

Facility Name & ID Number Hickorypoint Christian Vlg

0050682 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 3/17/2014

	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	47	Skilled (SNF)	64	23,360	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	47	TOTALS	64	23,360	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	395	5,810	10,810	17,015	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	395	5,810	10,810	17,015	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.84%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals, Lawn & Maintenance Care, Housekeeping, Laundry 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 07/15/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/15/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 64 and days of care provided 9,248

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL 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.

Facility Name & ID Number

Hickorypoint Christian Vlg

0050682

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

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	259,842	14,123	14,722	288,687		288,687	288,687		1	
2	Food Purchase		212,510		212,510		212,510	(1,045)	211,465	2	
3	Housekeeping	107,630	26,781	1,006	135,417		135,417		135,417	3	
4	Laundry	21,528	494		22,022		22,022		22,022	4	
5	Heat and Other Utilities			67,111	67,111		67,111	2,089	69,200	5	
6	Maintenance	116,049	2,032	46,271	164,352		164,352	5,460	169,812	6	
7	Other (specify):*									7	
8	TOTAL General Services	505,049	255,940	129,110	890,099		890,099	6,504	896,603	8	
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000	9	
10	Nursing and Medical Records	1,673,510	112,192	8,454	1,794,156		1,794,156		1,794,156	10	
10a	Therapy			1,200,075	1,200,075		1,200,075		1,200,075	10a	
11	Activities	73,061	1,992		75,053		75,053		75,053	11	
12	Social Services	89,956	1,125	3,503	94,584		94,584		94,584	12	
13	CNA Training									13	
14	Program Transportation			1,681	1,681		1,681		1,681	14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,836,527	115,309	1,231,713	3,183,549		3,183,549		3,183,549	16	
	C. General Administration										
17	Administrative	166,477		390,312	556,789		556,789	(261,752)	295,037	17	
18	Directors Fees									18	
19	Professional Services			17,144	17,144		17,144	43,111	60,255	19	
20	Dues, Fees, Subscriptions & Promotions			34,873	34,873		34,873		34,873	20	
21	Clerical & General Office Expenses	137,685	10,287	111,980	259,952		259,952	205,533	465,485	21	
22	Employee Benefits & Payroll Taxes			389,613	389,613		389,613	48,870	438,483	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			14,865	14,865		14,865	19,632	34,497	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			74,609	74,609		74,609	1,984	76,593	26	
27	Other (specify):* Marketing	81,949	3,988	12,307	98,244		98,244	(98,244)		27	
28	TOTAL General Administration	386,111	14,275	1,045,703	1,446,089		1,446,089	(40,866)	1,405,223	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,727,687	385,524	2,406,526	5,519,737		5,519,737	(34,362)	5,485,375	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			402,043	402,043		402,043	42,947	444,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			848,328	848,328		848,328	(437,651)	410,677			32
33	Real Estate Taxes			151,482	151,482		151,482		151,482			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			56,413	56,413		56,413		56,413			35
36	Other (specify):* Deferred Financing Costs			11,322	11,322		11,322		11,322			36
37	TOTAL Ownership			1,469,588	1,469,588		1,469,588	(394,704)	1,074,884			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			443,416	443,416		443,416	(19,516)	423,900			39
40	Barber and Beauty Shops			5,098	5,098		5,098	(7,934)	(2,836)			40
41	Coffee and Gift Shops			203	203		203		203			41
42	Provider Participation Fee			75,484	75,484		75,484		75,484			42
43	Other (specify):* Apt/Congregate			1,601,814	1,601,814		1,601,814	(1,601,814)				43
44	TOTAL Special Cost Centers			2,126,015	2,126,015		2,126,015	(1,629,264)	496,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,727,687	385,524	6,002,129	9,115,340		9,115,340	(2,058,330)	7,057,010			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(7,934)	40		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	(17,856)	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	(407,895)	32		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	(45,068)	21		24
25	Fund Raising, Advertising and Promotional	(98,244)	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	(1,603,552)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,180,549)		\$	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)	122,219	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 122,219		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,058,330)		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

Hickorypoint Christian VlgID# 0050682Report Period Beginning: July 1, 2013Ending: June 30, 2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Apartment/Congregate	\$ (1,601,814)	43	1
2	Vending Revenue	(1,045)	2	2
3	Late Fee	(369)	21	3
4	Late Fee	(62)	6	4
5	Miscellaneous Revenue	(262)	21	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	(1,603,552)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickorypoint Christian Vlg# 0050682

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	(1,045)	0	0	0	0	0	0	0	0	0	0	(1,045)	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	0	2,089	0	0	0	0	0	0	0	0	0	2,089	5
6	Maintenance	(62)	5,522	0	0	0	0	0	0	0	0	0	5,460	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,107)	7,611	0	6,504	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(261,752)	0	0	0	0	0	0	0	0	0	(261,752)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	43,111	0	0	0	0	0	0	0	0	0	43,111	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(45,699)	251,232	0	0	0	0	0	0	0	0	0	205,533	21
22	Employee Benefits & Payroll Taxes	0	48,870	0	0	0	0	0	0	0	0	0	48,870	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	19,632	0	0	0	0	0	0	0	0	0	19,632	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	1,984	0	0	0	0	0	0	0	0	0	1,984	26
27	Other (specify):*	(98,244)	0	0	0	0	0	0	0	0	0	0	(98,244)	27
28	TOTAL General Administration	(143,943)	103,077	0	(40,866)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(145,050)	110,688	0	(34,362)	29								

STATE OF ILLINOIS

Facility Name & ID Number Hickorypoint Christian VIg# 0050682

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)	
	D. Ownership													
30	Depreciation	0	42,947	0	0	0	0	0	0	0	0	0	42,947	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(425,751)	(11,900)	0	0	0	0	0	0	0	0	0	(437,651)	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	(425,751)	31,047	0	(394,704)	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	(19,516)	0	0	0	0	0	0	0	0	0	(19,516)	39
40	Barber and Beauty Shops	(7,934)	0	0	0	0	0	0	0	0	0	0	(7,934)	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):*	(1,601,814)	0	0	0	0	0	0	0	0	0	0	(1,601,814)	43
44	TOTAL Special Cost Centers	(1,609,748)	(19,516)	0	(1,629,264)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,180,549)	122,219	0	0	0	0	0	0	0	0	0	(2,058,330)	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%	\$ 2,089	\$ 2,089	1
2	V	6 Maintenance				5,522	5,522	2
3	V	17 Administrative	390,312			128,560	(261,752)	3
4	V	19 Professional Services				43,111	43,111	4
5	V	21 Clerical				250,568	250,568	5
6	V	22 Employee Benefits				48,870	48,870	6
7	V	24 Travel & Seminars				19,632	19,632	7
8	V	26 Insurance				1,984	1,984	8
9	V	30 Depreciation				42,947	42,947	9
10	V	32 Interest				(11,900)	(11,900)	10
11	V	21 Other Administrative Expense				664	664	11
12	V							12
13	V	39 Pharmacy Services	396,657	Senior Care Pharmacy Services	0.00%	377,141	(19,516)	13
14	Total		\$ 786,969			\$ 909,188	\$ * 122,219	14

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

Facility Name & ID Number Hickorypoint Christian Vlg # 0050682 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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 Hickorypoint Christian Vlg

0050682 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	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

Hickorypoint Christian Vlg

0050682

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**					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	IL Finance Authority - 2010		X	47 Bed SNF		7/29/10	\$ 7,200,000	\$ 7,090,661	5/15/2027	6.1300	\$ 440,433	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 7,200,000	\$ 7,090,661			\$ 440,433	9					
B. Non-Facility Related*																	
10	IL Finance Authority - 2007 Series		X	Refinance Debt		6/28/07	7,730,977	7,172,689	5/15/2031	5.6700	407,895	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$ 7,730,977	\$ 7,172,689			\$ 407,895	14					
15	TOTALS (line 9+line14)						\$ 14,930,977	\$ 14,263,350			\$ 848,328	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* 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 2013 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 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. (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:	2009	_____	8	FOR BHF USE ONLY		
	2010	_____	9			
	2011	_____	10			
	2012	_____	11			
	2013	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickorypoint Christian Vlg COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0050682

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

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.	<u>07-07-15-452-019</u>	<u>See Attachment</u>	\$ <u>6,795.96</u>	\$ _____
2.	<u>07-07-15-452-018</u>	<u>See Attachment</u>	\$ <u>4,459.02</u>	\$ _____
3.	<u>07-07-15-451-006</u>	<u>See Attachment</u>	\$ <u>206,685.86</u>	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>217,940.84</u></u>	\$ <u><u> </u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 Hickorypoint Christian Vlg

0050682 Report Period Beginning:

July 1, 2013 Ending:

June 30, 2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,326 B. General Construction Type: Exterior Siding/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).

Apartments
Congregate

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>Facility</u>			\$ <u>188,520</u>	1
2	<u>Home Office Allocation</u>			<u>8,206</u>	2
3	TOTALS			\$ <u>196,726</u>	3

Facility Name & ID Number Hickorypoint Christian Vlg

0050682

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	47	2011	2011	\$ 6,531,557	\$ 217,719	30	\$ 217,719	\$	\$ 653,156	4
5		2011	2011	342,749	11,425	30	11,425		34,275	5
6	17	2014	2014	1,966,535	16,388	40	16,388		16,388	6
7										7
8	Home Office Allocation			79,629	9,219		9,219		55,700	8
	Improvement Type**									
9	Landscaping for HPCV GradingSeeding	2006		52,728	2,636	10	2,636		22,190	9
10	Irrigation system	2006		31,650	1,583	10	1,583		13,319	10
11	Land Improvement	2006		185,674	9,284	10	9,284		78,138	11
12	Landscaping front entrance flagpole	2006		14,200	1,420	10	1,420		11,952	12
13	Vinyl Fence Panels	2010		770	77	15	77		314	13
14	2010 Landscaping	2010		9,793	979	10	979		3,836	14
15	Ansul fire suppression system rebuild	2011		1,016	102	10	102		288	15
16	Slit Seed Landscaping	2011		3,350	335	10	335		1,061	16
17	Pavement sealing & crackfilling & marki	2011		4,850	606	10	606		1,768	17
18	Elopement Accutech IS Haven House Wing	2012		30,500	3,050	15	3,050		5,338	18
19	AC Unit Warming Kitchen	2012		12,026	1,203	40	1,203		2,305	19
20	R&R Economizer for RTU #4	2012		4,935	494	10	494		864	20
21	Electronic Locks for SNF	2012		7,599	760	10	760		1,203	21
22	Set up Door Alarm w Key Pad Entry (SNF	2012		1,538	154	10	154		308	22
23	Cabinets Upper & Base Laminate	2012		3,300	330	10	330		660	23
24	R&R Water Main from Laundry & Main Bld	2013		2,681	179	20	179		223	24
25	870 Hope R&R Carpet & Vinyl	2013		4,441	444	20	444		481	25
26	Nursing Narcotic Cabinet	2013		14,432	962	20	962		962	26
27	Signage	2013		16,828	1,262	10	1,262		1,262	27
28	Full wall panel for lobby	2013		2,124	159	10	159		159	28
29	Accent lighting near receptionist	2013		1,150	96	10	96		96	29
30	HH room 321 carpet heven	2013		771	45	10	45		45	30
31	Landscape Renovations	2013		31,150	2,336	8	2,336		2,336	31
32	Shrubs, Tress Landscape	2013		12,000	1,100	10	1,100		1,100	32
33	Retaining wall utility road trees	2013		4,630	347	10	347		347	33
34	New sidewalk & driveway	2013		4,650	213	10	213		213	34
35	Repave Marion Av front entrance way	2014		44,726	373	20	373		373	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)

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	\$ 820,888	\$ 88,700	\$ 88,700	\$	various	\$ 246,681	71
72	Current Year Purchases	519,927	36,907	36,907		various	36,907	72
73	Fully Depreciated Assets	56,901	871	871		various	56,901	73
74	Home Office Allocation	313,907	30,413	30,413			187,131	74
75	TOTALS	\$ 1,711,623	\$ 156,891	\$ 156,891	\$		\$ 527,620	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	2006 Ford Startrans Senator		\$ 45,963	\$	\$	\$	4	\$ 45,963	76
77										77
78										78
79	Home Office Allocation			28,634	3,315	3,315			16,308	79
80	TOTALS			\$ 74,597	\$ 3,315	\$ 3,315	\$		\$ 62,271	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)	\$ 11,406,928	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 445,485	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 445,485	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,500,551	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	A/L Building & Equipment	\$ 7,999,143	\$ 278,643	\$ 2,087,221	86
87	Duplex Building/Equipment/Land Imp.	6,889,700	193,918	3,304,347	87
88	Land	668,388			88
89					89
90					90
91	TOTALS	\$ 15,557,231	\$ 472,561	\$ 5,391,568	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$ 122	92
93			93
94			94
95		\$ 122	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			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. _____ /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: \$ 56,413 Description: See Attachment

(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.

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><u>The organization only hires certified CNAs</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	10A-3	hrs	\$	9,752	\$ 535,236				9,752	\$ 535,236					1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,863	64,546				2,863	64,546					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A-3	hrs		13,064	600,293				13,064	600,293					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			\$	25,679	\$ 1,200,075	\$			25,679	\$ 1,200,075	\$				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 Hickorypoint Christian Vlg# 0050682Report Period Beginning: July 1, 2013

Ending:

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (5,921,044)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>86,958</u>)	1,255,635		3
4	Supply Inventory (priced at)	9,400		4
5	Short-Term Investments	36,727		5
6	Prepaid Insurance	13,445		6
7	Other Prepaid Expenses	13,203		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int. / Other A/R</u>	14,449		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (4,578,185)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	856,908		13
14	Buildings, at Historical Cost	22,197,611		14
15	Leasehold Improvements, at Historical Cost	1,057,992		15
16	Equipment, at Historical Cost	2,421,275		16
17	Accumulated Depreciation (book methods)	(6,635,979)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,218,368		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	203,802		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,319,977	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,741,792	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 252,437	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,343		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,970		32
33	Accrued Interest Payable	106,344		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	192,162		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 958,256	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	14,263,350		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	1,778,091		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,041,441	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,999,697	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (257,905)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,741,792	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (561,007)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (561,007)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	303,102	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)	\$ 303,102	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)	\$ (257,905)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hickorypoint Christian Vlg# 0050682Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,072,271	1
2	Discounts and Allowances for all Levels	(4,263,521)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 808,750	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,149,723	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,149,723	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	3,693	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,934	16
17	Sale of Drugs	599,299	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,521	19
20	Radiology and X-Ray	36,111	20
21	Other Medical Services	140,749	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 831,307	23
D. Non-Operating Revenue			
24	Contributions	42,345	24
25	Interest and Other Investment Income***	17,856	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 60,201	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	2,565,371	28
28a	Miscellaneous	3,090	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,568,461	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,418,442	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	890,099	31
32	Health Care	3,183,549	32
33	General Administration	1,446,089	33
B. Capital Expense			
34	Ownership	1,469,588	34
C. Ancillary Expense			
35	Special Cost Centers	2,050,531	35
36	Provider Participation Fee	75,484	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,115,340	40
41	Income before Income Taxes (line 30 minus line 40)**	303,102	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 303,102	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 51,601	44
45	Private Pay - Net Inpatient Revenue	1,739,670	45
46	Medicare - Net Inpatient Revenue	(643,133)	46
47	Other-(specify) <u>HMO/Nursing</u>	(62,358)	47
48	Other-(specify) <u>Medicare Advantage/Outpatient Pt B</u>	(277,030)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 808,750	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 Hickorypoint Christian Vlg

0050682

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	1,465	1,658	\$ 56,809	\$ 34.26	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	18,237	19,207	501,454	26.11	3
4	Licensed Practical Nurses	13,641	14,633	312,944	21.39	4
5	CNAs & Orderlies	55,378	58,583	648,562	11.07	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	4,156	4,257	61,394	14.42	9
10	Activity Assistants	1,138	1,193	11,667	9.78	10
11	Social Service Workers	3,633	4,020	89,956	22.38	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	25,059	26,503	259,842	9.80	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,942	7,336	116,049	15.82	17
18	Housekeepers	11,445	12,449	107,630	8.65	18
19	Laundry	2,373	2,552	21,528	8.44	19
20	Administrator	1,949	2,094	160,008	76.42	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,980	2,094	50,561	24.15	23
24	Clerical	6,352	6,668	93,594	14.04	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	2,450	2,679	31,162	11.63	31
32	Other Health C: <u>Community Nurse</u>	3,327	3,768	81,949	21.75	32
33	Other(specify) <u>MDS Coordinator</u>	4,037	4,359	122,579	28.12	33
34	TOTAL (lines 1 - 33)	163,561	174,051	\$ 2,727,687 *	\$ 15.67	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	212	\$ 10,990	ln 1, col 3	35
36	Medical Director	208	18,000	ln 9, col3	36
37	Medical Records Consultant	32	2,367	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	26	1,678	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	42	3,443	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	520	\$ 36,478		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-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												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Hickorypoint Christian Vlg

0050682

Report Period Beginning: July 1, 2013 Ending: June 30, 201

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN - \$4,885
- (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. \$ 21,520 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 75,484
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. \$ N/A Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.