

Facility Name & ID Number Heartland Christian Village

0048751 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	71	Skilled (SNF)	71	25,915	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	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,531	9,836	4,654	23,021	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	8,531	9,836	4,654	23,021	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.83%

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 units

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 4,028

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	153,231	18,931	7,437	179,599		179,599		179,599		1
2	Food Purchase		157,559		157,559		157,559	(4)	157,555		2
3	Housekeeping	78,300	10,653		88,953		88,953		88,953		3
4	Laundry	38,108	5,201		43,309		43,309		43,309		4
5	Heat and Other Utilities			104,380	104,380		104,380	(806)	103,574		5
6	Maintenance	60,722	5,859	27,505	94,086		94,086	2,459	96,545		6
7	Other (specify):*			5,079	5,079		5,079		5,079		7
8	TOTAL General Services	330,361	198,203	144,401	672,965		672,965	1,649	674,614		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	1,390,299	187,202	8,330	1,585,831	(111,133)	1,474,698		1,474,698		10
10a	Therapy			457,396	457,396		457,396		457,396		10a
11	Activities	53,155	918	730	54,803		54,803		54,803		11
12	Social Services	65,768	4,502	3,462	73,732		73,732	(499)	73,233		12
13	CNA Training										13
14	Program Transportation			2,724	2,724		2,724	(4,706)	(1,982)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,509,222	192,622	482,842	2,184,686	(111,133)	2,073,553	(5,205)	2,068,348		16
	C. General Administration										
17	Administrative	91,093	2,483	280,030	373,606		373,606	(239,406)	134,200		17
18	Directors Fees										18
19	Professional Services			23,022	23,022		23,022	19,190	42,212		19
20	Dues, Fees, Subscriptions & Promotions			8,352	8,352		8,352		8,352		20
21	Clerical & General Office Expenses	53,959	10,420	167,700	232,079		232,079	65,315	297,394		21
22	Employee Benefits & Payroll Taxes			396,607	396,607		396,607	18,497	415,104		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,878	10,878		10,878	9,028	19,906		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,787	50,787		50,787	730	51,517		26
27	Other (specify):* Marketing	50,511	2,929	23,374	76,814		76,814	(76,814)			27
28	TOTAL General Administration	195,563	15,832	960,750	1,172,145		1,172,145	(203,460)	968,685		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,035,146	406,657	1,587,993	4,029,796	(111,133)	3,918,663	(207,016)	3,711,647		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, 2009 Ending:

June 30, 2010

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			167,529	167,529		167,529	12,110	179,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			265,341	265,341		265,341	(15,600)	249,741			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,282	8,282		8,282		8,282			35
36	Other (specify):* Def Financing Cost			3,746	3,746		3,746		3,746			36
37	TOTAL Ownership			444,898	444,898		444,898	(3,490)	441,408			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			36,434	36,434		36,434		36,434			39
40	Barber and Beauty Shops	12,893	912		13,805	111,133	124,938		124,938			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* Apt/ Congregate			39,528	39,528		39,528	(68,973)	(29,445)			43
44	TOTAL Special Cost Centers	12,893	912	114,835	128,640	111,133	239,773	(68,973)	170,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,048,039	407,569	2,147,726	4,603,334		4,603,334	(279,479)	4,323,855			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				4
5	Telephone, TV & Radio in Resident Rooms	(5,490)	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	(20,099)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,509)	21		24
25	Fund Raising, Advertising and Promotional	(76,814)	27		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	(91,239)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (219,151)		\$	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)	(60,328)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,328)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (279,479)		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		111,133	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 111,133	47

BHF USE ONLY							
48		49		50		51	52

Heartland Christian VillageID# 0048751Report Period Beginning: July 1, 2009Ending: June 30, 2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (4)	2	1
2	Activity	(499)	12	2
3	Apartments/Congregate	(68,973)	43	3
4	Late Fees	(153)	21	4
5	Transportation Revenue	(4,706)	14	5
6	Miscellaneous Revenue	(570)	17	6
7	Charity Care	(3,074)	21	7
8	Fines and Penalties	(13,260)	21	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	(91,239)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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	(5,490)	4,684	0	0	0	0	0	0	0	0	0	(806)	5
6	Maintenance	0	2,459	0	0	0	0	0	0	0	0	0	2,459	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,494)	7,143	0	1,649	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	(499)	0	0	0	0	0	0	0	0	0	0	(499)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,706)	0	0	0	0	0	0	0	0	0	0	(4,706)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,205)	0	0	0	0	0	0	0	0	0	0	(5,205)	16
	C. General Administration													
17	Administrative	(570)	(238,836)	0	0	0	0	0	0	0	0	0	(239,406)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,190	0	0	0	0	0	0	0	0	0	19,190	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(41,996)	107,311	0	0	0	0	0	0	0	0	0	65,315	21
22	Employee Benefits & Payroll Taxes	0	18,497	0	0	0	0	0	0	0	0	0	18,497	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,028	0	0	0	0	0	0	0	0	0	9,028	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	730	0	0	0	0	0	0	0	0	0	730	26
27	Other (specify):*	(76,814)	0	0	0	0	0	0	0	0	0	0	(76,814)	27
28	TOTAL General Administration	(119,380)	(84,080)	0	(203,460)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(130,079)	(76,937)	0	(207,016)	29								

STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2009 Ending:

Summary B

June 30, 2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	12,110	0	0	0	0	0	0	0	0	0	12,110	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,099)	4,499	0	0	0	0	0	0	0	0	0	(15,600)	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	(20,099)	16,609	0	(3,490)	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):*	(68,973)	0	0	0	0	0	0	0	0	0	0	(68,973)	43
44	TOTAL Special Cost Centers	(68,973)	0	0	0	0	0	0	0	0	0	0	(68,973)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(219,151)	(60,328)	0	0	0	0	0	0	0	0	0	(279,479)	45

Facility Name & ID Number

Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2009

Ending:

June 30, 2010

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	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 4,684	\$ 4,684	1
2	V	6 Maintenance				2,459	2,459	2
3	V	17 Administrative	280,030			41,194	(238,836)	3
4	V	19 Professional Services				19,190	19,190	4
5	V	21 Clerical				107,311	107,311	5
6	V	22 Employee Benefits				18,497	18,497	6
7	V	24 Travel and Seminar				9,028	9,028	7
8	V	26 Insurance				730	730	8
9	V	30 Depreciation				12,110	12,110	9
10	V	32 Interest				4,499	4,499	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 280,030			\$ 219,702	\$ * (60,328)	14

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

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

0048751

Report Period Beginning:

July 1, 2009

Ending: ne 30, 2010

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

Facility Name & ID Number

Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2009 Ending:

June 30, 2010

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										
										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	7/19/07	\$ 4,292,500	\$ 4,126,010	8/1/2037	0.0588	\$ 265,341	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	\$ 4,126,010			\$ 265,341	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	\$ 4,126,010			\$ 265,341	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,794 Line # 32

* 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2009 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 2010 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:	2005	_____	8	FOR BHF USE ONLY		
	2006	_____	9			
	2007	_____	10			
	2008	_____	11			
	2009	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	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.

2009 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 2009 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 2009.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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, 2009 Ending:

June 30, 2010

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:

	1	2	3	4	
A. Land.	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>3,353</u>	<u>2</u>
3	TOTALS	32,630		\$ 45,120	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71		1992	1992	\$ 2,601,099	\$ 65,028	40	\$ 65,028	\$	\$ 1,154,238	4
5			1995	1995	119,926	2,998	40	2,998		45,972	5
6											6
7											7
8		Home Office Allocation			34,580	2,569		2,569		68,937	8
		Improvement Type**									
9		CARPETING	10/13/1992		9961.00		05			9,961	9
10		WALLCOVERINGS	10/13/1992		8385.00		05			8,385	10
11		WALLCOVERINGS	10/13/1992		16128.00		05			16,129	11
12		FIRE ALARM COMMTCOR	10/13/1992		578.00	29	20	29		513	12
13		TOWEL RINGS	11/16/1992		637.00		10			637	13
14		RAILGATE LOADING DOCK	4/29/1993		536.00		10			536	14
15		DOOR LOCK BYPASS SWITCH	12/9/1993		856.00		10			856	15
16		AUTODOOR CLOSEALERT	10/24/1994		908.00		10			908	16
17		ELECTRIC WORKFIRE ALARM	5/7/1998		1335.00		10			1,335	17
18		SMOKE DAMPERS5	4/21/1998		2284.00		10			2,284	18
19		WATER HEATER	12/13/1999		5831.00	243	10	243		5,831	19
20		EXPANSION TANK	12/13/1999		1126.00		05			1,126	20
21		CEILING FANS (2) ACTIVITY	1/3/2000		500.00		05			500	21
22		FLOOR COVERING ASSISTED LIVING AREA	12/18/2001		1161.00		05			1,161	22
23		TRANE AC UNIT	6/11/2002		1370.00	137	10	137		1,107	23
24		CARPET RMS #102104105116	9/23/2002		942.00		05			942	24
25		ROOFNH MAINTENANCE GARAGE	12/13/2002		1500.00		05			1,500	25
26		CARPETING RMS #110111113	12/2/2002		922.00		05			922	26
27		WATER HEATER	1/26/2003		3788.00	379	10	379		2,841	27
28		MIXING VALVE (PLUMBING SYSTEM)	6/18/2003		2330.00	233	10	233		1,650	28
29		FRIEDRICH 14400 BTU PTAC UNIT	7/15/2003		698.00	87	08	87		611	29
30		CARPETING ROOMS 101 & 115	7/23/2003		567.00		05			567	30
31		INSTALL EXHAUST FANO2 ROOM	2/11/2004		532.00		05			532	31
32		FRIEDRICH 14400 BTU PTAC UNIT	1/29/2004		648.00	81	08	81		527	32
33		ELEMCOOPTO 22 ENERGY MGMT SYSTEM	2/16/2004		5676.00	568	10	568		3,642	33
34		FRIEDRICH 14400 BTU PTAC UNIT	5/24/2004		701.00	88	08	88		540	34
35		AC UNIT FOR OFFICE	6/10/2004		1400.00	140	10	140		852	35
36		FRIEDRICH 14400 BTU PTAC UNIT	7/20/2004		609.00	76	08	76		457	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, 2009 Ending: June 30, 2010

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FINAL PMNTENERGY MGMT SYSTEM	8/20/2004	\$ 5674.00	\$ 567	10	\$ 567		\$ 3,357	37
38	DATAPHONES NETWORK CABLING	9/30/2004	18304.00	1,830	10	1,830		10,677	38
39	OAK FIRE DOOR	12/1/2004	641.00	64	10	64		358	39
40	FIRE ALARM ACCELERATORRELOCATE SPRINKLE	11/22/2004	2985.00	299	10	299		1,692	40
41	INSTALL DISHWASHER VENT FAN	12/20/2004	1052.00	105	10	105		587	41
42	INSTALL FIRE DAMPERS	3/11/2005	14750.00	1,475	10	1,475		7,867	42
43	KITCHEN FLOOR TILE WINSTALLATION	9/1/2004	792.00	26	05	26		792	43
44	FIRERATED STAIRCASE TO MECHANICAL ROOM	4/11/2005	5846.00	877	05	877		5,846	44
45	(46) ROOM SIGNS WBRILLE	4/8/2005	796.00	119	05	119		796	45
46	Install Emergency Exit LightsLife Safet	8/14/2006	541.00	54	10	54		212	46
47	Install 2 door alarm system	8/10/2006	1079.50	108	10	108		423	47
48	wall in dining room labor & materials	3/1/2007	1998.00	200	10	200		666	48
49	Ceramic tile flooring for dining room	3/1/2007	8636.60	432	20	432		1,439	49
50	Water drain for sprinkler system	3/1/2007	838.39	84	10	84		279	50
51	Ramp	7/9/2007	600.00	120	05	120		360	51
52	New Roof Main NH Bldg	7/1/2007	61000.00	6,100	10	6,100		18,300	52
53	Tile flooring 3 bathing room	7/1/2008	2350.68	470	05	470		940	53
54	Repairs on 109 windows in facility	11/29/2007	12670.00	2,534	05	2,534		6,757	54
55	Bathing Room Project	1/31/2008	2100.21	210	10	210		525	55
56	Bldg supplies for bathroom Hall 2	4/1/2008	2944.44	294	10	294		662	56
57	Wiring for heaters in restrooms	5/14/2008	1975.15	198	10	198		428	57
58	Pushbutton Door locks	5/14/2008	3298.83	330	10	330		715	58
59	Installed new Compressor for Walk-In	5/30/2008	5288.59	529	10	529		1,146	59
60	Commercial Garbage Disposal	1/27/2009	1859.01	186	10	186		279	60
61	Compressor for Walkin Cooler	12/30/2009	3745.43	218	10	218		218	61
62	Sprinkler System	12/12/2009	150125.32	8,757	10	8,757		8,757	62
63	Door Alarm System	4/1/2010	35519.83	888	10	888		888	63
64	Installation of ceiling airducts and fir	11/24/2005	1474.20	74	20	74		344	64
65	SEWER LINES	10/13/1992	37086.00	927	40	927		16,455	65
66	PATIO & SIDEWALK	10/13/1992	900.00	45	20	45		799	66
67	SIGN	10/13/1992	6286.00		10			6,286	67
68	LANDSCAPING	10/13/1992	21485.00	1,074	20	1,074		19,068	68
69	LANDSCAPING	7/3/1995	2602.00		05			2,602	69
70	TOTAL (lines 4 thru 69)		\$ 3,244,758	\$ 101,850		\$ 101,850		\$ 1,456,519	70

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,244,758	\$ 101,850		\$ 101,850	\$	\$ 1,456,519	1
2	SIDEWALK	11/25/1998	1405.00		05			1,405	2
3	FLAG POLE LIGHT @ FRONT ENTRANCE	6/17/2003	793.00	79	10	79		562	3
4	NEW SIDEWALKEXTEND PATIOCOURTYARD	9/24/2004	1646.00	206	08	206		1,200	4
5	Remove old and pour new 8x8 concrete pad	4/11/2007	1960.00	196	10	196		637	5
6	Parking lot	6/30/2009	13895.00	1,390	10	1,390		1,505	6
7	Concrete pad - entryway	6/30/2009	1572.17	105	15	105		114	7
8	Extend driveway drainage	6/30/2009	1300.00	130	10	130		141	8
9	Land Improvement by Thomas Lawn Care	9/30/2009	22689.50	1,891	10	1,891		1,891	9
10	12X26 CARPORT	10/24/2003	895.00	90	10	90		604	10
11	PAVILLION	5/4/2005	1550.00	155	10	155		801	11
12	Storage Shed	6/1/2007	19054.80	952	20	952		2,938	12
13	Garage Renovation	7/1/2007	589.91	118	05	118		354	13
14	Electrical Wiring South Garages	8/11/2007	2211.53	111	20	111		323	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,314,320	\$ 107,273		\$ 107,273	\$	\$ 1,468,994	34

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

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	\$ 366,761	\$ 44,731	\$ 44,731	\$	Various	\$ 118,632	71
72	Current Year Purchases	55,774	6,857	6,857		Various	6,857	72
73	Fully Depreciated Assets	288,369	541	541		Various	288,369	73
74	Home Office Allocation	110,860	8,236	8,236			16,868	74
75	TOTALS	\$ 821,764	\$ 60,365	\$ 60,365	\$		\$ 430,726	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/1993 Chevy Van	1994/1996	\$ 59,053	\$	\$	\$	8	\$ 59,053	76
77	Patient Transportation	2009 Chrysler T&C Van	2009	44,935	9,362	9,362		4	9,361	77
78	Overhaul	1994 Ford Eldorado Van	2008	5,336	1,334	1,334		4	2,335	78
79	Home Office Allocation			17,565	1,305	1,305			6,203	79
80	TOTALS			\$ 126,889	\$ 12,001	\$ 12,001	\$		\$ 76,952	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)	\$ 4,308,093	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,639	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,639	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)	\$ 1,976,672	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	2,258	42,576	87
88	Duplex Building	660,186	18,453	333,178	88
89	Duplex Equipment	24,911	1,624	18,969	89
90					90
91	TOTALS	\$ 792,066	\$ 22,335	\$ 394,723	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 25,351	92
93			93
94			94
95		\$ 25,351	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: _____

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

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: \$ 8,282 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

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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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>
<p><u>There is no training at Heartland Christian Village, LLC. There is an agreement with the local college to have clinicals at Heartland Christian Village, LLC.</u></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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,500	\$ 153,029	\$	2,500	\$ 153,029	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,040	80,094		1,040	80,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,599	224,273		3,599	224,273	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	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	7,139	\$ 457,396	\$	7,139	\$ 457,396	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# 0048751Report Period Beginning: July 1, 2009Ending: June 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2010 (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	\$ 566,151	\$	1
2	Cash-Patient Deposits	4,717		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,165</u>)	537,187		3
4	Supply Inventory (priced at)	20,036		4
5	Short-Term Investments	22,400		5
6	Prepaid Insurance	9,929		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	636		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,161,056	\$	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	3,826,306		14
15	Leasehold Improvements, at Historical Cost	178,822		15
16	Equipment, at Historical Cost	845,139		16
17	Accumulated Depreciation (book methods)	(2,279,389)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	789,320		21
22	Other Long-Term Assets (spe <u>Construction in Progr</u>	66,678		22
23	Other(specify): <u>Deferred Financing Costs</u>	82,402		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,592,812	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,753,868	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 71,855	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,717		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,329		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>Other Accrued Expenses</u>	104,847		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 371,748	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,126,010		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits Payable</u>	2,663		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,128,673	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,500,421	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 253,447	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,753,868	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (92,786)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (92,786)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,233	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)	\$ 346,233	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)	\$ 253,447	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2009Ending: June 30, 2010

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	\$ 3,956,459	1
2	Discounts and Allowances for all Levels	(806,921)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,149,538	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,520,352	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,520,352	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	14,823	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	5,490	15
16	Rental of Facility Space		16
17	Sale of Drugs	40,583	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,848	19
20	Radiology and X-Ray	9,933	20
21	Other Medical Services	10,438	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100,115	23
D. Non-Operating Revenue			
24	Contributions	62,307	24
25	Interest and Other Investment Income***	24,478	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,785	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apartment/Duplex)	68,973	28
28a	Miscellaneous/Unrealized gain on investments	23,804	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 92,777	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,949,567	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	672,965	31
32	Health Care	2,184,686	32
33	General Administration	1,172,145	33
B. Capital Expense			
34	Ownership	444,898	34
C. Ancillary Expense			
35	Special Cost Centers	89,767	35
36	Provider Participation Fee	38,873	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,603,334	40
41	Income before Income Taxes (line 30 minus line 40)**	346,233	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 346,233	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, 2009

Ending:

June 30, 2010

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	1,862	1,862	\$ 74,616	\$ 40.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,711	6,272	151,256	24.12	3
4	Licensed Practical Nurses	22,475	24,339	432,587	17.77	4
5	CNAs & Orderlies	47,417	50,205	571,530	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,383	1,383	16,621	12.02	8
9	Activity Director	1,972	1,972	18,142	9.20	9
10	Activity Assistants	3,448	3,448	35,013	10.15	10
11	Social Service Workers	2,847	3,628	65,768	18.13	11
12	Dietician					12
13	Food Service Supervisor	1,397	1,397	24,802	17.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,841	12,865	128,429	9.98	15
16	Dishwashers					16
17	Maintenance Workers	4,497	4,781	60,722	12.70	17
18	Housekeepers	7,230	7,649	78,300	10.24	18
19	Laundry	3,695	4,006	38,108	9.51	19
20	Administrator	1,810	1,810	91,093	50.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,947	1,947	30,304	15.56	23
24	Clerical	1,160	1,798	23,655	13.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,028	2,028	34,633	17.08	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,436	1,436	22,685	15.80	31
32	Other Health C: MDS Coordinator	5,973	5,973	86,372	14.46	32
33	Other(specify) Marketing, Barber	2,634	2,724	63,403	23.28	33
34	TOTAL (lines 1 - 33)	132,763	141,523	\$ 2,048,039 *	\$ 14.47	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	169	\$ 7,417	ln 1, col 3	35
36	Medical Director	168	10,200	ln 9, col3	36
37	Medical Records Consultant	35	2,393	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	336	2,141	ln 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	10	730	ln 11, col 3	44
45	Social Service Consultant	54	3,749	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	772	\$ 26,630		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2009 Ending: June 30, 201**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. LSN - \$4,198.20
- (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. \$ 7,409 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. \$ 38,873
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? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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. \$ 4,706
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.