

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0048751</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Heartland Christian Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2010</u> to <u>June 30, 2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>101 Trowbridge</u> <u>Neoga</u> <u>62447</u> Number City Zip Code																																																	
County: <u>Cumberland</u>																																																	
Telephone Number: <u>217-895-2665</u> Fax # <u>217-895-3399</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>10/12/1995</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Susan McGhee</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u></td></tr><tr><td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Susan McGhee</u>	(Title) <u>Chief Financial Officer</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Chad D. Kunze, CPA</u> <u>Principal</u>	(Firm Name & Address) <u>LarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u>	(Telephone) <u>314-925-4321</u> Fax # <u>314-925-4350</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																				
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		☐	Trust																																														
		☐	Other _____																																														
IRS Exemption Code <u>501c3</u>																																																	
In the event there are further questions about this report, please contact:																																																	
Name: <u>Susan McGhee</u> Telephone Number: <u>314-587-7903</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Heartland Christian Village

0048751 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,915</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,739</u>	<u>10,629</u>	<u>4,471</u>	<u>24,839</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,739</u>	<u>10,629</u>	<u>4,471</u>	<u>24,839</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.85%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Meals, Lawn Care, and maintenance for independent living units

F. Does the facility maintain a daily midnight census?

Yes

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

YES

☒

NO

☐

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

YES

☒

NO

☐

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

Date started

10/12/1992

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 10/12/1992

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number of beds certified 71 and days of care provided 4,173

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☐

NO

☐

Tax Year: 6/30/2010 Fiscal Year: 6/30/2010

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2010 Ending: June 30, 2011
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	145,005	13,515	7,822	166,342		166,342		166,342			1
2	Food Purchase		164,872		164,872		164,872	69	164,941			2
3	Housekeeping	80,807	11,630	854	93,291		93,291		93,291			3
4	Laundry	38,808	7,071		45,879		45,879		45,879			4
5	Heat and Other Utilities			103,061	103,061		103,061	(4,085)	98,976			5
6	Maintenance	61,303	1,912	21,595	84,810		84,810	9,649	94,459			6
7	Other (specify):* Trash			5,804	5,804		5,804		5,804			7
8	TOTAL General Services	325,923	199,000	139,136	664,059		664,059	5,633	669,692			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,439,537	89,827	7,938	1,537,302		1,537,302		1,537,302			10
10a	Therapy			503,568	503,568		503,568		503,568			10a
11	Activities	39,881	3,104	205	43,190		43,190		43,190			11
12	Social Services	90,421	2,300	5,037	97,758		97,758		97,758			12
13	CNA Training											13
14	Program Transportation			3,565	3,565		3,565	(6,350)	(2,785)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,569,839	95,231	535,913	2,200,983		2,200,983	(6,350)	2,194,633			16
	C. General Administration											
17	Administrative	89,987	6,137	295,088	391,212		391,212	(257,543)	133,669			17
18	Directors Fees											18
19	Professional Services			31,519	31,519		31,519	13,598	45,117			19
20	Dues, Fees, Subscriptions & Promotions			7,357	7,357		7,357	3,169	10,526			20
21	Clerical & General Office Expenses	55,177	9,762	54,366	119,305		119,305	84,349	203,654			21
22	Employee Benefits & Payroll Taxes			415,440	415,440		415,440	19,745	435,185			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,560	12,560		12,560	6,328	18,888			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,863	53,863		53,863	541	54,404			26
27	Other (specify):* Marketing	66,257	2,153	33,134	101,544		101,544	(101,544)				27
28	TOTAL General Administration	211,421	18,052	903,327	1,132,800		1,132,800	(231,357)	901,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,107,183	312,283	1,578,376	3,997,842		3,997,842	(232,074)	3,765,768			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			190,048	190,048		190,048	11,398	201,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			260,942	260,942		260,942	(6,770)	254,172			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,785	7,785		7,785	2,565	10,350			35
36	Other (specify):* Def Financing Cost			3,746	3,746		3,746		3,746			36
37	TOTAL Ownership			462,521	462,521		462,521	7,193	469,714			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			152,961	152,961		152,961	(12,599)	140,362			39
40	Barber and Beauty Shops	12,815	731		13,546		13,546		13,546			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* Apt/ Congregate			40,175	40,175		40,175	(40,175)				43
44	TOTAL Special Cost Centers	12,815	731	232,009	245,555		245,555	(52,774)	192,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,119,998	313,014	2,272,906	4,705,918		4,705,918	(277,655)	4,428,263			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(64)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,220)	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	(7,171)	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	(4,994)	21		24
25	Fund Raising, Advertising and Promotional	(101,544)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,993)		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(111,821)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (111,821)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (230,814)		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 Yes	2 No	3 Amount	4 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

Report Period Beginning:

Ending:

ID#

0048751

July 1, 2010

June 30, 2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Vending	\$ 133	2	1
2	Apartments/Congregate	(40,175)	43	2
3	Late Fees	(199)	21	3
4	Transportation Revenue	(6,350)	14	4
5	Space Rental Revenue	(250)	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
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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	(46,841)		49

Summary A

June 30, 2011

[illegible]

STATE OF ILLINOIS						Summary B
Facility Name & ID Number	Heartland Christian Village	#	0048751	Report Period Beginning:	July 1, 2010	Ending: June 30, 2011

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

[illegible]

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 1,135	\$ 1,135	1
2	V	6	Maintenance				9,649	9,649	2
3	V	17	Administrative	295,088			37,545	(257,543)	3
4	V	19	Professional Services				13,598	13,598	4
5	V	21	Clerical				89,792	89,792	5
6	V	22	Employee Benefits				19,745	19,745	6
7	V	24	Travel and Seminar				6,328	6,328	7
8	V	26	Insurance				541	541	8
9	V	30	Depreciation				11,398	11,398	9
10	V	32	Interest				401	401	10
11	V	20	Dues and Subscriptions				3,169	3,169	11
12	V	35	Rental and Leasing				2,565	2,565	12
13	V	39	Pharmacy Services	127,652	Senior Care Pharmacy Services	0.00%	115,053	(12,599)	13
14	Total			\$ 422,740			\$ 310,919	\$ * (111,821)	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2010 Ending: ne 30, 2011

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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Mortgage Payable		X	HUD Financing	\$31,240.00	08/01/07	\$ 4,292,500	\$ 4,062,048	08/01/37	5.8800	\$ 260,942	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$31,240.00		\$ 4,292,500	\$ 4,062,048			\$ 260,942	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,292,500	\$ 4,062,048			\$ 260,942	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,028 Line # 32

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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 2011 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:	2006		8	
	2007		9	
	2008		10	
	2009		11	
	2010		12	

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Heartland Christian Village</u>	COUNTY	<u>Cumberland</u>
---------------	------------------------------------	--------	-------------------

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 2010 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 2010.

(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	N/A		\$		\$	
2.				\$		\$	
3.				\$		\$	
4.				\$		\$	
5.				\$		\$	
6.				\$		\$	
7.				\$		\$	
8.				\$		\$	
9.				\$		\$	
10.				\$		\$	
TOTALS				\$		\$	

B. Real Estate Tax Cost Allocations

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

32,630

B. General Construction Type:

Exterior Brick

Frame Wood

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land	32,630	Various	\$ 41,767	1
2	Home Office Allocation			3,478	2
3	TOTALS	32,630		\$ 45,245	3

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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	\$ 65,028	40	\$ 65,028	\$	\$ 1,219,265
5			1995	1995	119,926	2,998	40	2,998		48,970
6										
7										
8	Home Office Allocation				35,960	2,321		2,321		82,588
	Improvement Type**									
9	1992 Fixed Assets		10/13/1992		76,355	2,048	Various	2,048		55,254
10	1993 Fixed Assets		12/31/1993		1,392		Various			1,392
11	1994 Fixed Assets		10/24/1994		908		Various			908
12	1995 Fixed Assets		7/31/1995		2,602		Various			2,602
13	1998 Fixed Assets		12/31/1998		5,024		Various			5,024
14	1999 Fixed Assets		12/13/1999		6,957		Various			6,957
15	2000 Fixed Assets		1/3/2000		500		Various			500
16	2001 Fixed Assets		12/31/2001		1,161		Various			1,161
17	2002 Fixed Assets		12/31/2002		4,734	137	Various	137		4,608
18	2003 Fixed Assets		12/31/2003		8,373	781	Various	781		7,005
19	2004 Fixed Assets		12/31/2004		40,012	3,867	Various	3,867		28,629
20	2005 Fixed Assets		12/31/2005		24,416	1,703	Various	1,703		17,357
21	2006 Fixed Assets		12/31/2006		1,621	162	Various	162		797
22	2007 Fixed Assets		12/31/2007		107,561	11,085	Various	11,085		42,034
23	Bathing Room Project		1/31/2008		2,100	210	10	210		735
24	Bldg supplies for bathroom Hall 2		4/1/2008		2,944	294	10	294		957
25	Wiring for heaters in restrooms		5/14/2008		1,975	197	10	197		625
26	Pushbutton Door locks		5/14/2008		3,299	330	10	330		1,045
27	Installed new Compressor for Walk-In		5/30/2008		5,289	529	10	529		1,675
28	Tile flooring 3 bathing room		7/1/2008		2,351	470	05	470		1,410
29	Commercial Garbage Disposal		1/27/2009		1,859	186	10	186		465
30	Parking lot		6/30/2009		13,895	1,390	10	1,390		2,895
31	Concrete pad - entryway		6/30/2009		1,572	104	15	104		218
32	Extend driveway drainage		6/30/2009		1,300	130	10	130		271
33	Land Improvement by Thomas Lawn Care		9/30/2009		22,690	2,269	10	2,269		4,160
34	Sprinkler System		12/12/2009		150,125	15,013	10	15,013		23,770
35	Compressor for Walkin Cooler		12/30/2009		3,745	375	10	375		593
36	Door Alarm System		4/1/2010		35,520	3,552	10	3,552		4,440

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2010 Ending: June 30, 2011

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	Smoke Detector for Life Safety	8/29/2010	\$ 1,054	\$ 97	10	\$ 97		\$ 97	37
38	Dock Door w/Lock & handle	10/21/2010	5,402	405	10	405		405	38
39	Fire Alarm System	1/31/2011	65,344	3,267	10	3,267		3,267	39
40	89 gal water heater	1/31/2011	12,834	642	10	642		642	40
41	PTAC Units	1/31/2011	6,733	337	10	337		337	41
42	Refurb Activity & Therapy Room	1/31/2011	3,474	174	10	174		174	42
43	Paint Main Hall	5/31/2011	38,671	645	10	645		645	43
44	Main Hall - Flooring	6/30/2011	87,059	725	10	725		725	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,507,837	\$ 121,471		\$ 121,471		\$ 1,574,601	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	\$411,621	\$53,794	\$53,794	\$		\$171,572	71
72	Current Year Purchases	22,754	3,162	3,162			3,162	72
73	Fully Depreciated Assets	284,389	1,624	1,624			284,389	73
74	Home Office Allocation	170,488	11,002	11,002			18,917	74
75	TOTALS	\$889,252	\$69,582	\$69,582	\$		\$478,040	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus/1993 Chevy Van	1994/1996	\$59,053	\$	\$	\$		\$59,053	76
77	Patient Transportation	2009 Chrysler T&C Van	2009	43,935	10,984	10,984			20,345	77
78	Overhaul	1994 Ford Eldorado Van	2008	5,336	1,334	1,334			3,669	78
79	Home office allocation			21,044	1,358	1,358			8,812	79
80	TOTALS			\$129,368	\$13,676	\$13,676	\$		\$91,879	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$4,571,702	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$204,729	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$204,729	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)	\$2,144,520	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplex Land	\$41,767	\$	\$	86
87	Duplex Land Improvements	65,202	1,901	44,477	87
88	Duplex Building	666,698	18,956	352,134	88
89	Duplex Equipment	24,911	1,383	20,354	89
90					90
91	TOTALS	\$798,578	\$22,240	\$416,965	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$33,245	92
93			93
94			94
95		\$33,245	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$8,313
- 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2012 | \$ |
| 13. | /2013 | \$ |
| 14. | /2014 | \$ |

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

There is no training at Heartland Christian Village, LLC. There is an agreement with the local college to have clinicals at Heartland Christian Village, LLC.

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,230	\$ 161,674	\$	3,230	\$ 161,674	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,876	116,986		1,876	116,986	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		7,036	224,908		7,036	224,908	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,142	\$ 503,568	\$	12,142	\$ 503,568	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,240,513	\$	1
2	Cash-Patient Deposits	1,439		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,556)	427,481		3
4	Supply Inventory (priced at)	19,940		4
5	Short-Term Investments	23,596		5
6	Prepaid Insurance	183		6
7	Other Prepaid Expenses	35,712		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int/ Other A/R	375		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,749,239	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,534		13
14	Buildings, at Historical Cost	4,024,955		14
15	Leasehold Improvements, at Historical Cost	178,822		15
16	Equipment, at Historical Cost	851,999		16
17	Accumulated Depreciation (book methods)	(2,451,168)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	578,814		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Assets	78,657		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,345,613	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,094,852	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 187,141	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,439		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,579		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Other Accrued Expenses</u>	64,665		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 470,824	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,062,048		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposits</u>	2,750		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,064,798	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,535,622	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 559,230	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,094,852	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (295,143)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (295,143)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	854,373	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)	\$ 854,373	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)	\$ 559,230	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Heartland Christian Village**# **0048751**Report Period Beginning: **July 1, 2010**Ending: **June 30, 2011**

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.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,184,820	1
2	Discounts and Allowances for all Levels	(765,049)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,419,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,710,572	6
7	Oxygen	20,630	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,731,202	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,250	13
14	Non-Patient Meals	64	14
15	Telephone, Television and Radio	5,220	15
16	Rental of Facility Space		16
17	Sale of Drugs	181,676	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,667	19
20	Radiology and X-Ray	16,711	20
21	Other Medical Services	2,095	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 253,683	23
	D. Non-Operating Revenue		
24	Contributions	66,114	24
25	Interest and Other Investment Income***	10,975	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 77,089	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center	69,156	28
28a	Miscellaneous	9,390	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 78,546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,560,291	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	664,059	31
32	Health Care	2,200,983	32
33	General Administration	1,132,800	33
	B. Capital Expense		
34	Ownership	462,521	34
	C. Ancillary Expense		
35	Special Cost Centers	206,682	35
36	Provider Participation Fee	38,873	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,705,918	40
41	Income before Income Taxes (line 30 minus line 40)**	854,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 854,373	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,742	2,004	\$ 78,390	\$ 39.12	1
2	Assistant Director of Nursing	0	0			2
3	Registered Nurses	7,458	7,896	172,896	21.90	3
4	Licensed Practical Nurses	22,144	23,875	445,877	18.68	4
5	CNAs & Orderlies	52,392	54,499	657,398	12.06	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	1,864	1,938	22,965	11.85	9
10	Activity Assistants	1,580	1,701	16,916	9.95	10
11	Social Service Workers	5,396	5,785	90,421	15.63	11
12	Dietician	0	0			12
13	Food Service Supervisor	1,521	1,633	19,367	11.86	13
14	Head Cook	0	0			14
15	Cook Helpers/Assistants	12,738	13,459	125,638	9.34	15
16	Dishwashers	0	0			16
17	Maintenance Workers	4,323	4,658	61,303	13.16	17
18	Housekeepers	7,020	7,514	80,807	10.75	18
19	Laundry	3,642	3,882	38,808	10.00	19
20	Administrator	1,783	2,000	89,987	44.99	20
21	Assistant Administrator	0	0			21
22	Other Administrative	0	0			22
23	Office Manager	1,821	2,035	32,627	16.04	23
24	Clerical	1,581	1,620	22,550	13.92	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	1,770	1,932	29,307	15.17	31
32	Other Health Care MDS Coord	2,149	2,299	55,669	24.21	32
33	Other(specify) Mark, Beauty	2,733	3,073	79,072	25.73	33
34	TOTAL (lines 1 - 33)	133,657	141,800	\$ 2,119,998 *	\$ 14.95	34

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	162	\$ 7,467	ln 1, col 3	35
36	Medical Director	182	15,600	ln 9, col3	36
37	Medical Records Consultant	27	1,849	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,140	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	2	130	ln 11, col 3	44
45	Social Service Consultant	80	5,037	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	549	\$ 32,223		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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		\$ 89,987	Workers' Compensation Insurance		\$ 44,292	IDPH License Fee		\$ 2,521		
				Unemployment Compensation Insurance		3,692	Advertising: Employee Recruitment		2,521		
				FICA Taxes		153,276	Health Care Worker Background Check				
				Employee Health Insurance		181,944	(Indicate # of checks performed _____)				
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Advertising and Promotion				
				Employee Physicals		3,024	License		279		
				Employee Expense		22,341	Dues		4,806		
				457 Plan Expense		8,000	Subscriptions		(250)		
				Employee Uniforms		(1,129)	Miscellaneous		1		
				Home Office Allocation		19,745	Less: Public Relations Expense	(	)		
							Non-allowable advertising	(	)		
							Yellow page advertising	(	)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 89,987	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,357		
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			\$ 295,088	N/A		\$	Out-of-State Travel		\$ 2,075		
							In-State Travel		8,236		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense		2,075		
C. Professional Services								Other Travel Expenses		174	
Vendor/Payee	Type		Amount								
LarsonAllen	Accounting		\$ 15,345					Home Office Allocation		6,328	
My Innerview	Consulting		448					Entertainment Expense	(	)	
Davis & Campbell	Legal		6,308					(agree to Sch. V, line 24, col. 8)			
Armstrong Teasdale	Legal		5,775					TOTAL		\$ 18,888	
Denton US	Legal		3,643								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL							
			\$ 31,519								

*** Attach copy of IMRF notifications**

****See instructions.**

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 & AAHSA \$4,475.75**
- (3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ **15,060** Line **10**
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES **X** NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ **38,873**
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation. _____

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. \$ **64**
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. \$ **391**
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: **LarsonAllen LLP**
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.