

Facility Name & ID Number Heartland Christian Village

0048751 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,329	9,906	4,464	22,699	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,329	9,906	4,464	22,699	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.59%

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)

Housekeeping/Laundry, Meals, Maintenance Services for IL Residents

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 4,284

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: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number

Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2012

Ending:

June 30, 2013

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	161,708	8,525	5,679	175,912		175,912		175,912		1
2	Food Purchase		160,214		160,214		160,214	(380)	159,834		2
3	Housekeeping	73,591	10,221		83,812		83,812		83,812		3
4	Laundry	42,345	7,894		50,239		50,239		50,239		4
5	Heat and Other Utilities			90,250	90,250		90,250	(2,393)	87,857		5
6	Maintenance	64,058	7,025	30,632	101,715		101,715	2,222	103,937		6
7	Other (specify):* Trash			6,823	6,823		6,823		6,823		7
8	TOTAL General Services	341,702	193,879	133,384	668,965		668,965	(551)	668,414		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,445,736	97,888	12,648	1,556,272		1,556,272	(690)	1,555,582		10
10a	Therapy			500,722	500,722		500,722		500,722		10a
11	Activities	53,583	5,780	112	59,475		59,475		59,475		11
12	Social Services	113,121	1,746	1,450	116,317		116,317		116,317		12
13	CNA Training										13
14	Program Transportation			7,741	7,741		7,741	(3,345)	4,396		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,612,440	105,414	537,073	2,254,927		2,254,927	(4,035)	2,250,892		16
	C. General Administration										
17	Administrative	74,948	3,742	351,308	429,998		429,998	(302,111)	127,887		17
18	Directors Fees										18
19	Professional Services			24,960	24,960		24,960	18,194	43,154		19
20	Dues, Fees, Subscriptions & Promotions			13,151	13,151		13,151		13,151		20
21	Clerical & General Office Expenses	73,382	8,926	78,707	161,015		161,015	101,789	262,804		21
22	Employee Benefits & Payroll Taxes			448,894	448,894		448,894	22,244	471,138		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,876	7,876		7,876	8,941	16,817		24
25	Other Admin. Staff Transportation			58,444	58,444		58,444		58,444		25
26	Insurance-Prop.Liab.Malpractice							4,717	4,717		26
27	Other (specify):* Marketing	12,505	1,509	12,913	26,927		26,927	(26,927)			27
28	TOTAL General Administration	160,835	14,177	996,253	1,171,265		1,171,265	(173,153)	998,112		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,114,977	313,470	1,666,710	4,095,157		4,095,157	(177,739)	3,917,418		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.

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			205,640	205,640	205,640	17,347	222,987				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179,532	179,532	179,532	161	179,693				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,730	12,730	12,730		12,730				35
36	Other (specify):* Deferred Financing Costs			6,315	6,315	6,315		6,315				36
37	TOTAL Ownership			404,217	404,217	404,217	17,508	421,725				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			162,026	162,026	162,026	(10,138)	151,888				39
40	Barber and Beauty Shops	15,040	1,399		16,439	16,439		16,439				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,457	150,457	150,457		150,457				42
43	Other (specify):* Apt/Congregate			47,329	47,329	47,329	(47,329)					43
44	TOTAL Special Cost Centers	15,040	1,399	359,812	376,251	376,251	(57,467)	318,784				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,130,017	314,869	2,430,739	4,875,625	4,875,625	(217,698)	4,657,927				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	(380)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,140)	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	(6,806)	32		10
11	Discounts, Allowances, Rebates & Refunds	(690)	10		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	(509)	21		24
25	Fund Raising, Advertising and Promotional	(26,927)	27		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule	(51,466)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,918)		\$	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)	(127,780)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (127,780)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (217,698)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	51
					52

Heartland Christian Village

ID# 0048751

Report Period Beginning: July 1, 2012

Ending: June 30, 2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Apartments/Congregate	\$ (47,329)	43	1
2	Late Fees	(792)	21	2
3	Transportation Revenue	(3,345)	14	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				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		(51,466)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2012

Ending:

June 30, 2013

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	(380)	0	0	0	0	0	0	0	0	0	0	(380)	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	(3,140)	747	0	0	0	0	0	0	0	0	0	(2,393)	5
6	Maintenance	0	2,222	0	0	0	0	0	0	0	0	0	2,222	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,520)	2,969	0	(551)	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	(690)	0	0	0	0	0	0	0	0	0	0	(690)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,345)	0	0	0	0	0	0	0	0	0	0	(3,345)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,035)	0	0	0	0	0	0	0	0	0	0	(4,035)	16
	C. General Administration													
17	Administrative	0	(302,111)	0	0	0	0	0	0	0	0	0	(302,111)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18,194	0	0	0	0	0	0	0	0	0	18,194	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,301)	103,090	0	0	0	0	0	0	0	0	0	101,789	21
22	Employee Benefits & Payroll Taxes	0	22,244	0	0	0	0	0	0	0	0	0	22,244	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,941	0	0	0	0	0	0	0	0	0	8,941	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	4,717	0	0	0	0	0	0	0	0	0	4,717	26
27	Other (specify):*	(26,927)	0	0	0	0	0	0	0	0	0	0	(26,927)	27
28	TOTAL General Administration	(28,228)	(144,925)	0	(173,153)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,783)	(141,956)	0	(177,739)	29								

STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2012 Ending:

Summary B

June 30, 2013

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	17,347	0	0	0	0	0	0	0	0	0	17,347	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,806)	6,967	0	0	0	0	0	0	0	0	0	161	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	(6,806)	24,314	0	17,508	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	(10,138)	0	0	0	0	0	0	0	0	0	(10,138)	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):*	(47,329)	0	0	0	0	0	0	0	0	0	0	(47,329)	43
44	TOTAL Special Cost Centers	(47,329)	(10,138)	0	(57,467)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(89,918)	(127,780)	0	(217,698)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Listing of board of directors						

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 747	\$ 747	1
2	V	6 Maintenance				2,222	2,222	2
3	V	17 Administrative	351,308			49,197	(302,111)	3
4	V	19 Professional Services				18,194	18,194	4
5	V	21 Clerical				103,090	103,090	5
6	V	22 Employee Benefits				22,244	22,244	6
7	V	24 Travel and Seminar				8,941	8,941	7
8	V	26 Insurance				4,717	4,717	8
9	V	30 Depreciation				17,347	17,347	9
10	V	32 Interest				6,967	6,967	10
11	V							11
12	V							12
13	V	39 Pharmacy Services	120,120	Senior Care Pharmacy Services	0.00%	109,982	(10,138)	13
14	Total		\$ 471,428			\$ 343,648	\$ * (127,780)	14

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

Facility Name & ID Number

Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2012

Ending: June 30, 2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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, 2012

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ne 30, 2013

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

Facility Name & ID Number

Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2012 Ending:

June 30, 2013

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	Mortgage Payable		X	HUD Financing	\$32,080.00	10/28/11	\$ 4,072,900	\$ 3,917,146	07/01/37	4.0500	\$ 179,532	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$32,080.00		\$ 4,072,900	\$ 3,917,146			\$ 179,532	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 4,072,900	\$ 3,917,146			\$ 179,532	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,797 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 2012 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 2013 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:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0048751

CONTACT PERSON REGARDING THIS REPORT This page is N/A

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 2012 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 2012.

	(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.	N/A		\$	\$
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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, 2012 Ending: June 30, 2013

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).

8 Independent Living Units

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>3,598</u>	<u>2</u>
3	TOTALS	32,630		\$ 45,365	3

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71		1992	1992	\$ 2,601,099	\$		\$	\$	\$	4
5			1995	1995	119,926						5
6											6
7											7
8		Home Office Allocation			35,245	4,003		4,003		23,269	8
		Improvement Type**									
9		1992 Fixed Assets		10/13/1992	66,394		Various				9
10		1993 Fixed Assets		12/31/1993	1,392		Various				10
11		1994 Fixed Assets		10/24/1994	908		Various				11
12		1995 Fixed Assets		7/31/1995	2,602		Various				12
13		1998 Fixed Assets		12/31/1998	5,024		Various				13
14		1999 Fixed Assets		12/13/1999	6,957		Various				14
15		2000 Fixed Assets		1/3/2000	500		Various				15
16		2002 Fixed Assets		12/31/2002	4,734		Various				16
17		2003 Fixed Assets		12/31/2003	8,373		Various				17
18		2004 Fixed Assets		12/31/2004	20,398		Various				18
19		2005 Fixed Assets		12/31/2005	23,620		Various				19
20		2006 Fixed Assets		12/31/2006	1,621		Various				20
21		2007 Fixed Assets		12/31/2007	107,561		Various				21
22		Bathing Room Project		1/31/2008	2,100		10				22
23		Bldg supplies for bathroom Hall 2		4/1/2008	2,944		10				23
24		Wiring for heaters in restrooms		5/14/2008	1,975		10				24
25		Pushbutton Door locks		5/14/2008	3,299		10				25
26		Tile flooring 3 bathing room		7/1/2008	2,351		10				26
27		Commercial Garbage Disposal		1/27/2009	1,859		05				27
28		Parking lot		6/30/2009	13,895		10				28
29		Concrete pad - entryway		6/30/2009	1,572		10				29
30		Extend driveway drainage		6/30/2009	1,300		15				30
31		Land Improvement by Thomas Lawn Care		9/30/2009	22,690		10				31
32		Sprinkler System		12/12/2009	150,125		10				32
33		Compressor for Walkin Cooler		12/30/2009	3,745		10				33
34		Door Alarm System		4/1/2010	35,520		10				34
35		Smoke Detector for Life Safety		8/29/2010	1,054		10				35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dock Door w/Lock & handle	10/21/2010	\$ 5,402	\$	10	\$	\$	\$	37
38	Fire Alarm System	1/31/2011	65,344		10				38
39	89 gal water heater	1/31/2011	12,834		10				39
40	PTAC Units	1/31/2011	6,733		10				40
41	Refurb Activity & Therapy Room	1/31/2011	3,474		10				41
42	Paint Main Hall	5/31/2011	38,671		10				42
43	Main Hall - Flooring	6/30/2011	87,059		10				43
44	Flooring - Service Hallway Tekno	8/21/2011	5,490		10				44
45	PTAC Digismart, 15,000 BTU 30am	7/12/2011	2,113		10				45
46	Vinyl Flooring & Covebase RM 115	10/25/2011	2,462		10				46
47	A/C Condensor	7/11/2012	2,375		15				47
48	R&R Generator	1/18/2013	3,419		12				48
49	90 gal water Heater	4/10/2013	6,250		10				49
50	East Wing Shower	4/10/2013	917		20				50
51	Rm 106 Toilet	4/10/2013	700		20				51
52	R&R Sliding Door	6/24/2013	7,398		10				52
53	R&R South Sliding Door	6/24/2013	8,802		10				53
54	Hall 2 - R&R Vinyl Floor & Covebase	5/1/2013	49,870		10				54
55	Total Building & Building Improvements Depreciation Expense			128,804		128,804		1,728,856	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,560,096	\$ 132,807		\$ 132,807	\$	\$ 1,752,125	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 400,562	\$ 62,531	\$ 62,531	\$		\$ 228,292	71
72	Current Year Purchases	63,009	2,988	2,988			2,988	72
73	Fully Depreciated Assets	284,389					284,389	73
74	Home Office Allocation	144,304	11,871	11,871			78,433	74
75	TOTALS	\$ 892,264	\$ 77,390	\$ 77,390	\$		\$ 594,102	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus/1993 Chevy Van	1994/1996	\$ 59,053	\$	\$	\$		\$ 59,053	76
77	Patient Transportation	2009 Chrysler T&C Van	2009	43,935	10,984	10,984			42,313	77
78	Overhaul	1994 Ford Eldorado Van	2008	5,336	333	333			5,336	78
79	Home office allocation			12,972	1,473	1,473			5,219	79
80	TOTALS			\$ 121,296	\$ 12,790	\$ 12,790	\$		\$ 111,921	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)	\$ 4,619,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,987	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,458,148	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	1,241	47,587	87
88	Duplex Building	669,114	18,915	389,929	88
89	Duplex Equipment	12,061	1,322	10,145	89
90					90
91	TOTALS	\$ 788,144	\$ 21,478	\$ 447,661	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 84,313	92
93			93
94			94
95		\$ 84,313	95

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

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

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning: July 1, 2012

Ending: June 30, 2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 12,731

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			\$ _____	\$ _____	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.

HLCV
 FY2013
 Rental & Leasing

Account	Vendor	Service	Amount
7645-10	Neopost Inc.	Postage Meter	305.62
	RK Dixon	Copiers	4,750.99
	Wells Fargo	Printers	1,500.82
	Total 7645-10		6,557.43
7645-21	Swisher Hygiene	<u>Dishwashing Machine</u>	1,375.00
		Total 7645-21	1,375.00
7645-30	KCI USA, Inc.	Vac Freedom Wound Vac	632.50
	RCS Management Corporation	Oxygen Concentrators	1,341.76
	Total 7645-30		1,974.26
7645-31	KCI USA, Inc. National Wound Care	Vac Freedom Wound Vac	1,834.25
		<u>APM w/air flow vent</u>	990.00
		Total 7645-31	2,824.25
Grand Total 7645		12,730.94	

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2012 Ending: June 30, 2013
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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<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	\$	3,246	\$ 176,252	\$	3,246	\$ 176,252	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,834	108,216		1,834	108,216	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,455	216,254		6,455	216,254	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			\$	11,535	\$ 500,722	\$	11,535	\$ 500,722	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, 2012Ending: June 30, 2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2013 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 992,982	\$	1
2	Cash-Patient Deposits	2,422		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>26,615</u>)	622,483		3
4	Supply Inventory (priced at)	16,262		4
5	Short-Term Investments	26,517		5
6	Prepaid Insurance	23,425		6
7	Other Prepaid Expenses	9,463		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc Int/ Other A/R</u>	20,468		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,714,022	\$	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	4,080,345		14
15	Leasehold Improvements, at Historical Cost	17,822		15
16	Equipment, at Historical Cost	868,345		16
17	Accumulated Depreciation (book methods)	(2,798,942)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	705,718		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	151,034		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,107,856	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,821,878	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 245,989	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,422		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,210		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>	161,390		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 629,011	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,917,146		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	3,750		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,920,896	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,549,907	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,231,642	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,781,549	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 859,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 859,736	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	371,906	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)	\$ 371,906	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)	\$ 1,231,642	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2012Ending: June 30, 2013

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,358,505	1
2	Discounts and Allowances for all Levels	(1,580,879)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,777,626	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,974,589	6
7	Oxygen	6,910	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,981,499	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	16,253	13
14	Non-Patient Meals	380	14
15	Telephone, Television and Radio	3,140	15
16	Rental of Facility Space		16
17	Sale of Drugs	222,081	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,202	19
20	Radiology and X-Ray	22,017	20
21	Other Medical Services	21,822	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 312,895	23
D. Non-Operating Revenue			
24	Contributions	84,681	24
25	Interest and Other Investment Income***	9,480	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94,161	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center</u>	74,400	28
28a	<u>Miscellaneous</u>	6,950	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 81,350	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,247,531	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	668,965	31
32	Health Care	2,254,927	32
33	General Administration	1,171,265	33
B. Capital Expense			
34	Ownership	404,217	34
C. Ancillary Expense			
35	Special Cost Centers	225,794	35
36	Provider Participation Fee	150,457	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,875,625	40
41	Income before Income Taxes (line 30 minus line 40)**	371,906	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 371,906	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,111,305	44
45	Private Pay - Net Inpatient Revenue	1,734,292	45
46	Medicare - Net Inpatient Revenue	(52,169)	46
47	Other-(specify) <u>HMO</u>	(11,401)	47
48	Other-(specify) <u>Medicare Advantage/Nursing</u>	(4,401)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,777,626	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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, 2012

Ending: June 30, 2013

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	1,421	1,545	\$ 62,072	\$ 40.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,930	12,116	281,332	23.22	3
4	Licensed Practical Nurses	18,858	20,666	393,071	19.02	4
5	CNAs & Orderlies	49,971	52,645	617,077	11.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	1,952	28,072	14.38	9
10	Activity Assistants	2,612	2,771	26,485	9.56	10
11	Social Service Workers	6,225	6,743	111,169	16.49	11
12	Dietician					12
13	Food Service Supervisor	1,852	2,112	30,520	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,145	13,197	135,316	10.25	15
16	Dishwashers					16
17	Maintenance Workers	4,300	4,582	64,561	14.09	17
18	Housekeepers	6,449	6,974	76,025	10.90	18
19	Laundry	3,686	4,096	41,712	10.18	19
20	Administrator	1,840	2,152	74,948	34.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,914	2,095	35,671	17.03	23
24	Clerical	1,955	2,076	23,098	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,859	2,015	36,003	17.87	31
32	Other Health C: MDS Cordinator	2,138	2,213	63,957	28.90	32
33	Other(specify) <u>Marketing/Beauty</u>	1,731	1,868	28,928	15.49	33
34	TOTAL (lines 1 - 33)	131,724	141,818	\$ 2,130,017 *	\$ 15.02	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	112	\$ 5,679	ln 1, col 3	35
36	Medical Director	208	14,400	ln 9, col3	36
37	Medical Records Consultant	32	2,372	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	312	2,189	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				44
45	Social Service Consultant	25	1,450	ln 12, col 3	45
46	Other(specify) <u>Forefront Telecare</u>	219	5,325	ln 10, col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	908	\$ 31,415		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
John Letizia	Administrator		\$ 74,948	Workers' Compensation Insurance	\$ 73,458	IDPH License Fee	\$	
				Unemployment Compensation Insurance	607	Advertising: Employee Recruitment		
				FICA Taxes	154,050	Health Care Worker Background Check	320	
				Employee Health Insurance	190,950	(Indicate # of checks performed <u>10</u>)		
				Employee Meals		Patient Background Checks	135 1,350	
				Illinois Municipal Retirement Fund (IMRF)*		License	2,055	
				Employee Physicals	2,687	Dues	8,541	
				Employee Expense	22,373	Subscriptions	885	
				457 Plan Expense	5,000			
				Employee Uniforms	(231)			
				Home Office Allocation	22,244	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,948	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 471,138		\$ 13,151		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Expense			\$ 351,308				Out-of-State Travel	\$ 3,098
							In-State Travel	3,140
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 351,308				Seminar Expense	1,538
							Home Office Allocation	8,940
							Entertainment Expense	100
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 16,816
C. Professional Services								
Vendor/Payee	Type	Amount						
My Innerview	Consulting	\$ 1,445						
CliftonLarsonAllen	Accounting	14,317						
Davis & Campbell	Legal	4,559						
Armstrong Teasdale	Legal	4,639						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,960	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2012 Ending: June 30, 2012**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 \$3,998
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,232 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 150,457
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. \$ 380
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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: CliftonLarsonAllenLLP
- (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.