

Facility Name & ID Number Heartland Christian Village# 0038372 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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 n/a

	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	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	365	5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF	10,745	9,940	2,864	23,549	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		352		352	12
13	DD 16 OR LESS					13
14	TOTALS	10,745	10,292	2,864	23,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.23%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

meal, lawn, and maintenance services for the independent livingF. 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 10/12/1992

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

YES Date 10/12/1992 NO

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

YES NO If YES, enter number of beds certified 70 and days of care provided 2,720Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/06 Fiscal Year: 06/30/06

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

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Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	123,527	15,875	5,022	144,424		144,424		144,424		1
2	Food Purchase		118,929		118,929		118,929	(1,662)	117,267		2
3	Housekeeping	70,027	15,548		85,575		85,575		85,575		3
4	Laundry	25,582			25,582		25,582		25,582		4
5	Heat and Other Utilities			82,058	82,058		82,058	(959)	81,099		5
6	Maintenance	39,322	3,228	23,571	66,121		66,121	5,811	71,932		6
7	Other (specify):* Trash			3,967	3,967		3,967		3,967		7
8	TOTAL General Services	258,458	153,580	114,618	526,656		526,656	3,190	529,846		8
	B. Health Care and Programs										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	1,089,515	146,432	7,740	1,243,687		1,243,687	(81,133)	1,162,554		10
10a	Therapy			177,215	177,215		177,215		177,215		10a
11	Activities	15,124			15,124		15,124		15,124		11
12	Social Services	74,579	2,000	4,960	81,539		81,539	(108)	81,431		12
13	CNA Training										13
14	Program Transportation			2,389	2,389		2,389		2,389		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,179,218	148,432	194,104	1,521,754		1,521,754	(81,241)	1,440,513		16
	C. General Administration										
17	Administrative	90,333	2,250	194,484	287,067		287,067	(151,584)	135,483		17
18	Directors Fees										18
19	Professional Services			7,250	7,250		7,250	7,444	14,694		19
20	Dues, Fees, Subscriptions & Promotions			32,442	32,442		32,442	(11,947)	20,495		20
21	Clerical & General Office Expenses	69,856	4,923	66,306	141,085		141,085	21,217	162,302		21
22	Employee Benefits & Payroll Taxes			304,085	304,085		304,085	12,503	316,588		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,543	10,543		10,543	4,395	14,938		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,186	64,186		64,186	1,529	65,715		26
27	Other (specify):*										27
28	TOTAL General Administration	160,189	7,173	679,296	846,658		846,658	(116,443)	730,215		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,597,865	309,185	988,018	2,895,068		2,895,068	(194,494)	2,700,574		29

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

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

Facility Name & ID Number

Heartland Christian Village

#0038372

Report Period Beginning:

July 1, 2005

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,140	106,140		106,140	13,316	119,456			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			282,666	282,666		282,666	(2,449)	280,217			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Def. Bond Costs			1,922	1,922		1,922		1,922			36
37	TOTAL Ownership			390,728	390,728		390,728	10,867	401,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,767	8,767		8,767		8,767			39
40	Barber and Beauty Shops	13,002	712		13,714		13,714		13,714			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):* Apt/Congregate			99,474	99,474		99,474	(99,474)				43
44	TOTAL Special Cost Centers	13,002	712	146,566	160,280		160,280	(99,474)	60,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,610,867	309,897	1,525,312	3,446,076		3,446,076	(283,101)	3,162,975			45

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

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,003)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,587)	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	(2,628)	32		10
11	Discounts, Allowances, Rebates & Refunds	(902)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(34,182)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,006)	21		24
25	Fund Raising, Advertising and Promotional	(11,947)	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 Attached	(177,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (259,411)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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))	\$ (259,411)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heartland Christian Village

ID# 0038372

Report Period Beginning: July 1, 2005

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending	\$ 341	2	1
2	Activity	(108)	12	2
3	Marketing Salary	(22,255)	21	3
4	Marketing Supplies	(2,848)	21	4
5	Marketing Printing	(8)	21	5
6	Marketing Late Fees/Finance Charges	(81)	21	6
7	Marketing Travel	(3,526)	24	7
8	Assisted Living Salary	(30,442)	43	8
9	Apt/Congregate Supplies	(233)	43	9
10	Apt/Congregate Management Fee Expense	(2,952)	43	10
11	Apt/Congregate Contracted Services	(55)	43	11
12	Apt/Congregate Repairs and Maintenance	(432)	43	12
13	Apt/Congregate Electricity	(273)	43	13
14	Apt/Congregate Natural Gas	(236)	43	14
15	Apt/Congregate Water	(1,366)	43	15
16	Apt/Congregate Sewerage	(822)	43	16
17	Apt/Congregate Trash	(496)	43	17
18	Apt/Congregate Depreciation	(20,338)	43	18
19	Apt/Congregate Insurance	(7,647)	43	19
20	Pharmacy Chargeable	(44)	10	20
21	Pharmacy Chargeable	(70,134)	10	21
22	Pharmacy Non-Chargeable	(10,676)	10	22
23	Pharmacy Non-Chargeable	(279)	10	23
24	Legal Fees (related to civil penalty)	(2,246)	19	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	(177,156)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village# 0038372 Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,662)	0	0	0	0	0	0	0	0	0	0	(1,662)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,587)	4,628	0	0	0	0	0	0	0	0	0	(959)	5
6	Maintenance	0	5,811	0	0	0	0	0	0	0	0	0	5,811	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,249)	10,439	0	3,190	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	(81,133)	0	0	0	0	0	0	0	0	0	0	(81,133)	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	(108)	0	0	0	0	0	0	0	0	0	0	(108)	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	(81,241)	0	0	0	0	0	0	0	0	0	0	(81,241)	16
	C. General Administration													
17	Administrative	0	(151,584)	0	0	0	0	0	0	0	0	0	(151,584)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,246)	9,690	0	0	0	0	0	0	0	0	0	7,444	19
20	Fees, Subscriptions & Promotions	(11,947)	0	0	0	0	0	0	0	0	0	0	(11,947)	20
21	Clerical & General Office Expenses	(51,100)	72,317	0	0	0	0	0	0	0	0	0	21,217	21
22	Employee Benefits & Payroll Taxes	0	12,503	0	0	0	0	0	0	0	0	0	12,503	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,526)	7,921	0	0	0	0	0	0	0	0	0	4,395	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,529	0	0	0	0	0	0	0	0	0	1,529	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(68,819)	(47,624)	0	(116,443)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(157,309)	(37,185)	0	(194,494)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Christian Village# 0038372

Report Period Beginning:

July 1, 2005 Ending:

June 30, 2006

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	0	13,316	0	0	0	0	0	0	0	0	0	13,316 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,628)	179	0	0	0	0	0	0	0	0	0	(2,449) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(2,628)	13,495	0	10,867 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):*	(99,474)	0	0	0	0	0	0	0	0	0	0	(99,474) 43
44	TOTAL Special Cost Centers	(99,474)	0	0	0	0	0	0	0	0	0	0	(99,474) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(259,411)	(23,690)	0	(283,101) 45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule.						

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Christian Homes, Inc.	100.00%	\$ 4,628	\$ 4,628	1
2	V	6 Maintenance		Christian Homes, Inc.	100.00%	5,811	5,811	2
3	V	17 Administration	194,484	Christian Homes, Inc.	100.00%	42,900	(151,584)	3
4	V	19 Professional Services		Christian Homes, Inc.	100.00%	9,690	9,690	4
5	V	21 Clerical		Christian Homes, Inc.	100.00%	72,317	72,317	5
6	V	22 Employee Benefits		Christian Homes, Inc.	100.00%	12,503	12,503	6
7	V	24 Travel & Seminars		Christian Homes, Inc.	100.00%	7,921	7,921	7
8	V	26 Insurance		Christian Homes, Inc.	100.00%	1,529	1,529	8
9	V	30 Depreciation		Christian Homes, Inc.	100.00%	13,316	13,316	9
10	V	32 Interest		Christian Homes, Inc.	100.00%	179	179	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 194,484			\$ 170,794	\$ * (23,690)	14

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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2005 Ending: ne 30, 2006

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 Christian Homes, Inc.
 Street Address 200 N. Postville Dr.
 City / State / Zip Code Lincoln, IL 62656
 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

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
	YES	NO										
A. Directly Facility Related												
Long-Term												
1	1993-A (60%)		x	Building and Equipment	\$12,437.00	1/1/1993	\$ 1,080,000	\$ 779,490	1/1/2018	0.0800	\$ 51,272	1
2	1996-A		x	Building and Equipment	\$3,187.00	1/1/1996	450,000	366,300	7/1/2021	0.0700	25,953	2
3	1997-A		x	Redeem Debt	\$5,075.00	1/1/1997	720,000	595,680	1/1/2022	0.0700	42,176	3
4	2001-Y		x	Redeem Debt	\$6,053.00	1/1/2001	1,000,000	977,167	10/1/2031	0.0600	61,414	4
5	CHI Bond		x	Operations	\$2,500.00	5/1/2003	272,958	249,088	12/1/2020	0.0850	21,566	5
Working Capital												
6	T/E Mortgage Payable		x	Building and Equipment	\$20,955.00	1/1/2005	1,259,228	1,020,975	4/1/2011	0.0725	80,285	6
7												7
8												8
9	TOTAL Facility Related				\$50,207.00		\$ 4,782,186	\$ 3,988,700			\$ 282,666	9
B. Non-Facility Related*												
10	1993-A (40%)		x	Building and Equipment	\$12,437.00	1/1/1993	720,000	519,660	1/1/2018	0.0800	34,182	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				\$12,437.00		\$ 720,000	\$ 519,660			\$ 34,182	14
15	TOTALS (line 9+line14)						\$ 5,502,186	\$ 4,508,360			\$ 316,848	15

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 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.)		\$ N/A	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2006 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.		\$ #VALUE!	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2001	8																						
2002	9																						
2003	10																						
2004	11																						
2005	12																						
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2005 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0038372

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 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 2005.

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

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

Facility Name & ID Number Heartland Christian Village

0038372 Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. 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 ground (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)

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	29,980	Various	\$ 41,767	1
2	Home Office			3,880	2
3	TOTALS	29,980		\$ 45,647	3

Facility Name & ID Number Heartland Christian Village

0038372

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71	1992	1992	\$ 2,601,099	\$ 65,028	40	\$ 65,028		\$ 894,128	4
5		1995	1995	119,926	2,998	40	2,998		33,977	5
6										6
7										7
8	Home Office Allocations			32,396	4,057		4,057		10,148	8
	Improvement Type**									
9	Carpeting		1992	9,961		5			9,961	9
10	Wallcoverings		1992	8,385		5			8,385	10
11	Wallcoverings		1992	16,128		5			16,128	11
12	Fire Alarm Commctor		1992	578	29	20	29		399	12
13	Towel Rings		1992	637		10			637	13
14	Rail & Gate Loading		1993	536		10			536	14
15	Door Lock		1993	856		10			856	15
16	Autodoor		1994	908		10			908	16
17	Electric Work - Fire Alarm		1998	1,335	134	10	134		1,094	17
18	Smoke Dampers		1998	2,284	228	10	228		1,881	18
19	Water Heater		2000	5,831	583	10	583		3,838	19
20	Expansion Tank		2000	1,126		5			1,126	20
21	Ceiling Fans (2) Activity		2000	500		5			500	21
22	Floor Covering-Assisted Living Area		12/18/2001	1,161	232	5	232		1,063	22
23	Trane A/C Unit		6/11/2002	1,370	137	10	137		559	23
24						8				24
25	Carpet - Rooms 102,104,105 & 116		9/23/2002	942	188	5	188		721	25
26	Roof-NH Maintenance Garage		12/13/2002	1,500	300	5	300		1,075	26
27	Carpet - Rooms 110,111 & 113		12/2/2002	922	184	5	184		659	27
28	Water Heater		1/26/2003	3,788	379	10	379		1,329	28
29	Mixing Valve/Plumbing System		6/18/2003	2,330	233	10	233		718	29
30	Sewer lines		10/13/1992	37,086	927	40	927		12,746	30
31	Patio & Sidewalks		10/13/1992	900	45	20	45		619	31
32	Sign		10/13/1992	6,286		10			6,286	32
33	Landscaping		10/13/1992	21,485	1,074	20	1,074		14,768	33
34	Landscaping		7/3/1995	2,602		5			2,602	34
35	Sidewalk		11/25/1998	1,405		5			1,405	35
36	Flagpole light at entrance		6/17/2003	793	79	10	79		244	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Friedrich 14400 BTU PTAC Unit	7/15/2003	\$ 698	\$ 87	8	\$ 87	\$	\$ 261	37
38	Carpeting - Rooms #101 & 105	7/23/2003	567	113	5	113		339	38
39	Install Exhaust Fan - O2 Room	2/11/2004	532	106	5	106		256	39
40	Friedrich 14400 BTU PTAC Unit	1/29/2004	648	81	8	81		203	40
41	Elemco/Opto Energy Management System	2/16/2004	5,676	568	10	568		1,373	41
42	Friedrich 14400 BTU PTAC Unit	5/24/2004	702	88	8	88		191	42
43	A/C Unit for Office	6/10/2004	1,400	140	10	140		292	43
44	Blank								44
45	Friedrich 14400 BTU PTAC Unit	7/20/2004	609	76	8	76		152	45
46	Final Pymt Energy Mgmt System	8/20/2004	5,674	567	10	567		1,087	46
47	Data/Phones - Network Cabling	9/30/2004	18,304	1,830	10	1,830		3,355	47
48	Oak Fire Door	12/1/2004	641	64	10	64		101	48
49	Fire Alarm Accelerator/Relocate Sprinkler	11/22/2004	2,985	299	10	299		498	49
50	Install Dishwasher Vent Fan	12/20/2004	1,052	105	10	105		166	50
51	Install Fire Dampers	3/11/2005	14,750	1,475	10	1,475		1,967	51
52	Kitchen Floor Tile w/Installation	9/1/2004	792	158	5	158		290	52
53	Fire Rated Staircase to Mechanical Room	4/11/2005	5,846	1,169	5	1,169		1,266	53
54	(46) Room Signs w/Braille	4/8/2005	796	159	5	159		199	54
55	New Sidewalk/Extend Patio/Courtyard	9/24/2004	1,646	206	8	206		378	55
56	Installation of Ceiling Airducts	11/24/2005	1,374	49	20	49		49	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)		\$ 2,949,848	\$ 84,175		\$ 84,175	\$	\$ 1,041,719	70

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 222,219	\$ 21,451	\$ 21,451	\$	Various	\$ 170,097	71
72	Current Year Purchases	60,234	4,091	4,091		Various	4,091	72
73	Fully Depreciated Assets	191,130	480	480		Various	191,130	73
74	Home Office Allocations	65,958	8,260	8,260			49,815	74
75	TOTALS	\$ 539,541	\$ 34,282	\$ 34,282	\$		\$ 415,133	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus	1994	\$ 42,670	\$	\$	\$	8	\$ 42,670	76
77	Patient Transportation	1993 Chevy Van w/Lift	1996	16,383				8	16,383	77
78										78
79	Home Office Allocations			7,975	999	999			999	79
80	TOTALS			\$ 67,028	\$ 999	\$ 999	\$		\$ 60,052	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,602,064	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,456	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,456	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)	\$ 1,516,904	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	Duplex Land	\$ 41,767	\$	\$	86
87	Duplex Land Improvements	65,202	2,286	33,541	87
88	Duplex Buildings	643,097	17,235	260,726	88
89	Duplex Equipment	18,363	483	15,588	89
90	Carport	2,445	245	557	90
91	TOTALS	\$ 770,874	\$ 20,249	\$ 310,412	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 1,770	92
93			93
94			94
95		\$ 1,770	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

		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. _____/2007 \$ _____
13. _____/2008 \$ _____
14. _____/2009 \$ _____

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.

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			Total
		1 Drop-outs	2 Completed	3 Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	N/A	hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Heartland Christian Village

0038372

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2006

(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	\$ 35,534	\$	1
2	Cash-Patient Deposits	10,435		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,915)	510,038		3
4	Supply Inventory (priced at)	16,271		4
5	Short-Term Investments	13,089		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,584		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest/Other A/R</u>	6,303		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 595,254	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,534		13
14	Buildings, at Historical Cost	3,490,791		14
15	Leasehold Improvements, at Historical Cost	137,405		15
16	Equipment, at Historical Cost	550,999		16
17	Accumulated Depreciation (book methods)	(1,766,354)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	136,410		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Bond Costs</u>	9,449		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,642,234	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,237,488	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 99,388	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,435		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,463		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,084		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Liabilities</u>	19,260		36
37	<u>Due to Auxiliary</u>	7,819		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 246,449	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,020,975		40
41	Bonds Payable	3,487,385		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	11,317		43
44	<u>Security Deposits Payable</u>	600		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,520,277	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,766,726	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,529,238)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,237,488	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,788,384)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,788,384)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	179,145	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)	\$ 179,145	17
B. Transfers (Itemize):			
18	Transfers from Affiliate	80,000	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 80,000	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,529,239)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,557,740	1
2	Discounts and Allowances for all Levels	(459,482)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,098,258	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	340,891	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 340,891	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	15,777	13
14	Non-Patient Meals	2,003	14
15	Telephone, Television and Radio	8,046	15
16	Rental of Facility Space		16
17	Sale of Drugs	706	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,223	19
20	Radiology and X-Ray	4,752	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,507	23
D. Non-Operating Revenue			
24	Contributions	53,255	24
25	Interest and Other Investment Income***	4,529	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,784	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	90,306	28
28a	Miscellaneous	(2,525)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 87,781	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,625,221	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	526,656	31
32	Health Care	1,521,754	32
33	General Administration	846,658	33
B. Capital Expense			
34	Ownership	390,728	34
C. Ancillary Expense			
35	Special Cost Centers	38,325	35
36	Provider Participation Fee	121,955	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,446,076	40
41	Income before Income Taxes (line 30 minus line 40)**	179,145	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 179,145	43

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

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

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

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

Facility Name & ID Number Heartland Christian Village

0038372

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,852	1,991	\$ 81,112	\$ 40.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,513	4,699	99,724	21.22	3
4	Licensed Practical Nurses	18,480	19,452	304,658	15.66	4
5	CNAs & Orderlies	45,176	48,645	491,640	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,883	3,332	45,393	13.62	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	5,535	6,036	64,875	10.75	11
12	Dietician					12
13	Food Service Supervisor	1,785	1,975	28,474	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,145	12,321	95,053	7.71	15
16	Dishwashers					16
17	Maintenance Workers	2,949	3,174	39,322	12.39	17
18	Housekeepers	7,387	7,858	70,027	8.91	18
19	Laundry	3,001	3,214	25,582	7.96	19
20	Administrator	1,690	1,910	90,333	47.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,851	2,003	31,832	15.89	23
24	Clerical	1,001	1,327	15,769	11.88	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					31
32	Other Health Care MDS Coordinator	3,945	4,365	76,692	17.57	32
33	Other(specify) Community Liasor	2,872	3,553	50,381	14.18	33
34	TOTAL (lines 1 - 33)	116,065	125,855	\$ 1,610,867 *	\$ 12.80	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	124	\$ 5,022	ln 1, col 3	35
36	Medical Director	96	1,800	ln 9, col 3	36
37	Medical Records Consultant	32	1,883	ln 10, col 3	37
38	Nurse Consultant	51	2,798	ln 10, col 3	38
39	Pharmacist Consultant	96	2,045	ln 10, col 3	39
40	Physical Therapy Consultant	1,362	81,385	ln 10a, col 3	40
41	Occupational Therapy Consultant	1,227	68,086	ln 10a, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	451	27,744	ln 10a, col 3	43
44	Activity Consultant				44
45	Social Service Consultant	72	4,643	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,511	\$ 195,406		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

Facility Name & ID Number Heartland Christian Village

0038372

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

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	
John Letizia	Administrator	0	\$ 90,333	Workers' Compensation Insurance	\$ 66,260	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,906	Advertising: Employee Recruitment	2,145	
				FICA Taxes	116,938	Health Care Worker Background Check (Indicate # of checks performed <u>75</u>)	750	
				Employee Health Insurance	110,640			
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Physicals	1,208	Advertising and Promotion	11,947	
				Employee Uniforms	200	License, Dues, and Subscriptions	17,600	
				Employee Expense	4,933			
				Home Office Allocation	12,503			
						Less: Public Relations Expense	()	
						Non-allowable advertising	(11,947)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,333	TOTAL (agree to Schedule V, line 22, col.8)	\$ 316,588	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,495	
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
Management Fee Expense			\$ 194,484				Out-of-State Travel	\$
							In-State Travel	5,748
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 194,484				Seminar Expense	1,248
							Home Office Allocation	7,921
C. Professional Services								
Vendor/Payee	Type		Amount					
Davis & Campbell	Legal		\$ 5,005				Entertainment Expense	21
Van Ostrand & E. Kelley	Legal		2,245				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 14,938
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,250	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Christian Village# 0038372Report Period Beginning: July 1, 2005 Ending: June 30, 200**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network, \$4026.62
- (3) Did the nursing home make political contributions or payments to a political 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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,163 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. _____
- (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. \$ 38,325
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,003
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,246
c. What percent of all travel expense relates to transportation of nurses and patients? 42%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eck, Schafer & Punke LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.