



Facility Name & ID Number Heartland Christian Village

# 0048751 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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	8,358	10,955	4,645	23,958	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,358	10,955	4,645	23,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.45%

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 4,332

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: 6/30/2014 Fiscal Year: 6/30/2014

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	148,540	11,434	5,479	165,453		165,453		165,453	1	
2	Food Purchase		156,076		156,076		156,076	(125)	155,951	2	
3	Housekeeping	76,702	9,871	450	87,023		87,023		87,023	3	
4	Laundry	40,161	6,237		46,398		46,398		46,398	4	
5	Heat and Other Utilities			92,453	92,453		92,453	(965)	91,488	5	
6	Maintenance	65,687	3,720	26,747	96,154		96,154	3,011	99,165	6	
7	Other (specify):* <b>Trash</b>			8,774	8,774		8,774		8,774	7	
8	<b>TOTAL General Services</b>	331,090	187,338	133,903	652,331		652,331	1,921	654,252	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200	9	
10	Nursing and Medical Records	1,510,357	78,390	12,179	1,600,926		1,600,926		1,600,926	10	
10a	Therapy			482,209	482,209		482,209		482,209	10a	
11	Activities	52,389	4,479		56,868		56,868	(627)	56,241	11	
12	Social Services	95,528	1,194	1,818	98,540		98,540		98,540	12	
13	CNA Training									13	
14	Program Transportation			8,175	8,175		8,175	(4,875)	3,300	14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	1,658,274	84,063	517,581	2,259,918		2,259,918	(5,502)	2,254,416	16	
	<b>C. General Administration</b>										
17	Administrative	102,972	1,828	318,720	423,520		423,520	(248,617)	174,903	17	
18	Directors Fees									18	
19	Professional Services			25,036	25,036		25,036	23,508	48,544	19	
20	Dues, Fees, Subscriptions & Promotions			15,029	15,029		15,029		15,029	20	
21	Clerical & General Office Expenses	60,769	6,848	89,551	157,168		157,168	111,651	268,819	21	
22	Employee Benefits & Payroll Taxes			484,070	484,070		484,070	26,649	510,719	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			6,319	6,319		6,319	10,705	17,024	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			51,700	51,700		51,700	1,082	52,782	26	
27	Other (specify):* <b>Marketing</b>	37,650	348	10,149	48,147		48,147	(48,147)		27	
28	<b>TOTAL General Administration</b>	201,391	9,024	1,000,574	1,210,989		1,210,989	(123,169)	1,087,820	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,190,755	280,425	1,652,058	4,123,238		4,123,238	(126,750)	3,996,488	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	
	<b>D. Ownership</b>											
30	Depreciation			222,430	222,430	222,430	23,419	245,849				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,186	176,186	176,186	(25,687)	150,499				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,427	20,427	20,427		20,427				35
36	Other (specify):* <b>Deferred Financing Costs</b>			6,315	6,315	6,315		6,315				36
37	<b>TOTAL Ownership</b>			425,358	425,358	425,358	(2,268)	423,090				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			230,017	230,017	230,017	(8,322)	221,695				39
40	Barber and Beauty Shops	17,340	882		18,222	18,222		18,222				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,004	158,004	158,004		158,004				42
43	Other (specify):* <b>Apt/Congregate</b>			43,749	43,749	43,749	(43,749)					43
44	<b>TOTAL Special Cost Centers</b>	17,340	882	431,770	449,992	449,992	(52,071)	397,921				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,208,095	281,307	2,509,186	4,998,588	4,998,588	(181,089)	4,817,499				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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(125)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,104)	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	(19,198)	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	(25,338)	21		24
25	Fund Raising, Advertising and Promotional	(48,147)	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	(49,258)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (144,170)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(36,919)	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (36,919)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (181,089)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

<b>BHF USE ONLY</b>					
48		49		50	51
					52

Heartland Christian Village

ID# 0048751

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Apartment/Congregate	\$ (43,749)	43	1
2	Late Fees	(7)	21	2
3	Transportation Revenue	(4,731)	14	3
4	Vending Revenue	(144)	14	4
5	Activity Revenue	(627)	11	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	<b>Total</b>		(49,258)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

## 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	(125)	0	0	0	0	0	0	0	0	0	0	(125)	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	(2,104)	1,139	0	0	0	0	0	0	0	0	0	(965)	5
6	Maintenance	0	3,011	0	0	0	0	0	0	0	0	0	3,011	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,229)</b>	<b>4,150</b>	<b>0</b>	<b>1,921</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	(627)	0	0	0	0	0	0	0	0	0	0	(627)	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	(4,875)	0	0	0	0	0	0	0	0	0	0	(4,875)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(5,502)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,502)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(248,617)	0	0	0	0	0	0	0	0	0	(248,617)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	23,508	0	0	0	0	0	0	0	0	0	23,508	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(25,345)	136,996	0	0	0	0	0	0	0	0	0	111,651	21
22	Employee Benefits & Payroll Taxes	0	26,649	0	0	0	0	0	0	0	0	0	26,649	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	10,705	0	0	0	0	0	0	0	0	0	10,705	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,082	0	0	0	0	0	0	0	0	0	1,082	26
27	Other (specify):*	(48,147)	0	0	0	0	0	0	0	0	0	0	(48,147)	27
28	<b>TOTAL General Administration</b>	<b>(73,492)</b>	<b>(49,677)</b>	<b>0</b>	<b>(123,169)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(81,223)</b>	<b>(45,527)</b>	<b>0</b>	<b>(126,750)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2013 Ending:

Summary B

June 30, 2014

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	23,419	0	0	0	0	0	0	0	0	0	23,419	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,198)	(6,489)	0	0	0	0	0	0	0	0	0	(25,687)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,198)</b>	<b>16,930</b>	<b>0</b>	<b>(2,268)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(8,322)	0	0	0	0	0	0	0	0	0	(8,322)	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):*	(43,749)	0	0	0	0	0	0	0	0	0	0	(43,749)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(43,749)</b>	<b>(8,322)</b>	<b>0</b>	<b>(52,071)</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(144,170)</b>	<b>(36,919)</b>	<b>0</b>	<b>(181,089)</b>	<b>45</b>								

**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%	\$ 1,139	\$ 1,139	1
2	V	6 Maintenance				3,011	3,011	2
3	V	17 Administrative	318,720			70,103	(248,617)	3
4	V	19 Professional Services				23,508	23,508	4
5	V	21 Clerical				136,634	136,634	5
6	V	22 Employee Benefits				26,649	26,649	6
7	V	24 Travel and Seminar				10,705	10,705	7
8	V	26 Insurance				1,082	1,082	8
9	V	30 Depreciation				23,419	23,419	9
10	V	32 Interest				(6,489)	(6,489)	10
11	V	21 Other Administrative Expense				362	362	11
12	V							12
13	V	39 Pharmacy Services	169,153	Senior Care Pharmacy	0.00%	160,831	(8,322)	13
14	Total		\$ 487,873			\$ 450,954	\$ * (36,919)	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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
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, 2013 Ending: ne 30, 2014

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	<b>This workpaper is not applicable</b>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Heartland Christian Village

# 0048751

Report Period Beginning:

July 1, 2013 Ending:

June 30, 2014

**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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	Mortgage Payable		X	HUD Financing	\$32,080.00	10/28/11	\$ 4,072,900	\$ 3,818,530	07/01/2037	4.0500	\$ 156,827	1				
2												2				
3												3				
4												4				
5												5				
	<b>Working Capital</b>															
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>				\$32,080.00		\$ 4,072,900	\$ 3,818,530			\$ 156,827	9				
	<b>B. Non-Facility Related*</b>															
10												10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 4,072,900	\$ 3,818,530			\$ 156,827	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,359 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.)

Facility Name & ID Number Heartland Christian Village# 0048751

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>	\$	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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2009 _____ 8	<b>FOR BHF USE ONLY</b>	
		2010 _____ 9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
		2011 _____ 10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2012 _____ 11	15	LESS REFUND FROM LINE 6 \$ 15
		2013 _____ 12	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.**

## 2013 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 2013 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 2013.

	(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.			\$	\$
		<b>TOTALS</b>	\$	\$

**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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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, 2013 Ending:

June 30, 2014

**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>4,475</u>	<u>2</u>
3	<b>TOTALS</b>	<b>32,630</b>		<b>\$ 46,242</b>	<b>3</b>

Facility Name &amp; ID Number Heartland Christian Village

# 0048751

Report Period Beginning:

July 1, 2013 Ending: June 30, 2014

**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			43,422	5,027		5,027		30,373	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	1,126		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	7,806		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

Facility Name &amp; ID Number Heartland Christian Village

**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	Unit #7 AC System	9/11/2013	3,883		10				55
56	Furnace	5/17/2014	3,294		15				56
57	Paint Resient & Bath Walls	4/24/2014	3,833		5				57
58	Install AC Unit in Laundry Room	6/23/2014	2,382		10				58
59	Paint All Resient Rooms Walls Only	4/24/2014	7,667		5				59
60	Install Leonard Mixing Valve	6/5/2014	3,485		10				60
61	Remodel Flooring Hall 1 & 3	10/31/2013	54,720		10				61
62									62
63									63
64									64
65	Other Building & Building Improvements Depreciation Exp.			140,168		140,168		1,862,626	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,641,139	\$ 145,195		\$ 145,195	\$	\$ 1,892,999	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	\$ 404,569	\$ 58,617	\$ 58,617	\$	various	\$ 230,980	71
72	Current Year Purchases	226,383	22,022	22,022		various	22,022	72
73	Fully Depreciated Assets	298,097				various	298,097	73
74	Home Office Allocation	171,173	16,584	16,584			102,042	74
75	TOTALS	\$ 1,100,222	\$ 97,223	\$ 97,223	\$		\$ 653,141	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	1,622	1,622			43,935	77
78	Overhaul	1994 Ford Eldorado Van	2008	5,336					5,336	78
79	Home Office Allocation			15,614	1,808	1,808			8,893	79
80	TOTALS			\$ 123,938	\$ 3,430	\$ 3,430	\$		\$ 117,217	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)	\$ 4,911,541	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,848	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)	\$ 2,663,357	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 Building/Land Improvements/Eq	748,158	19,643	466,920	87
88					88
89					89
90					90
91	TOTALS	\$ 789,925	\$ 19,643	\$ 466,920	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 66	92
93			93
94			94
95		\$ 66	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, 2013

Ending: June 30, 2014

**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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 20,427 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	<b>TOTAL</b>		\$ _____	\$ _____	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2013 Ending: June 30, 2014  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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>HLCV only hired certified CNAs</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	3,216	\$ 171,681	\$	3,216	\$ 171,681	1	
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,833	103,236		1,833	103,236	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A-3	hrs		6,803	207,292		6,803	207,292	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	<b>TOTAL</b>			\$	11,852	\$ 482,209	\$	11,852	\$ 482,209	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, 2013Ending: June 30, 2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2014 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,280,604	\$	1
2	Cash-Patient Deposits	3,896		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>36,428</u> )	627,162		3
4	Supply Inventory (priced at )	17,847		4
5	Short-Term Investments	28,403		5
6	Prepaid Insurance	4,274		6
7	Other Prepaid Expenses	15,049		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int. / Other A/R</u>	3,069		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,980,304	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,534		13
14	Buildings, at Historical Cost	4,154,130		14
15	Leasehold Improvements, at Historical Cost	178,822		15
16	Equipment, at Historical Cost	1,048,789		16
17	Accumulated Depreciation (book methods)	(2,987,462)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,021,356		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	144,719		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,643,888	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,624,192	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 127,831	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,896		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	265,216		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Other Accrued Expenses</u>	103,324		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 500,267	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,818,530		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Security Deposits</u>	4,750		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,823,280	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,323,547	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,300,645	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,624,192	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,231,642	1
2	Restatements (describe):		2
3	PY Equity Transfer from Affiliate	(798,668)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 432,974	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	558,108	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 558,105	17
<b>B. Transfers (Itemize):</b>			
18	Equity Transfer from Affiliate	309,566	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 309,566	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,300,645	24 *

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

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2013Ending: June 30, 2014

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,618,823	1
2	Discounts and Allowances for all Levels	(1,695,010)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,923,813</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,983,072	6
7	Oxygen	3,606	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,986,678</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	20,040	13
14	Non-Patient Meals	125	14
15	Telephone, Television and Radio	2,104	15
16	Rental of Facility Space		16
17	Sale of Drugs	304,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,235	19
20	Radiology and X-Ray	22,204	20
21	Other Medical Services	47,602	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 427,920</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	108,556	24
25	Interest and Other Investment Income***	22,931	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 131,487</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Retirement Center</u>	75,744	28
28a	<u>Miscellaneous</u>	11,054	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 86,798</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,556,696</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	652,331	31
32	Health Care	2,259,918	32
33	General Administration	1,210,989	33
<b>B. Capital Expense</b>			
34	Ownership	425,358	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	291,988	35
36	Provider Participation Fee	158,004	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,998,588</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>558,108</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 558,108</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,025,883	44
45	Private Pay - Net Inpatient Revenue	2,026,675	45
46	Medicare - Net Inpatient Revenue	(159,493)	46
47	Other-(specify) <u>HMO</u>	22,321	47
48	Other-(specify) <u>Medicare Advantage/Nursing</u>	8,427	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,923,813</b>	49

\* 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, 2013

Ending: June 30, 2014

**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	1,860	2,068	\$ 85,879	\$ 41.53	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	16,844	18,051	380,147	21.06	3
4	Licensed Practical Nurses	15,718	16,903	325,135	19.24	4
5	CNAs & Orderlies	51,393	53,659	617,703	11.51	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,605	1,825	25,248	13.83	9
10	Activity Assistants	2,720	2,813	27,141	9.65	10
11	Social Service Workers	5,042	5,843	95,528	16.35	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,640	2,080	31,271	15.03	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	11,891	12,411	117,269	9.45	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	4,426	4,687	65,687	14.02	17
18	Housekeepers	6,767	7,215	76,702	10.63	18
19	Laundry	3,577	3,817	40,161	10.52	19
20	Administrator	1,812	2,080	105,525	50.73	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,999	2,138	38,320	17.93	23
24	Clerical	1,758	1,899	19,895	10.48	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,904	2,054	36,382	17.71	31
32	Other Health Care(specify)	2,104	2,220	65,111	29.34	32
33	Other(specify)	3,212	3,475	54,990	15.83	33
34	TOTAL (lines 1 - 33)	136,271	145,236	\$ 2,208,095 *	\$ 15.20	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	102	\$ 4,959	ln 1, col 3	35
36	Medical Director	208	13,200	ln 9, col3	36
37	Medical Records Consultant	33	2,417	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	312	2,138	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	31	1,818	ln 12, col 3	45
46	Other(specify) <u>Forefront Telecare</u>	159	3,861	ln 10, col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	845	\$ 28,393		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	0	\$ 102,972	Workers' Compensation Insurance	\$ 79,120	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,505	Advertising: Employee Recruitment	(1,500)	
				FICA Taxes	158,202	Health Care Worker Background Check		
				Employee Health Insurance	216,030	(Indicate # of checks performed <u>16</u> )	512	
				Employee Meals		Patient Background Checks	131 1,310	
				Illinois Municipal Retirement Fund (IMRF)*		License	2,417	
				Employee Physicals	3,853	Dues	11,639	
				Employee Expense	20,068	Subscriptions	651	
				457 Plan Expense	6,000			
				Employee Uniforms	(1,708)			
				Home Office Allocation	26,649			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 102,972		\$ 510,719		\$ 15,029	
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			\$ 318,720				Out-of-State Travel	\$ 2,352
							In-State Travel	2,425
							Seminar Expense	1,542
							Home Office Allocation	10,705
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
			\$ 318,720					\$ 17,024
C. Professional Services								
Vendor/Payee	Type		Amount					
CliftonLarsonAllen	Accounting		\$ 16,419					
My Innerview	Consulting		359					
National Research	Consulting		1,455					
Davis & Campbell	Legal		6,803					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
			\$ 25,036					

\* 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												
5												
6												
7												
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12												
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14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2013 Ending: June 30, 2013**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 \$5,288
- (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. \$ 23,826 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. \$ 158,004  
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. \$ 125
- (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: CliftonLarsonAllen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.