

Facility Name & ID Number Heartland Christian Village# 0048751 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,986</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,986</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>9,128</u>	<u>10,072</u>	<u>4,579</u>	<u>23,779</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,128</u>	<u>10,072</u>	<u>4,579</u>	<u>23,779</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.51%

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)

Meals, lawn care, and maintenance for independent living unitsF. 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 71 and days of care provided 4,260Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,510	15,634	9,207	163,351		163,351		163,351		1
2	Food Purchase		146,228		146,228		146,228	(41)	146,187		2
3	Housekeeping	108,882	13,340	1,157	123,379		123,379		123,379		3
4	Laundry		3,064		3,064		3,064		3,064		4
5	Heat and Other Utilities			103,044	103,044		103,044	(390)	102,654		5
6	Maintenance	46,290	3,740	37,004	87,034		87,034	1,892	88,926		6
7	Other (specify):* Trash			4,752	4,752		4,752		4,752		7
8	TOTAL General Services	293,682	182,006	155,164	630,852		630,852	1,461	632,313		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,290,056	173,325	4,959	1,468,340	(107,339)	1,361,001		1,361,001		10
10a	Therapy			304,873	304,873		304,873		304,873		10a
11	Activities	15,856			15,856		15,856		15,856		11
12	Social Services	90,441	4,968	5,805	101,214		101,214	(139)	101,075		12
13	CNA Training										13
14	Program Transportation			5,388	5,388		5,388	(6,547)	(1,159)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,396,353	178,293	328,225	1,902,871	(107,339)	1,795,532	(6,686)	1,788,846		16
	C. General Administration										
17	Administrative	94,760	1,978	228,396	325,134		325,134	(191,799)	133,335		17
18	Directors Fees										18
19	Professional Services			3,104	3,104		3,104	24,558	27,662		19
20	Dues, Fees, Subscriptions & Promotions			23,417	23,417		23,417	(12,526)	10,891		20
21	Clerical & General Office Expenses	115,365	14,683	30,833	160,881		160,881	28,425	189,306		21
22	Employee Benefits & Payroll Taxes			302,407	302,407		302,407	9,224	311,631		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,894	13,894		13,894	9,477	23,371		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,723	105,723		105,723	667	106,390		26
27	Other (specify):*										27
28	TOTAL General Administration	210,125	16,661	707,774	934,560		934,560	(131,974)	802,586		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,900,160	376,960	1,191,163	3,468,283	(107,339)	3,360,944	(137,199)	3,223,745		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

#0048751

Report Period Beginning: July 1, 2007 Ending: June 30, 2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			117,146	117,146		117,146	8,678	125,824		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			218,806	218,806		218,806	(23,992)	194,814		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,579	3,579		3,579		3,579		35
36	Other (specify):* Financing, Loss on Advance Refunding			61,154	61,154		61,154		61,154		36
37	TOTAL Ownership			400,685	400,685		400,685	(15,314)	385,371		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			40,474	40,474	107,339	147,813		147,813		39
40	Barber and Beauty Shops	12,163	850		13,013		13,013		13,013		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,980	38,980		38,980		38,980		42
43	Other (specify):* Apt./Congregate			39,893	39,893		39,893	(39,893)			43
44	TOTAL Special Cost Centers	12,163	850	119,347	132,360	107,339	239,699	(39,893)	199,806		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,912,323	377,810	1,711,195	4,001,328		4,001,328	(192,406)	3,808,922		45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	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	(105)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,513)	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	(23,992)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,121	21		24
25	Fund Raising, Advertising and Promotional	(12,526)	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	(121,274)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,301)		\$	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)	(31,105)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,105)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (192,406)		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	X		107,339	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 107,339		47

BHF USE ONLY					
48		49		50	51
					52

Heartland Christian Village

ID# 0048751

Report Period Beginning: July 1, 2007

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ 64	2	1
2	Activity	(139)	12	2
3	Marketing Salary	(62,078)	21	3
4	Marketing Supplies	(9,439)	21	4
5	Apartment/Congregate	(39,893)	43	5
6	Late Fees	(849)	21	6
7	Transportation Revenue	(6,547)	14	7
8	Miscellaneous Revenue	(2,393)	17	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				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	(121,274)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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	(6,513)	6,123	0	0	0	0	0	0	0	0	0	(390)	5
6	Maintenance	0	1,892	0	0	0	0	0	0	0	0	0	1,892	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,554)	8,015	0	1,461	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(139)	0	0	0	0	0	0	0	0	0	0	(139)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(6,547)	0	0	0	0	0	0	0	0	0	0	(6,547)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,686)	0	0	0	0	0	0	0	0	0	0	(6,686)	16
	C. General Administration													
17	Administrative	(2,393)	(189,406)	0	0	0	0	0	0	0	0	0	(191,799)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,558	0	0	0	0	0	0	0	0	0	24,558	19
20	Fees, Subscriptions & Promotions	(12,526)	0	0	0	0	0	0	0	0	0	0	(12,526)	20
21	Clerical & General Office Expenses	(69,257)	97,682	0	0	0	0	0	0	0	0	0	28,425	21
22	Employee Benefits & Payroll Taxes	0	9,224	0	0	0	0	0	0	0	0	0	9,224	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,477	0	0	0	0	0	0	0	0	0	9,477	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	667	0	0	0	0	0	0	0	0	0	667	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(84,176)	(47,798)	0	(131,974)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(97,416)	(39,783)	0	(137,199)	29								

STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village

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Report Period Beginning:

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Summary B
June 30, 2008

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	8,678	0	0	0	0	0	0	0	0	0	8,678	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,992)	0	0	0	0	0	0	0	0	0	0	(23,992)	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	(23,992)	8,678	0	(15,314)	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):*	(39,893)	0	0	0	0	0	0	0	0	0	0	(39,893)	43
44	TOTAL Special Cost Centers	(39,893)	0	0	0	0	0	0	0	0	0	0	(39,893)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(161,301)	(31,105)	0	(192,406)	45								

Facility Name & ID Number Heartland Christian Village

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Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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 listing						

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%	\$ 6,123	\$ 6,123 1
2	V	6 Maintenance				1,892	1,892 2
3	V	17 Administrative	228,396			38,990	(189,406) 3
4	V	19 Professional Services				24,558	24,558 4
5	V	21 Clerical				97,682	97,682 5
6	V	22 Employee Benefits				9,224	9,224 6
7	V	24 Travel and Seminars				9,477	9,477 7
8	V	26 Insurance				667	667 8
9	V	30 Depreciation				8,678	8,678 9
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 228,396			\$ 197,291	\$ * (31,105) 14

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

Facility Name & ID Number

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#

0048751

Report Period Beginning:

July 1, 2007

Ending:

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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	This workpaper is not applicable									
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13								TOTAL	\$	

* 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.

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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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	HUD Sect. 232 Ins. Mortgage		X	Refinance Old Debt	\$25,405.00	7/19/2007	\$ 4,292,500	\$ 4,243,210	8/1/2037	0.0588	\$ 218,806	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$25,405.00		\$ 4,292,500	\$ 4,243,210			\$ 218,806	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 4,292,500	\$ 4,243,210			\$ 218,806	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,085 Line # 26

* 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 2007 report.		Important , 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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0048751

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 2007 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 2007.

	(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>\$</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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

0048751

Report Period Beginning:

July 1, 2007 Ending:

June 30, 2008

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>3,125</u>	<u>2</u>
3	TOTALS	32,630		\$ 44,892	3

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 1,024,184	4
5			1995	1995	119,926	2,998	40	2,998		39,973	5
6											6
7											7
8		Home Office Allocation			29,092	2,037		2,037		48,364	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		457	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	107	10	107		1,335	17
18		Smoke Dampers		1998	2,284	175	10	175		2,284	18
19		Water Heater		2000	5,831	583	10	583		5,004	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		2001	1,161		5			1,161	22
23		Trane A/C Unit		2002	1,370	137	10	137		833	23
24		Carpet - Rooms 102,104,105 & 116		2002	942	33	5	33		942	24
25		Roof-NH Maintenance Garage		2002	1,500	125	5	125		1,500	25
26		Carpet - Rooms 110,111 & 113		2002	922	79	5	79		922	26
27		Water Heater		2003	3,788	379	10	379		2,087	27
28		Mixing Valve/Plumbing System		2003	2,330	233	10	233		1,184	28
29		Sewer lines		1992	37,086	927	40	927		14,600	29
30		Patio & Sidewalks		1992	900	45	20	45		709	30
31		Sign		1992	6,286		10			6,286	31
32		Landscaping		1992	21,485	1,074	20	1,074		16,916	32
33		Landscaping		1995	2,602		5			2,602	33
34		Sidewalk		1998	1,405		5			1,405	34
35		Flagpole light at entrance		2003	793	79	10	79		402	35
36		Friedrich 14400 BTU PTAC Unit		2003	698	87	8	87		435	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 & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	Carpeting - Rooms #101 & 105	2003	\$ 567	\$ 115	5	\$ 115	\$	\$ 567	37
38	Install Exhaust Fan - O2 Room	2004	532	106	5	106		468	38
39	Friedrich 14400 BTU PTAC Unit	2004	648	81	8	81		365	39
40	Elemco/Opto Energy Management System	2004	5,676	568	10	568		2,509	40
41	Friedrich 14400 BTU PTAC Unit	2004	702	88	8	88		367	41
42	A/C Unit for Office	2004	1,400	140	10	140		572	42
43	Friedrich 14400 BTU PTAC Unit	2004	609	76	8	76		304	43
44	Final Pymt Energy Mgmt System	2004	5,674	567	10	567		2,221	44
45	Data/Phones - Network Cabling	2004	18,304	1,830	10	1,830		7,015	45
46	Oak Fire Door	2004	641	64	10	64		229	46
47	Fire Alarm Accelerator/Relocate Sprinkler	2004	2,985	299	10	299		1,096	47
48	Install Dishwasher Vent Fan	2004	1,052	105	10	105		376	48
49	Install Fire Dampers	2005	14,750	1,475	10	1,475		4,917	49
50	Kitchen Floor Tile w/Installation	2004	792	158	5	158		606	50
51	Fire Rated Staircase to Mechanical Room	2005	5,846	1,169	5	1,169		3,604	51
52	(46) Room Signs w/Braille	2005	796	159	5	159		517	52
53	New Sidewalk/Extend Patio/Courtyard	2004	1,646	206	8	206		790	53
54	Installation of Ceiling Airducts	2005	1,474	74	20	74		197	54
55	Install Emergency Exit Lights	2006	541	54	10	54		104	55
56	Install 2-door alarm system	2006	1,080	108	10	108		207	56
57	Dining Room Wall - labor and materials	2007	1,998	200	10	200		267	57
58	Ceramic Tile in Dining Room	2007	8,637	432	20	432		576	58
59	Water Drain for Sprinkler System	2007	838	84	10	84		112	59
60	Remove old and pour new 8X8 concrete pad	2007	1,960	196	10	196		245	60
61	Ramp	2007	600	120	5	120		120	61
62	New Roof, Main Nursing Home Building	2007	61,000	6,100	10	6,100		6,100	62
63	Tile Flooring for 3 bathrooms	2007	2,430	486	5	486		486	63
64	Repairs on 109 Windows	2007	12,670	1,689	5	1,689		1,689	64
65	Bathing Room Project	2008	2,100	105	10	105		105	65
66	Building Supplies for Hall Bathroom	2008	2,864	74	10	74		74	66
67	Wiring for Heaters in Restrooms	2008	1,975	33	10	33		33	67
68	Pushbutton Door Locks	2008	3,299	55	10	55		55	68
69	New Compressor Installed	2008	5,289	88	10	88		88	69
70	TOTAL (lines 4 thru 69)		\$ 3,053,825	\$ 91,259		\$ 91,259	\$	\$ 1,249,603	70

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	\$ 145,086	\$ 22,735	\$ 22,735	\$	Various	\$ 70,776	71
72	Current Year Purchases	68,350	5,189	5,189		Various	5,189	72
73	Fully Depreciated Assets	328,735				Various	328,735	73
74	Home Office Allocation	85,395	5,980	5,980			13,424	74
75	TOTALS	\$ 627,566	\$ 33,904	\$ 33,904	\$		\$ 418,124	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			9,440	661	661			3,590	79
80	TOTALS			\$ 68,493	\$ 661	\$ 661	\$		\$ 62,643	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)	\$ 3,794,776	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,824	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,824	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)	\$ 1,730,370	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	2,261	38,060	87
88	Duplex Building	656,188	18,630	296,848	88
89	Duplex Equipment	20,602	698	16,886	89
90	Carport/Storage Shed	24,301	1,356	2,167	90
91	TOTALS	\$ 808,060	\$ 22,945	\$ 353,961	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 3,300	92
93			93
94			94
95		\$ 3,300	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,579 Description: See attached schedule

(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	<u>N/A</u>		\$ _____	\$ _____	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.

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)	
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 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	\$	1,635	\$ 110,339	\$	1,635	\$	110,339	1
2	Licensed Speech and Language Development Therapist		hrs		824	65,010		824		65,010	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		1,914	129,524		1,914		129,524	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$	4,373	\$ 304,873	\$	4,373	\$	304,873	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 # 0048751 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 533,136	\$	1
2	Cash-Patient Deposits	4,918		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>9,155</u>)	416,317		3
4	Supply Inventory (priced at)	17,375		4
5	Short-Term Investments	926		5
6	Prepaid Insurance	1,229		6
7	Other Prepaid Expenses	13,129		7
8	Accounts Receivable (owners or related parties)	24,507		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,011,537	\$	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	3,631,059		14
15	Leasehold Improvements, at Historical Cost	139,365		15
16	Equipment, at Historical Cost	621,826		16
17	Accumulated Depreciation (book methods)	(2,018,953)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	415,650		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	89,893		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,962,374	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,973,911	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 103,414	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,918		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,624		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Liabilities</u>	8,246		36
37	<u>Due to Auxiliary</u>	4,612		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 277,814	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,243,210		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Deferred Life Right Revenue</u>	4,413		43
44	<u>Apt./Congregate Security Deposits</u>	1,600		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,249,223	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,527,037	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (553,126)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,973,911	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,016,941)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,016,941)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	463,815	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)	\$ 463,815	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (553,126)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2007Ending: June 30, 2008**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,881,725	1
2	Discounts and Allowances for all Levels	(72,009)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,809,716	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	457,887	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 457,887	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	15,872	13
14	Non-Patient Meals	105	14
15	Telephone, Television and Radio	6,858	15
16	Rental of Facility Space		16
17	Sale of Drugs	5,439	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,230	19
20	Radiology and X-Ray	3,630	20
21	Other Medical Services	6,114	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 53,248	23
D. Non-Operating Revenue			
24	Contributions	66,346	24
25	Interest and Other Investment Income***	25,615	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 91,961	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apartment/Duplex)	66,509	28
28a	Miscellaneous/Unrealized loss on investments	(14,178)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,331	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,465,143	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	630,852	31
32	Health Care	1,916,146	32
33	General Administration	934,357	33
B. Capital Expense			
34	Ownership	401,293	34
C. Ancillary Expense			
35	Special Cost Centers	79,700	35
36	Provider Participation Fee	38,980	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,001,328	40
41	Income before Income Taxes (line 30 minus line 40)**	463,815	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 463,815	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

0048751

Report Period Beginning: July 1, 2007

Ending:

June 30, 2008

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	1,444	1,607	\$ 58,059	\$ 36.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,077	4,613	113,391	24.58	3
4	Licensed Practical Nurses	20,506	23,140	422,363	18.25	4
5	CNAs & Orderlies	44,706	49,332	544,999	11.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,468	3,798	44,521	11.72	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	6,806	7,566	91,430	12.08	11
12	Dietician					12
13	Food Service Supervisor	1,890	2,008	29,476	14.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,990	12,750	109,033	8.55	15
16	Dishwashers					16
17	Maintenance Workers	3,451	3,716	46,290	12.46	17
18	Housekeepers	10,662	11,519	108,882	9.45	18
19	Laundry					19
20	Administrator	1,787	2,040	101,116	49.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,852	2,016	28,049	13.91	23
24	Clerical	984	1,284	15,075	11.74	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(specify)	3,516	3,870	45,246	11.69	32
33	Other(specify)	6,256	6,877	154,393	22.45	33
34	TOTAL (lines 1 - 33)	122,395	136,136	\$ 1,912,323 *	\$ 14.05	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	178	\$ 9,207	In 1, col 3	35
36	Medical Director	72	7,200	In 9, col3	36
37	Medical Records Consultant	36	2,213	In 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	2,258	In 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	83	4,945	In 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	489	\$ 25,823		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 - \$3,876
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,456 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. \$ 38,980
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. \$ 105
- (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. \$ 6,547
- 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? 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 \$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.