

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0048751

Facility Name: Heartland Christian Village

Address: 101 Trowbridge Road Neoga 62447
Number City Zip Code

County: Cumberland

Telephone Number: 217-895-2665 Fax # 217-895-3399

HFS ID Number:

Date of Initial License for Current Owners: 10/12/1995

Type of Ownership:

☒	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501c3	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Susan McGhee Telephone Number: 314-587-7903
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2011 to June 30, 2012 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.

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)	Susan McGhee		
	(Title)	Chief Financial Officer		
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)	Allan B. Larson Partner		
	(Firm Name & Address)	CliftonLarsonAllen LLP 600 Washington Ave, Suite 1800, St. Louis, MO 63101		
	(Telephone)	314-925-4379	Fax #	314-925-4350

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

Facility Name & ID Number Heartland Christian Village# 0048751 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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 4/1/12

	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>25,986</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>25,986</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,698</u>	<u>10,682</u>	<u>4,987</u>	<u>24,367</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>8,698</u>	<u>10,682</u>	<u>4,987</u>	<u>24,367</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.77%

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?

YesG. 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

4,698Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐Tax Year: 6/30/2012Fiscal Year: 6/30/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	163,150	14,140	7,629	184,919		184,919		184,919		1
2	Food Purchase		170,652		170,652		170,652	(93)	170,559		2
3	Housekeeping	81,235	9,835		91,070		91,070		91,070		3
4	Laundry	38,952	7,573		46,525		46,525		46,525		4
5	Heat and Other Utilities			94,633	94,633		94,633	(3,240)	91,393		5
6	Maintenance	62,739	4,682	21,669	89,090		89,090	2,178	91,268		6
7	Other (specify):* Trash			5,593	5,593		5,593		5,593		7
8	TOTAL General Services	346,076	206,882	129,524	682,482		682,482	(1,155)	681,327		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,561,766	94,546	10,672	1,666,984		1,666,984	(1,566)	1,665,418		10
10a	Therapy			520,355	520,355		520,355		520,355		10a
11	Activities	45,278	3,823		49,101		49,101	(237)	48,864		11
12	Social Services	96,507	614	4,569	101,690		101,690		101,690		12
13	CNA Training										13
14	Program Transportation			6,840	6,840		6,840	(6,626)	214		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,703,551	98,983	556,836	2,359,370		2,359,370	(8,429)	2,350,941		16
	C. General Administration										
17	Administrative	111,053	2,800	349,504	463,357		463,357	(301,594)	161,763		17
18	Directors Fees										18
19	Professional Services			14,014	14,014		14,014	25,267	39,281		19
20	Dues, Fees, Subscriptions & Promotions			9,350	9,350		9,350		9,350		20
21	Clerical & General Office Expenses	55,523	10,563	83,839	149,925		149,925	83,004	232,929		21
22	Employee Benefits & Payroll Taxes			464,432	464,432		464,432	23,866	488,298		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,376	6,376		6,376	8,742	15,118		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			59,930	59,930		59,930	(5,168)	54,762		26
27	Other (specify):* Marketing	59,759	2,560	24,492	86,811		86,811	(86,811)			27
28	TOTAL General Administration	226,335	15,923	1,011,937	1,254,195		1,254,195	(252,694)	1,001,501		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,275,962	321,788	1,698,297	4,296,047		4,296,047	(262,278)	4,033,769		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			213,209	213,209		213,209	17,479	230,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			435,283	435,283		435,283	(242,284)	192,999			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,570	7,570		7,570	21,572	29,142			35
36	Other (specify):* Deferred Financing Costs			5,546	5,546		5,546		5,546			36
37	TOTAL Ownership			661,608	661,608		661,608	(203,233)	458,375			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			167,309	167,309		167,309	(9,709)	157,600			39
40	Barber and Beauty Shops	13,191	972		14,163		14,163		14,163			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,982	188,982		188,982		188,982			42
43	Other (specify):* Apt/Congregate			41,435	41,435		41,435	(41,435)				43
44	TOTAL Special Cost Centers	13,191	972	397,726	411,889		411,889	(51,144)	360,745			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,289,153	322,760	2,757,631	5,369,544		5,369,544	(516,655)	4,852,889			45

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

		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	(56)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,100)	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	(7,557)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,566)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,637)	21		24
25	Fund Raising, Advertising and Promotional	(86,811)	27		25
	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	(295,246)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (419,973)		\$	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	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)	(96,682)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (96,682)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (516,655)		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

STATE OF ILLINOIS
Heartland Christian Village

Page 5A

ID# 0048751
Report Period Beginning: July 1, 2011
Ending: June 30, 2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (37)	2	1
2	Apartments/Congregate	(41,435)	43	2
3	Late Fees	(195)	21	3
4	Transportation Revenue	(6,626)	14	4
5	Space Rental Revenue	(150)	21	5
6	Loss on Refinancing	(242,728)	32	6
7	Activity Revenue	(237)	11	7
8	Miscellaneous Revenue	(3,838)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(295,246)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2011

Ending:

June 30, 2012

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	(93)	0	0	0	0	0	0	0	0	0	0	(93)	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	(4,100)	860	0	0	0	0	0	0	0	0	0	(3,240)	5
6	Maintenance	0	2,178	0	0	0	0	0	0	0	0	0	2,178	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,193)	3,038	0	0	0	0	0	0	0	0	0	(1,155)	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	(1,566)	0	0	0	0	0	0	0	0	0	0	(1,566)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(237)	0	0	0	0	0	0	0	0	0	0	(237)	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	(6,626)	0	0	0	0	0	0	0	0	0	0	(6,626)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(8,429)	0	0	0	0	0	0	0	0	0	0	(8,429)	16
	C. General Administration													
17	Administrative	0	(301,594)	0	0	0	0	0	0	0	0	0	(301,594)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,267	0	0	0	0	0	0	0	0	0	25,267	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(28,820)	111,824	0	0	0	0	0	0	0	0	0	83,004	21
22	Employee Benefits & Payroll Taxes	0	23,866	0	0	0	0	0	0	0	0	0	23,866	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,742	0	0	0	0	0	0	0	0	0	8,742	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	(5,168)	0	0	0	0	0	0	0	0	0	(5,168)	26
27	Other (specify):*	(86,811)	0	0	0	0	0	0	0	0	0	0	(86,811)	27
28	TOTAL General Administration	(115,631)	(137,063)	0	0	0	0	0	0	0	0	0	(252,694)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(128,253)	(134,025)	0	0	0	0	0	0	0	0	0	(262,278)	29

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%	\$ 860	\$ 860	1
2	V	6	Maintenance				2,178	2,178	2
3	V	17	Administrative	349,504			47,910	(301,594)	3
4	V	19	Professional Services				25,267	25,267	4
5	V	21	Clerical				111,824	111,824	5
6	V	22	Employee Benefits				23,866	23,866	6
7	V	24	Travel and Seminar				8,742	8,742	7
8	V	26	Insurance				(5,168)	(5,168)	8
9	V	30	Depreciation				17,479	17,479	9
10	V	32	Interest				8,001	8,001	10
11	V	35	Rental & Leasing				21,572	21,572	11
12	V								12
13	V	39	Pharmacy Services	118,406	Senior Care Pharmacy Services	0.00%	108,697	(9,709)	13
14	Total			\$ 467,910			\$ 371,228	\$ * (96,682)	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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, 2011 Ending: ne 30, 2012

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

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	\$	08/01/37	5.8800	\$ 326,032	1	
2	Mortgage Payable		X	HUD Financing	\$32,434.00	10/28/11	4,072,900	4,019,576	07/01/37	4.0500	109,251	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$63,674.00		\$ 8,365,400	\$ 4,019,576			\$ 435,283	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,365,400	\$ 4,019,576			\$ 435,283	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,711 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

[illegible]

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village COUNTY Cumberland
FACILITY IDPH LICENSE NUMBER 0048751
CONTACT PERSON REGARDING THIS REPORT This page is N/A
TELEPHONE 217-732-5175 FAX #: 217-895-3399

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>N/A</u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <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? 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet:

32,630

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

X

(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?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

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

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

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

YES

X

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			3,665	2
3	TOTALS	32,630		\$ 45,432	3

Facility Name & ID Number Heartland Christian Village

0048751

Report Period Beginning:

July 1, 2011 Ending: June 30, 2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1992	1992	\$ 2,601,099	\$ 65,028	40	\$ 65,028	\$	\$ 1,284,293	4
5			1995	1995	119,926	2,998	40	2,998		51,968	5
6											6
7											7
8	Home Office Allocation				33,490	3,801		3,801		20,487	8
	Improvement Type**										
9	1992 Fixed Assets			10/13/1992	66,394	2,075	Various	2,075		47,339	9
10	1993 Fixed Assets			12/31/1993	1,392		Various			1,392	10
11	1994 Fixed Assets			10/24/1994	908		Various			908	11
12	1995 Fixed Assets			7/31/1995	2,602		Various			2,602	12
13	1998 Fixed Assets			12/31/1998	5,024		Various			5,024	13
14	1999 Fixed Assets			12/13/1999	6,957		Various			6,957	14
15	2000 Fixed Assets			1/3/2000	500		Various			500	15
16	2001 Fixed Assets			12/31/2001	1,161		Various			1,161	16
17	2002 Fixed Assets			12/31/2002	4,734	126	Various	126		4,734	17
18	2003 Fixed Assets			12/31/2003	8,373	781	Various	781		7,786	18
19	2004 Fixed Assets			12/31/2004	20,398	1,949	Various	1,949		16,910	19
20	2005 Fixed Assets			12/31/2005	23,620	1,704	Various	1,704		18,265	20
21	2006 Fixed Assets			12/31/2006	1,621	162	Various	162		959	21
22	2007 Fixed Assets			12/31/2007	107,561	10,647	Various	10,647		52,681	22
23	Bathing Room Project			1/31/2008	2,100	210	10	210		945	23
24	Bldg supplies for bathroom Hall 2			4/1/2008	2,944	294	10	294		1,251	24
25	Wiring for heaters in restrooms			5/14/2008	1,975	198	10	198		823	25
26	Pushbutton Door locks			5/14/2008	3,299	330	10	330		1,375	26
27	Tile flooring 3 bathing room			7/1/2008	2,351	470	10	470		1,881	27
28	Commercial Garbage Disposal			1/27/2009	1,859	186	05	186		651	28
29	Parking lot			6/30/2009	13,895	1,390	10	1,390		4,284	29
30	Concrete pad - entryway			6/30/2009	1,572	105	10	105		324	30
31	Extend driveway drainage			6/30/2009	1,300	130	15	130		401	31
32	Land Improvement by Thomas Lawn Care			9/30/2009	22,690	1,891	10	1,891		6,429	32
33	Sprinkler System			12/12/2009	150,125	8,757	10	8,757		38,782	33
34	Compressor for Walkin Cooler			12/30/2009	3,745	218	10	218		968	34
35	Door Alarm System			4/1/2010	35,520	888	10	888		7,992	35
36	Smoke Detector for Life Safety			8/29/2010	1,054	105	10	105		202	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dock Door w/Lock & handle	10/21/2010	\$ 5,402	\$ 540	10	\$ 540	\$	\$ 945	37
38	Fire Alarm System	1/31/2011	65,344	6,534	10	6,534		9,801	38
39	89 gal water heater	1/31/2011	12,834	1,283	10	1,283		1,925	39
40	PTAC Units	1/31/2011	6,733	673	10	673		1,010	40
41	Refurb Activity & Therapy Room	1/31/2011	3,474	347	10	347		521	41
42	Paint Main Hall	5/31/2011	38,671	3,867	10	3,867		4,512	42
43	Main Hall - Flooring	6/30/2011	87,059	8,706	10	8,706		9,431	43
44	Flooring - Service Hallway Tekno	8/21/2011	5,490	503	10	503		503	44
45	PTAC Digismart, 15,000 BTU 30am	7/12/2011	2,113	211	10	211		211	45
46	Vinyl Flooring & Covebase RM 115	10/25/2011	2,462	185	10	185		185	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)		\$ 3,479,771	\$ 127,292		\$ 127,292	\$	\$ 1,619,318	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	\$401,565	\$50,292	\$50,292	\$		\$186,301	71
72	Current Year Purchases	39,953	8,857	8,857			8,857	72
73	Fully Depreciated Assets	284,389	4,832	4,832			300,184	73
74	Home Office Allocation	145,195	16,479	16,479			62,134	74
75	TOTALS	\$871,102	\$80,460	\$80,460	\$		\$557,476	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			31,329	77
78	Overhaul	1994 Ford Eldorado Van	2008	5,336	1,334	1,334			5,003	78
79	Home office allocation			10,908	1,238	1,238			4,055	79
80	TOTALS			\$119,232	\$13,556	\$13,556	\$		\$99,440	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)	\$4,515,53781
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$221,30882
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$221,30883**
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)	\$2,276,23485

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	46,346	87
88	Duplex Building	667,513	18,976	371,014	88
89	Duplex Equipment	12,061	1,383	8,823	89
90					90
91	TOTALS	\$786,543	\$22,260	\$426,183	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	\$50,782	92
93			93
94			94
95		\$50,782	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? ☐ YES ☐ NO
- If NO, see instructions.

		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

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. _____/2013 \$ _____
13. _____/2014 \$ _____
14. _____/2015 \$ _____

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: \$ 8,224 Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,722	\$ 192,545	\$	3,722	\$ 192,545	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,851	113,035		1,851	113,035	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,937	214,775		6,937	214,775	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			\$	12,510	\$ 520,355	\$	12,510	\$ 520,355	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 524,986	\$	1
2	Cash-Patient Deposits	3,019		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,904)	654,077		3
4	Supply Inventory (priced at)	19,353		4
5	Short-Term Investments	24,987		5
6	Prepaid Insurance	15,159		6
7	Other Prepaid Expenses	9,286		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc Int/ Other A/R</u>	65,374		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,316,241	\$	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	4,000,175		14
15	Leasehold Improvements, at Historical Cost	178,822		15
16	Equipment, at Historical Cost	846,292		16
17	Accumulated Depreciation (book methods)	(2,615,742)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,416,706		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Other Assets</u>	157,349		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,067,136	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,383,377	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 135,697	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,019		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,165		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>	142,155		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 508,036	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,011,855		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security Deposits</u>	3,750		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,015,605	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,523,641	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 859,736	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,383,377	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 559,230	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 559,230	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,506	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)	\$ 300,506	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)	\$ 859,736	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2011Ending: June 30, 2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,483,757	1
2	Discounts and Allowances for all Levels	(1,344,362)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,139,395	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,016,336	6
7	Oxygen	9,696	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,026,032	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,635	13
14	Non-Patient Meals	56	14
15	Telephone, Television and Radio	4,100	15
16	Rental of Facility Space		16
17	Sale of Drugs	241,914	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,304	19
20	Radiology and X-Ray	21,166	20
21	Other Medical Services	19,725	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 320,900	23
	D. Non-Operating Revenue		
24	Contributions	100,256	24
25	Interest and Other Investment Income***	8,685	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 108,941	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Retirement Center</u>	69,156	28
28a	<u>Miscellaneous</u>	5,626	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,782	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,670,050	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	682,482	31
32	Health Care	2,359,370	32
33	General Administration	1,254,195	33
	B. Capital Expense		
34	Ownership	661,608	34
	C. Ancillary Expense		
35	Special Cost Centers	222,907	35
36	Provider Participation Fee	188,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,369,544	40
41	Income before Income Taxes (line 30 minus line 40)**	300,506	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 300,506	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,224,560	44
45	Private Pay - Net Inpatient Revenue	1,845,844	45
46	Medicare - Net Inpatient Revenue	59,304	46
47	Other-(specify) <u>HMO</u>	(7,715)	47
48	Other-(specify) <u>Medicare Advantage/Nursing</u>	17,402	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,139,395	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? N/A If not, please attach a reconciliation.

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

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

Facility Name & ID Number Heartland Christian Village# 0048751Report Period Beginning: July 1, 2011Ending: June 30, 2012

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	1,918	2,075	\$ 90,562	\$ 43.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,362	14,905	340,449	22.84	3
4	Licensed Practical Nurses	19,521	22,332	360,184	16.13	4
5	CNAs & Orderlies	57,051	62,217	671,858	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,764	1,917	25,311	13.20	9
10	Activity Assistants	1,839	2,052	19,967	9.73	10
11	Social Service Workers	5,548	6,037	96,507	15.99	11
12	Dietician					12
13	Food Service Supervisor	1,911	2,147	29,259	13.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,844	14,419	133,891	9.29	15
16	Dishwashers					16
17	Maintenance Workers	4,412	4,725	62,739	13.28	17
18	Housekeepers	7,107	8,395	81,235	9.68	18
19	Laundry	3,495	4,324	38,952	9.01	19
20	Administrator	1,873	2,168	111,053	51.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,920	2,103	35,200	16.74	23
24	Clerical	1,497	1,716	20,323	11.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,024	2,054	33,616	16.37	31
32	Other Health Care MDS Coordinator	1,870	2,410	65,096	27.01	32
33	Other(specify) <u>Marketing/Beauty</u>	2,842	2,868	72,951	25.44	33
34	TOTAL (lines 1 - 33)	142,798	158,864	\$ 2,289,153 *	\$ 14.41	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	149	\$ 6,323	ln 1, col 3	35
36	Medical Director	208	14,400	ln 9, col3	36
37	Medical Records Consultant	32	2,441	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	2,308	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	51	3,075	ln 11, col 3	44
45	Social Service Consultant	73	4,569	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	585	\$ 33,116		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

STATE OF ILLINOIS

0048751

Report Period Beginning:

July 1, 2011

Page 21

Ending: June 30, 2012

Facility Name & ID Number

Heartland Christian Village

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>John Letizia</td> <td>Administrator</td> <td></td> <td>\$ 111,053</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 111,053</td> </tr> </table>				Name	Function	Ownership %	Amount	John Letizia	Administrator		\$ 111,053																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,053	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>Workers' Compensation Insurance</td><td>\$ 45,684</td></tr> <tr><td>Unemployment Compensation Insurance</td><td>7,404</td></tr> <tr><td>FICA Taxes</td><td>166,835</td></tr> <tr><td>Employee Health Insurance</td><td>204,630</td></tr> <tr><td>Employee Meals</td><td> </td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Employee Physicals</td><td>3,072</td></tr> <tr><td>Employee Expense</td><td>25,403</td></tr> <tr><td>457 Plan Expense</td><td>10,000</td></tr> <tr><td>Employee Uniforms</td><td>1,404</td></tr> <tr><td>Home Office Allocation</td><td>23,866</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 488,298</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 45,684	Unemployment Compensation Insurance	7,404	FICA Taxes	166,835	Employee Health Insurance	204,630	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Employee Physicals	3,072	Employee Expense	25,403	457 Plan Expense	10,000	Employee Uniforms	1,404	Home Office Allocation	23,866					TOTAL (agree to Schedule V, line 22, col.8)	\$ 488,298	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>IDPH License Fee</td><td>\$ </td></tr> <tr><td>Advertising: Employee Recruitment</td><td>615</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed 30)</td><td>300</td></tr> <tr><td>Patient Background Checks</td><td>104</td></tr> <tr><td>License</td><td>1,866</td></tr> <tr><td>Dues</td><td>4,257</td></tr> <tr><td>Subscriptions</td><td>1,272</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Less: Public Relations Expense</td><td>()</td></tr> <tr><td>Non-allowable advertising</td><td>()</td></tr> <tr><td>Yellow page advertising</td><td>()</td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 9,350</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	615	Health Care Worker Background Check (Indicate # of checks performed 30)	300	Patient Background Checks	104	License	1,866	Dues	4,257	Subscriptions	1,272					Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,350
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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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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14													
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16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$3,807
- (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.

\$ 21,886

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 188,982

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.

\$ 56
- (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 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.