



Facility Name & ID Number Heartland Christian Village# 0038372 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

## 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 03/16/2007

	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	<u>70</u>	Skilled (SNF)	<u>71</u>	<u>25,657</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>1</u>	Sheltered Care (SC)	<u>0</u>	<u>258</u>	5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,915</u>	7

## B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,715</u>	<u>9,337</u>	<u>3,349</u>	<u>23,401</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>2</u>		<u>2</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,715</u>	<u>9,339</u>	<u>3,349</u>	<u>23,403</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.31%

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)

meal, lawn, and maintenance services for the independent livingF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 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 71 and days of care provided 3,301Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	130,866	17,364	4,021	152,251		152,251		152,251		1
2	Food Purchase		124,133		124,133		124,133	(817)	123,316		2
3	Housekeeping	98,618	16,305		114,923		114,923		114,923		3
4	Laundry										4
5	Heat and Other Utilities			87,863	87,863		87,863	80	87,943		5
6	Maintenance	43,107	5,957	32,646	81,710		81,710	2,587	84,297		6
7	Other (specify):* <b>Trash Removal</b>			2,739	2,739		2,739		2,739		7
8	<b>TOTAL General Services</b>	<b>272,591</b>	<b>163,759</b>	<b>127,269</b>	<b>563,619</b>		<b>563,619</b>	<b>1,850</b>	<b>565,469</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,136,096	163,775	6,562	1,306,433		1,306,433	(99,690)	1,206,743		10
10a	Therapy			200,817	200,817		200,817		200,817		10a
11	Activities	11,644			11,644		11,644		11,644		11
12	Social Services	82,471	3,142	5,540	91,153		91,153	(69)	91,084		12
13	CNA Training										13
14	Program Transportation			4,464	4,464		4,464	(4,855)	(391)		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,230,211</b>	<b>166,917</b>	<b>224,583</b>	<b>1,621,711</b>		<b>1,621,711</b>	<b>(104,614)</b>	<b>1,517,097</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	64,553	2,459	211,720	278,732		278,732	(194,750)	83,982		17
18	Directors Fees										18
19	Professional Services			70,617	70,617		70,617	20,654	91,271		19
20	Dues, Fees, Subscriptions & Promotions			20,085	20,085		20,085	(7,731)	12,354		20
21	Clerical & General Office Expenses	89,086	6,657	41,739	137,482		137,482	42,816	180,298		21
22	Employee Benefits & Payroll Taxes			329,451	329,451		329,451	14,410	343,861		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,620	8,620		8,620	9,333	17,953		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,445	49,445		49,445	593	50,038		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>153,639</b>	<b>9,116</b>	<b>731,677</b>	<b>894,432</b>		<b>894,432</b>	<b>(114,675)</b>	<b>779,757</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,656,441</b>	<b>339,792</b>	<b>1,083,529</b>	<b>3,079,762</b>		<b>3,079,762</b>	<b>(217,439)</b>	<b>2,862,323</b>		<b>29</b>

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

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

Facility Name & ID Number Heartland Christian Village

#0038372

Report Period Beginning: July 1, 2006 Ending:

June 30, 2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			109,547	109,547	109,547	11,916	121,463			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			251,978	251,978	251,978	(13,844)	238,134			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>Financing Cost</b>			1,922	1,922	1,922		1,922			36
37	<b>TOTAL Ownership</b>			363,447	363,447	363,447	(1,928)	361,519			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			7,974	7,974	7,974		7,974			39
40	Barber and Beauty Shops	11,925	640		12,565	12,565		12,565			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,462	38,462	38,462		38,462			42
43	Other (specify):* <b>Apt./Congregate</b>			75,028	75,028	75,028	(105,770)	(30,742)			43
44	<b>TOTAL Special Cost Centers</b>	11,925	640	121,464	134,029	134,029	(105,770)	28,259			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,668,366	340,432	1,568,440	3,577,238	3,577,238	(325,137)	3,252,101			45

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

Facility Name & ID Number Heartland Christian Village

# 0038372

Report Period Beginning: July 1, 2006

Ending: June 30, 2007

**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	(275)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,875)	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	(13,980)	32		10
11	Discounts, Allowances, Rebates & Refunds	(141)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(30,742)	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	10,321	21		24
25	Fund Raising, Advertising and Promotional	(7,731)	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	(276,714)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (325,137)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (325,137)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Heartland Christian Village

ID# 0038372

Report Period Beginning: July 1, 2006

Ending: June 30, 2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ (542)	2	1
2	Activity	(69)	12	2
3	Marketing Salary	(37,393)	21	3
4	Marketing Supplies	(3,570)	21	4
5	Marketing Other	(2,237)	21	5
6	Apt/Congregate	(75,028)	43	6
7	Pharmacy Chargeable	(99,690)	10	7
8	Late Fees	(147)	21	8
9	Fines and Penalties	(483)	21	9
10	Transportation Revenue	(4,855)	14	10
11	Miscellaneous Revenue	(52,700)	17	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(276,714)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heartland Christian Village

# 0038372

Report Period Beginning:

July 1, 2006

Ending:

June 30, 2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(817)	0	0	0	0	0	0	0	0	0	0	(817)	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	(5,875)	5,955	0	0	0	0	0	0	0	0	0	80	5
6	Maintenance	0	2,587	0	0	0	0	0	0	0	0	0	2,587	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,692)</b>	<b>8,542</b>	<b>0</b>	<b>1,850</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(99,690)	0	0	0	0	0	0	0	0	0	0	(99,690)	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	(69)	0	0	0	0	0	0	0	0	0	0	(69)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,855)	0	0	0	0	0	0	0	0	0	0	(4,855)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(104,614)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(104,614)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(52,700)	(142,050)	0	0	0	0	0	0	0	0	0	(194,750)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,654	0	0	0	0	0	0	0	0	0	20,654	19
20	Fees, Subscriptions & Promotions	(7,731)	0	0	0	0	0	0	0	0	0	0	(7,731)	20
21	Clerical & General Office Expenses	(33,650)	76,466	0	0	0	0	0	0	0	0	0	42,816	21
22	Employee Benefits & Payroll Taxes	0	14,410	0	0	0	0	0	0	0	0	0	14,410	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,333	0	0	0	0	0	0	0	0	0	9,333	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	593	0	0	0	0	0	0	0	0	0	593	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(94,081)</b>	<b>(20,594)</b>	<b>0</b>	<b>(114,675)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(205,387)</b>	<b>(12,052)</b>	<b>0</b>	<b>(217,439)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village

# 0038372

Report Period Beginning:

July 1, 2006 Ending:

Summary B

June 30, 2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	11,916	0	0	0	0	0	0	0	0	0	11,916	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,980)	136	0	0	0	0	0	0	0	0	0	(13,844)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(13,980)</b>	<b>12,052</b>	<b>0</b>	<b>(1,928)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(105,770)	0	0	0	0	0	0	0	0	0	0	(105,770)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(105,770)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(105,770)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(325,137)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(325,137)</b>	<b>45</b>

**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
<a href="#">See attached listing</a>						

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%	\$ 5,955	\$ 5,955	1
2	V	6 Maintenance				2,587	2,587	2
3	V	17 Administrative	185,455			43,405	(142,050)	3
4	V	19 Professional Services				20,654	20,654	4
5	V	21 Clerical				76,466	76,466	5
6	V	22 Employee Benefits				14,410	14,410	6
7	V	32 Interest				136	136	7
8	V	24 Travel & Seminar				9,333	9,333	8
9	V	26 Insurance				593	593	9
10	V	30 Depreciation				11,916	11,916	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 185,455			\$ 185,455	\$ *	14

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

Facility Name &amp; ID Number

Heartland Christian Village

#

0038372

Report Period Beginning:

July 1, 2006

Ending:

June 30, 2007

## 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	This workpaper is not applicable								\$		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	This workpaper is not applicable				\$	\$		\$	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

**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											
										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				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	1993-A (60%)	X		Building & Equipment	\$4,299.00	1/1/1993	\$ 1,080,000	\$ 253,800	1/1/2018	0.0800	\$ 46,112	1								
2	1996-A	X		Building & Equipment	\$6,845.00	1/1/1996	450,000	783,473	7/1/2021	0.0700	26,605	2								
3	1997-A	X		Redeem Debt	\$5,075.00	1/1/1997	720,000	595,680	1/1/2022	0.0650	37,433	3								
4	2001-Y	X		Redeem Debt		1/1/2001	1,000,000		10/1/2031	0.0600	53,277	4								
5	CHI Bond	X		Operations	\$2,500.00	5/1/2003	272,958	239,908	12/1/2020	0.0850	19,115	5								
<b>Working Capital</b>																				
6	T/E Mortgage Payable		X	Building & Equipment	\$20,955.00	1/1/2005	1,259,228	837,522	4/1/2011	0.0725	67,453	6								
7	1992-A	X		Building & Equipment	\$4,015.00	4/1/1992	4,000,000	366,000	4/1/2017	0.0650	1,983	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$43,689.00		\$ 8,782,186	\$ 3,076,383			\$ 251,978	9								
<b>B. Non-Facility Related*</b>																				
10	1993-A (40%)	X		Building & Equipment	\$4,299.00	1/1/1993	720,000	169,200	1/1/2018	0.0800	30,742	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				\$4,299.00		\$ 720,000	\$ 169,200			\$ 30,742	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,502,186	\$ 3,245,583			\$ 282,720	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

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ #VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heartland Christian Village COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0038372

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-895-3399

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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/</u>	<u>\$</u>
2. _____	_____	<u>\$</u>	<u>\$</u>
3. _____	_____	<u>\$</u>	<u>\$</u>
4. _____	_____	<u>\$</u>	<u>\$</u>
5. _____	_____	<u>\$</u>	<u>\$</u>
6. _____	_____	<u>\$</u>	<u>\$</u>
7. _____	_____	<u>\$</u>	<u>\$</u>
8. _____	_____	<u>\$</u>	<u>\$</u>
9. _____	_____	<u>\$</u>	<u>\$</u>
10. _____	_____	<u>\$</u>	<u>\$</u>
<b>TOTALS</b>		<u>\$</u>	<u>\$</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES N/A 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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, 2006 Ending:

June 30, 2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,630 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>32,630</u>	<u>Various</u>	<u>\$ 41,767</u>	<u>1</u>
2	<u>Home Office Allocation</u>			<u>3,356</u>	<u>2</u>
3	<b>TOTALS</b>	<b>32,630</b>		<b>\$ 45,123</b>	<b>3</b>

Facility Name &amp; ID Number Heartland Christian Village

# 0038372

Report Period Beginning:

July 1, 2006 Ending: June 30, 2007

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1992	1992	\$ 2,601,099	\$ 65,028	40	\$ 65,028		\$ 959,156	4
5			1995	1995	119,926	2,998	40	2,998		36,975	5
6											6
7											7
8		Home Office Allocation			28,946	3,588		3,588		45,356	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 Commtector		1992	578	29	20	29		428	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		1,228	17
18		Smoke Dampers		1998	2,284	228	10	228		2,109	18
19		Water Heater		2000	5,831	583	10	583		4,421	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	98	5	98		1,161	22
23		Trane A/C Unit		6/11/2002	1,370	137	10	137		696	23
24		Carpet - Rooms 102,104,105 & 116		9/23/2002	942	188	5	188		909	24
25		Roof-NH Maintenance Garage		12/13/2002	1,500	300	5	300		1,375	25
26		Carpet - Rooms 110,111 & 113		12/2/2002	922	184	5	184		843	26
27		Water Heater		1/26/2003	3,788	379	10	379		1,708	27
28		Mixing Valve/Plumbing System		6/18/2003	2,330	233	10	233		951	28
29		Sewer lines		10/13/1992	37,086	927	40	927		13,673	29
30		Patio & Sidewalks		10/13/1992	900	45	20	45		664	30
31		Sign		10/13/1992	6,286		10			6,286	31
32		Landscaping		10/13/1992	21,485	1,074	20	1,074		15,842	32
33		Landscaping		7/3/1995	2,602		5			2,602	33
34		Sidewalk		11/25/1998	1,405		5			1,405	34
35		Flagpole light at entrance		6/17/2003	793	79	10	79		323	35
36		Friedrich 14400 BTU PTAC Unit		7/15/2003	698	87	8	87		348	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heartland Christian Village

# 0038372

Report Period Beginning:

July 1, 2006 Ending: June 30, 2007

**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	<a href="#">Carpeting - Rooms #101 &amp; 105</a>	7/23/2003	\$ 567	\$ 113	5	\$ 113	\$	\$ 452	37
38	<a href="#">Install Exhaust Fan - O2 Room</a>	2/11/2004	532	106	5	106		362	38
39	<a href="#">Friedrich 14400 BTU PTAC Unit</a>	1/29/2004	648	81	8	81		284	39
40	<a href="#">Elemco/Opto Energy Management System</a>	2/16/2004	5,676	568	10	568		1,941	40
41	<a href="#">Friedrich 14400 BTU PTAC Unit</a>	5/24/2004	702	88	8	88		279	41
42	<a href="#">A/C Unit for Office</a>	6/10/2004	1,400	140	10	140		432	42
43	<a href="#">Friedrich 14400 BTU PTAC Unit</a>	7/20/2004	609	76	8	76		228	43
44	<a href="#">Final Pymt Energy Mgmt System</a>	8/20/2004	5,674	567	10	567		1,654	44
45	<a href="#">Data/Phones - Network Cabling</a>	9/30/2004	18,304	1,830	10	1,830		5,185	45
46	<a href="#">Oak Fire Door</a>	12/1/2004	641	64	10	64		165	46
47	<a href="#">Fire Alarm Accelerator/Relocate Sprinkler</a>	11/22/2004	2,985	299	10	299		797	47
48	<a href="#">Install Dishwasher Vent Fan</a>	12/20/2004	1,052	105	10	105		271	48
49	<a href="#">Install Fire Dampers</a>	3/11/2005	14,750	1,475	10	1,475		3,442	49
50	<a href="#">Kitchen Floor Tile w/Installation</a>	9/1/2004	792	158	5	158		448	50
51	<a href="#">Fire Rated Staircase to Mechanical Room</a>	4/11/2005	5,846	1,169	5	1,169		2,435	51
52	<a href="#">(46) Room Signs w/Braille</a>	4/8/2005	796	159	5	159		358	52
53	<a href="#">New Sidewalk/Extend Patio/Courtyard</a>	9/24/2004	1,646	206	8	206		584	53
54	<a href="#">Installation of Ceiling Airducts</a>	11/24/2005	1,474	74	20	74		123	54
55	<a href="#">Install Emergency Exit Lights</a>	8/14/2006	541	50	10	50		50	55
56	<a href="#">Install 2-door alarm system</a>	8/10/2006	1,080	99	10	99		99	56
57	<a href="#">Dining Room Wall - labor and materials</a>	3/1/2007	1,998	67	10	67		67	57
58	<a href="#">Ceramic Tile in Dining Room</a>	3/1/2007	8,637	144	20	144		144	58
59	<a href="#">Water Drain for Sprinkler System</a>	3/1/2007	838	28	10	28		28	59
60	<a href="#">Remove old and pour new 8X8 concrete pad</a>	4/11/2007	1,960	49	10	49		49	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,961,452	\$ 84,034		\$ 84,034	\$	\$ 1,157,373	70

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

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

## XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 271,774	\$ 27,325	\$ 27,325	\$	Various	\$ 190,285	71
72	Current Year Purchases	17,504	1,776	1,776		Various	1,776	72
73	Fully Depreciated Assets	194,915				Various	194,915	73
74	Home Office Allocation	61,081	7,571	7,571			13,458	74
75	TOTALS	\$ 545,274	\$ 36,672	\$ 36,672	\$		\$ 400,434	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 Allocation			6,104	757	757			2,110	79
80	TOTALS			\$ 65,157	\$ 757	\$ 757	\$		\$ 61,163	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)		\$ 3,617,006	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 121,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 121,463	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)		\$ 1,618,970	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	Dulex Land	\$ 41,767	\$	\$	86
87	Duplex Land Improvements	65,202	2,258	35,799	87
88	Duplex Buildings	646,351	17,492	278,218	88
89	Duplex Equipment	19,098	600	16,188	89
90	Carport/Storage Shed	21,500	324	881	90
91	TOTALS	\$ 793,918	\$ 20,674	\$ 331,086	91

## G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 40,000	92
93	Home Office Allocation	8,337	93
94			94
95		\$ 48,337	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.

Facility Name & ID Number Heartland Christian Village

# 0038372

Report Period Beginning: July 1, 2006

Ending: June 30, 2007

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: This workpaper is not applicable

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

If NO, see instructions.

YES  NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	<b>TOTAL</b>		\$	\$	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	This workpaper is not applicable	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.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2006 Ending: June 30, 2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 232,343	\$	1
2	Cash-Patient Deposits	8,131		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (15,989) )	433,449		3
4	Supply Inventory (priced at )	16,736		4
5	Short-Term Investments	16,984		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable/Other A/R</u>	63,374		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 771,017	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,534		13
14	Buildings, at Historical Cost	3,526,193		14
15	Leasehold Improvements, at Historical Cost	139,365		15
16	Equipment, at Historical Cost	562,344		16
17	Accumulated Depreciation (book methods)	(1,889,357)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	40,269		21
22	Other Long-Term Assets (spe CIP )	40,000		22
23	Other(specify): <u>Deferred Financing Costs</u>	7,528		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,509,876	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,280,893	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 116,601	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,131		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,828		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,530		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Liabilities</u>	12,519		36
37	<u>Due to Auxiliary</u>	6,769		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 271,378	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	837,522		40
41	Bonds Payable	3,178,381		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Life Right Revenue</u>	9,253		43
44	<u>Apt/Cong Security Deposits Payable</u>	1,300		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,026,456	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,297,834	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,016,941)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,280,893	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,529,239)	1
2	Restatements (describe):		2
3	<u>Prior Period Adjustment - Insurance Accrual</u>	19,857	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,509,382)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	305,849	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)	\$ 305,849	17
	<b>B. Transfers (Itemize):</b>		
18	<u>Transfer to Affiliate</u>	186,590	18
19	<u>Rounding</u>	2	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 186,592	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,016,941)	24 *

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

Facility Name & ID Number Heartland Christian Village# 0038372Report Period Beginning: July 1, 2006Ending: June 30, 2007**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,708,072	1
2	Discounts and Allowances for all Levels	(406,894)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,301,178</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	344,399	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 344,399</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,568	13
14	Non-Patient Meals	275	14
15	Telephone, Television and Radio	8,064	15
16	Rental of Facility Space		16
17	Sale of Drugs	3,622	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,270	19
20	Radiology and X-Ray	2,941	20
21	Other Medical Services	2,927	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 39,667</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	65,232	24
25	Interest and Other Investment Income***	16,138	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 81,370</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Retirement Center (Apt/Duplex)</b>	<b>58,851</b>	28
28a	<b>Miscellaneous</b>	<b>57,622</b>	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 116,473</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,883,087</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	563,619	31
32	Health Care	1,621,711	32
33	General Administration	894,432	33
<b>B. Capital Expense</b>			
34	Ownership	363,447	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	95,567	35
36	Provider Participation Fee	38,462	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,577,238</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>305,849</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 305,849</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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, 2006

Ending:

June 30, 2007

**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	2,140	2,328	\$ 75,241	\$ 32.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,991	3,199	73,030	22.83	3
4	Licensed Practical Nurses	19,880	21,206	382,326	18.03	4
5	CNAs & Orderlies	44,045	48,738	513,812	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,626	4,197	47,561	11.33	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	6,341	6,933	83,417	12.03	11
12	Dietician					12
13	Food Service Supervisor	1,583	2,008	26,919	13.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,186	12,476	103,947	8.33	15
16	Dishwashers					16
17	Maintenance Workers	3,150	3,502	43,107	12.31	17
18	Housekeepers	10,174	11,145	98,618	8.85	18
19	Laundry					19
20	Administrator	1,666	2,001	64,553	32.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,853	2,006	26,214	13.07	23
24	Clerical	981	1,492	17,109	11.47	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 Ward Clerk	1,779	2,020	25,200	12.48	32
33	Other(specify) <u>MDS Coord, Vol. C</u>	4,336	4,790	87,311	18.23	33
34	TOTAL (lines 1 - 33)	115,731	128,041	\$ 1,668,365 *	\$ 13.03	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	95	\$ 4,021	ln 1, col 3	35
36	Medical Director	360	7,200	ln 9, col 3	36
37	Medical Records Consultant	39	2,309	ln 10, col 3	37
38	Nurse Consultant	13	133	ln 10, col 3	38
39	Pharmacist Consultant	96	2,125	ln 10, col 3	39
40	Physical Therapy Consultant	1,279	79,695	ln 10a, col 3	40
41	Occupational Therapy Consultant	1,190	75,464	ln 10a, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	601	45,655	ln 10a, col 3	43
44	Activity Consultant				44
45	Social Service Consultant	77	4,911	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,750	\$ 221,513		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





**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, \$2,749
- (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? N/A
- (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. \$ 7,783 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 NO NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,462  
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 benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 275
- (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. \$ 4,855
- c. What percent of all travel expense relates to transportation of nurses and patients? 45%
- 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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: LarsonAllen 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? NO If no, please explain. Will be sent when audit is complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.