7	179		1,104	18
19	Heaters and Air Conditioners		2011	10,860	1,139	5	1,139		9,436	19
20	5 Ton Air Conditioner Unit		2012	4,663	466	10	466		3,730	20
21	Sprinklers Clean Out		2012	15,501	1,033	15	1,033		4,649	21
22	Ceramic Tiles		2012	3,995	200	20	200		817	22
23	Water Heaters		2013	7,540	754	10	754		2,890	23
24	Canopy for Resident Smoke Areas		2013	920	61	15	61		234	24
25	Walk-In Refrigerator		2013	770	51	15	51		170	25
26	Air Conditioner - 5 Ton R22 Unit		2014	1,497	150	10	150		375	26
27	Sprinkler System Repair		2014	9,991	400	25	400		900	27
28	Sprinkler System Repair		2015	2,290	229	10	229		458	28
29	5 Ton AC Unit		2015	2,585	259	10	259		409	29
30	Pull Side Mount		2015	950	190	5	190		285	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								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)	\$ 4,349,902	\$ 118,086		\$ 118,086	\$	\$ 1,422,761	70

SEE ACCOUNTANTS' PREPARATION 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	\$ 1,010,260	\$ 54,866	\$ 54,866	\$	Various	\$ 463,562	71
72	Current Year Purchases	13,898	1,597	1,597		Various	1,597	72
73	Fully Depreciated Assets	168,160					168,160	73
74								74
75	TOTALS	\$ 1,192,318	\$ 56,463	\$ 56,463	\$		\$ 633,319	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,891,259	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,549	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,549	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)	\$ 2,056,080	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 Page 25	\$ 68,846	\$ 3,442	\$ 28,037	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 68,846	\$ 3,442	\$ 28,037	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' PREPARATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam

0046656

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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' PREPARATION REPORT

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			
		1	2	3	4
		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' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	8,941	\$ 157,399	\$	8,941	\$ 157,399	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,437	49,846		2,437	49,846	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		8,943	157,145		8,943	157,145	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				108,891		108,891	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	20,321	\$ 364,390	\$ 108,891	20,321	\$ 473,281	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' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2016**

(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	\$ 55,676	\$	1
2	Cash-Patient Deposits	27,641		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>708,000</u>)	3,273,400		3
4	Supply Inventory (priced at)	21,176		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>Contribution Receivable</u>	21,928		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,399,821	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	37,552		12
13	Land	508,747		13
14	Buildings, at Historical Cost	19,259,569		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,923,676		16
17	Accumulated Depreciation (book methods)	(19,105,947)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Beneficial Interest In Trust</u>	481,857		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,105,454	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,505,275	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,768,492	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,641		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,033		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,745		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 Accrued Exp/Deferred Rev</u>	694,054		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,856,798	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,041,888		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>	86,762		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,128,650	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,985,448	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,519,827	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,505,275	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (505,205)	1
2	Restatements (describe):		2
3	Include UMV-South Campus Equity	5,431,240	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,926,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,406,208)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,406,208)	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)	\$ 3,519,827	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION 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	\$ 9,145,794	1
2	Discounts and Allowances for all Levels	(2,589,544)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,556,250	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,735,689	6
7	Oxygen	45,904	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,781,593	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	(336)	13
14	Non-Patient Meals	52,233	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	228,277	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,603	19
20	Radiology and X-Ray		20
21	Other Medical Services	116,288	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 418,065	23
D. Non-Operating Revenue			
24	Contributions	79,463	24
25	Interest and Other Investment Income***	(3,038)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 76,425	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	143,353	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 143,353	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,975,686	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	756,710	31
32	Health Care	2,128,119	32
33	General Administration	1,232,072	33
B. Capital Expense			
34	Ownership	387,654	34
C. Ancillary Expense			
35	Special Cost Centers	178,778	35
36	Provider Participation Fee	53,802	36
D. Other Expenses (specify):			
37	<u>Expenses Reported on Related Party Cost Report</u>	5,644,759	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,381,894	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,406,208)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,406,208)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,695,071	44
45	Private Pay - Net Inpatient Revenue	2,752,039	45
46	Medicare - Net Inpatient Revenue	1,109,140	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,556,250	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number United Methodist Vlg N Cam

0046656

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	5,397	5,815	\$ 123,798	\$ 21.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,949	14,024	306,627	21.86	3
4	Licensed Practical Nurses	16,332	17,100	316,440	18.51	4
5	CNAs & Orderlies	71,560	76,552	807,237	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,368	7,940	79,920	10.07	10
11	Social Service Workers	1,934	2,158	29,731	13.78	11
12	Dietician	19,932	21,080	207,312	9.83	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,831	3,231	46,180	14.29	17
18	Housekeepers	8,918	9,752	98,395	10.09	18
19	Laundry	5,452	6,026	54,037	8.97	19
20	Administrator	1,872	1,892	130,633	69.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,673	7,657	112,690	14.72	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	1,959	2,121	21,537	10.15	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplain</u>	1,032	1,040	18,101	17.40	33
34	TOTAL (lines 1 - 33)	164,209	176,388	\$ 2,352,638 *	\$ 13.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	215	\$ 12,273	1-3	35
36	Medical Director	Monthly	9,600	9-3	36
37	Medical Records Consultant	1	88	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	2,031	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	79	2,595	11-3	44
45	Social Service Consultant	79	3,154	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	374	\$ 29,741		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' PREPARATION REPORT

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			
Paula McKnight	Administrator	0	\$ 130,633	Workers' Compensation Insurance	\$ 71,001	IDPH License Fee	\$			
				Unemployment Compensation Insurance	25,991	Advertising: Employee Recruitment				
				FICA Taxes	174,434	Health Care Worker Background Check				
				Employee Health Insurance	65,962	(Indicate # of checks performed)				
				Employee Meals		Resident Background Checks	102 1,020			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising/Public Relations	10,684			
				Life Insurance	1,880	Dues	3,070			
				401k	7,061					
				Miscellaneous Employee Benefits	3,378					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 130,633							
(List each licensed administrator separately.)										
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$	Out-of-State Travel	\$		
							In-State Travel	4,617		
							Seminar Expense			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 349,707	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,090
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
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		
Hochschild, Bloom & Company	Accounting Services	\$ 18,100				\$	Out-of-State Travel	\$		
Templin Healthcare Accounting	Accounting Services	11,368								
Duane Morris LLP	Legal Services	192,916								
Latimer LeVay Fyock LLC	Legal Services	426								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 222,810	TOTAL			\$	Entertainment Expense ()		
(For legal fee disclosure, see page 39 of instructions)								(agree to Sch. V, line 24, col. 8)		
								TOTAL		\$ 4,617

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number United Methodist Vlg N Cam# 0046656Report Period Beginning: 01/01/2016Ending: 12/31/2016**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? N/A
- (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? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,095 Line 10
- (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. N/A
- (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. \$ 53,802
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes - See Pg 23 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? Yes Indicate the amount. \$ 15,045
- (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? Adequate records maintained
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. \$ N/A
- (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

SEE ACCOUNTANTS' PREPARATION REPORT

Page 22 - General Information, #14 - Allocation for Assisted Living

<u>Revenues Summary</u>	<u>Operating Revenues</u>	<u>Percentage</u>	<u>Beds/Units</u>	<u>Percentage</u>
Assisted Living	\$ 98,218	2.21%	6	5.77%
Nursing Home	4,338,672	97.79%	98	94.23%
	<u>\$ 4,436,890</u>	<u>100.00%</u>	<u>104</u>	<u>100.00%</u>

<u>Expense Allocation</u>	<u>Total Amount</u>	<u>Assist. Living Percentage</u>	<u>Assist. Living Costs</u>	<u>Basis for Allocation</u>	<u>Line</u>
Dietary	\$ 234,716	2.21%	\$ 5,196	Revenues	1
Food Purchase	154,173	2.21%	3,413	Revenues	2
Housekeeping	111,748	2.21%	2,474	Revenues	3
Laundry	71,373	2.21%	1,580	Revenues	4
Utilities	110,018	2.21%	2,435	Revenues	5
Maintenance	78,500	2.21%	1,738	Revenues	6
Depreciation (See Page 25)	3,442		3,442	Actual Cost	30
Nursing Salaries	123,798		936	Estimated	10
Cert. Nursing Assistant	678,723		7,320	Estimated	10
Billing	33,955		467	Estimated	21
Totals	<u>\$ 1,600,446</u>		<u>\$ 29,001</u>		

NOTE: Assisted Living costs adjustments have been included on Page 5A.

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 12 - 13 - Schedule XI Ownership Cost

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment and Vehciles	Total
Schedule XI Ownership Cost	\$ 349,039	\$ 4,418,747	\$ 1,192,318	\$ 5,960,104
Non-care Assets	-	68,846	-	68,846
Related Facility	159,708	9,612,884	4,724,862	14,497,454
Non-care Assets of Related Facility	-	5,010,459	155,403	5,165,862
Reconciliation variance	-	148,633	(148,907)	(274)
Schedule XV Balance Sheet	<u>\$ 508,747</u>	<u>\$ 19,259,569</u>	<u>\$ 5,923,676</u>	<u>\$ 25,691,992</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, Inc. - South Campus, IDPH # 0014506.

SEE ACCOUNTANTS' COMPILATION REPORT.

Facility Name & ID Number

United Methodist Vlg N Cam

0046656

Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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

Description of Non Care Assets and Depreciation

Description	Year	Cost	Depreciation	Accumulated Depreciation
Assisted Living Addition	2009	\$ 29,645	\$ 1,482	\$ 12,845
Assisted Living Project	2010	34,321	1,716	13,728
Assisted Living Addition	2011	4,880	244	1,464
TOTAL - To Page 13		\$ 68,846	\$ 3,442	\$ 28,037

SEE ACCOUNTANTS' COMPILATION REPORT.

Facility Name & ID Number **United Methodist Vlg N Cam** **# 0046656** **Report Period Beginning: 01/01/2016** **Ending: 12/31/2016**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT.

Vendor/Payee	Invoice Date	Description of Services	Allowable		Non-Allowable		Campus Totals		Grand Total
			South Campus	North Campus	South Campus	North Campus	South	North	
Duane Morris LLP	6/27/2016	Regulatory Counsel	\$ -	\$ -	\$ 29,634	\$ -	\$ 29,634	\$ -	\$ 29,634
Duane Morris LLP	7/27/2016	Employment Law Advice	-	-	7,725	7,725	7,725	7,725	15,450
Duane Morris LLP	7/27/2016	Regulatory Counsel	-	-	9,674	9,673	9,674	9,673	19,347
Duane Morris LLP	7/27/2016	IDPH Survey	15,965	-	-	-	15,965	-	15,965
Duane Morris LLP	8/23/2016	Employment Law Advice	-	-	6,768	6,768	6,768	6,768	13,536
Duane Morris LLP	8/23/2016	Regulatory Counsel	-	-	6,835	6,834	6,835	6,834	13,669
Duane Morris LLP	9/23/2016	Employment Law Advice	-	-	6,378	6,378	6,378	6,378	12,756
Duane Morris LLP	9/23/2016	Regulatory Counsel	-	-	8,606	8,605	8,606	8,605	17,211
Duane Morris LLP	9/23/2016	United Methodist Fund	-	-	2,954	2,953	2,954	2,953	5,907
Duane Morris LLP	11/16/2016	Employment Law Advice	-	-	7,227	7,226	7,227	7,226	14,453
Duane Morris LLP	10/27/2016	Employment Law Advice	-	-	3,259	3,258	3,259	3,258	6,517
Duane Morris LLP	11/16/2016	Regulatory Counsel	-	-	4,964	4,964	4,964	4,964	9,928
Duane Morris LLP	10/27/2016	Regulatory Counsel	-	-	11,290	11,289	11,290	11,289	22,579
Duane Morris LLP	1/25/2016	Regulatory Counsel	-	-	13,979	13,978	13,979	13,978	27,957
Duane Morris LLP	2/8/2016	Employment Law Advice	-	-	6,956	6,956	6,956	6,956	13,912
Duane Morris LLP	2/8/2016	Employment Law Advice	-	-	70	69	70	69	139
Duane Morris LLP	1/25/2016	Employment Law Advice	-	-	7,888	7,888	7,888	7,888	15,776
Duane Morris LLP	1/25/2016	United Methodist Village	-	-	799	798	799	798	1,597
Duane Morris LLP	1/25/2016	United Methodist Fund	-	-	1,326	1,325	1,326	1,325	2,651
Duane Morris LLP	2/8/2016	Regulatory Counsel	-	-	13,161	13,161	13,161	13,161	26,322
Duane Morris LLP	2/8/2016	United Methodist Fund	-	-	4,697	4,696	4,697	4,696	9,393
Duane Morris LLP	3/15/2016	Employment Law Advice	-	-	10,021	10,020	10,021	10,020	20,041
Duane Morris LLP	3/15/2016	Regulatory Counsel	-	-	29,235	-	29,235	-	29,235
Duane Morris LLP	3/15/2016	United Methodist Fund	-	-	5,375	-	5,375	-	5,375
Duane Morris LLP	4/20/2016	Employment Law Advice	-	-	8,735	8,735	8,735	8,735	17,470
Duane Morris LLP	4/20/2016	Regulatory Counsel	-	-	11,080	11,080	11,080	11,080	22,160
Duane Morris LLP	4/20/2016	United Methodist Fund	-	-	2,355	-	2,355	-	2,355
Duane Morris LLP	5/16/2016	Employment Law Advice	-	-	1,082	1,081	1,082	1,081	2,163
Duane Morris LLP	5/16/2016	United Methodist Village (Logo)	-	-	105	104	105	104	209
Duane Morris LLP	5/16/2016	United Methodist Fund	-	-	5,599	5,598	5,599	5,598	11,197
Duane Morris LLP	5/16/2016	Regulatory Counsel	-	-	12,846	12,845	12,846	12,845	25,691
Duane Morris LLP	6/27/2016	Employment Law Advice	-	-	11,148	-	11,148	-	11,148
Duane Morris LLP	6/27/2016	United Methodist Fund	-	-	5,699	-	5,699	-	5,699
Duane Morris LLP	6/27/2016	IDPH Survey	4,513	-	-	-	4,513	-	4,513
Duane Morris LLP	8/23/2016	IDPH Survey	-	3,545	-	-	-	3,545	3,545
Duane Morris LLP	9/23/2016	IDPH Survey	834	-	-	-	834	-	834
Duane Morris LLP	8/23/2016	United Methodist Fund	-	-	-	1,350	-	1,350	1,350
Duane Morris LLP	8/23/2016	US Foods, Inc.	-	-	681	680	681	680	1,361
Duane Morris LLP	9/23/2016	US Foods, Inc.	-	-	869	868	869	868	1,737
Duane Morris LLP	10/27/2016	Resident Transfer & Discharge	1,321	-	-	-	1,321	-	1,321
Duane Morris LLP	10/27/2016	IDES Protest	-	-	3,434	-	3,434	-	3,434
Duane Morris LLP	11/16/2016	United Methodist Fund	-	-	1,129	1,128	1,129	1,128	2,257
Duane Morris LLP	10/27/2016	United Methodist Fund	-	-	375	375	375	375	750
Duane Morris LLP	11/16/2016	US Foods, Inc.	-	-	779	779	779	779	1,558
Duane Morris LLP	10/27/2016	US Foods, Inc.	-	-	799	799	799	799	1,598
Duane Morris LLP	11/16/2016	Resident Transfer & Discharge	1,251	-	-	-	1,251	-	1,251
Duane Morris LLP	12/19/2016	Employment Law Advice	-	-	2,443	2,442	2,443	2,442	4,885
Duane Morris LLP	12/19/2016	Regulatory Counsel	-	-	1,871	1,871	1,871	1,871	3,742
Duane Morris LLP	12/19/2016	United Methodist Fund	-	-	804	803	804	803	1,607
Duane Morris LLP	12/19/2016	US Foods, Inc.	-	-	340	340	340	340	680
Gosnell Borden Enloe Sloss & McCullough	5/3/2016	Resident Guardianship	1,500	-	-	-	1,500	-	1,500
Duane Morris LLP	12/19/2016	IDES Protest	-	-	1,108	1,107	1,108	1,107	2,215
Gosnell Borden Enloe Sloss & McCullough	10/13/2016	Resident Guardianship	512	-	-	-	512	-	512
Latimer LeVay Fyock LLC	4/30/2016	Aramark Uniform Services matters	-	-	426	426	426	426	852
Duane Morris LLP	11/30/2016	US Foods, Inc.	-	-	3,306	3,305	3,306	3,305	6,611
Reversal of Prior Year Accruals			-	-	(47,942)	(1,963)	(47,942)	(1,963)	(49,905)
TOTALS			\$ 25,896	\$ 3,545	\$ 227,891	\$ 188,317	\$ 253,787	\$ 191,862	\$ 445,649

SEE ACCOUNTANTS' COMPILATION REPORT.

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

Breakout of Other General Administrative Expenses

Column 3

Settlement Expense	\$ 45,000
Auxiliary Purchases	729
Resident Services Purchases	<u>1,005</u>
	<u>\$ 46,734</u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Schedule V. Cost Center Expenses - Reclassifications

<u>Cost Center</u>	<u>Line</u>	<u>Increase</u>	<u>Decrease</u>
Dues, Fees, Subscriptions & Promotions	23	\$ 1,020	
Other	27		\$ 1,020
(Reclassify background check expenses)			
In-Service Training & Education	23	\$ 2,268	
Travel and Seminar	24		\$ 2,268
(Reclassify in-service training and education expenses)			

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 7, Schedule VII: Members of the Board of Directors.

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
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
Jack Vayhinger	N	N/A	N/A	N/A
Rev. Tim Pearce	N	N/A	N/A	N/A
Steve Schonert	N	N/A	N/A	N/A
Eileen Enlow	N	N/A	N/A	N/A
Morgan Newell, South Campus Administrator	N	N/A	N/A	N/A
Ashli Wesley, Interim 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.