FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0048751

Facility Name: Heartland Christian Village

Address: 101 Trowbridge Road (Number) Neoga (City) 62447 (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:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314-587-7924
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 7/1/14 to 6/30/15 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) Dr. Timothy Phillippe
(Title) CEO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Amanda Tinney, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800 St. Louis MO 63101
(Telephone) 314-925-4389 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: 7/1/14 Ending: 6/30/15

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 N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,850	10,097	4,413	22,360	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,850	10,097	4,413	22,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.28%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Housekeeping/Laundry, Meals, Maintenance Services for IL Residents

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 10/12/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 3,976

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	148,521	14,423	8,175	171,119		171,119		171,119			1
2	Food Purchase		132,516		132,516		132,516	(440)	132,076			2
3	Housekeeping	81,296	12,440	486	94,222		94,222		94,222			3
4	Laundry	37,198	5,217	631	43,046		43,046		43,046			4
5	Heat and Other Utilities			89,322	89,322		89,322	(300)	89,022			5
6	Maintenance	70,723	4,288	25,064	100,075		100,075	2,612	102,687			6
7	Other (specify):* Trash			9,139	9,139		9,139		9,139			7
8	**TOTAL General Services**	337,738	168,884	132,817	639,439		639,439	1,872	641,311			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,493,449	73,000	12,536	1,578,985		1,578,985		1,578,985			10
10a	Therapy			462,692	462,692		462,692		462,692			10a
11	Activities	52,003	4,207	2,551	58,761		58,761	(2,181)	56,580			11
12	Social Services	93,037	409	1,450	94,896		94,896		94,896			12
13	CNA Training											13
14	Program Transportation			4,890	4,890		4,890	(2,800)	2,090			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,638,489	77,616	498,519	2,214,624		2,214,624	(4,981)	2,209,643			16
	C. General Administration											
17	Administrative	92,954	1,209	326,000	420,163		420,163	(250,157)	170,006			17
18	Directors Fees											18
19	Professional Services			18,261	18,261		18,261	22,719	40,980			19
20	Dues, Fees, Subscriptions & Promotions			24,425	24,425		24,425		24,425			20
21	Clerical & General Office Expenses	66,333	6,512	94,351	167,196		167,196	121,158	288,354			21
22	Employee Benefits & Payroll Taxes			449,563	449,563		449,563	25,550	475,113			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,725	12,725		12,725	13,530	26,255			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,457	48,457		48,457	(5,999)	42,458			26
27	Other (specify):* Marketing	37,445	1,522	9,207	48,174		48,174	(48,174)				27
28	**TOTAL General Administration**	196,732	9,243	982,989	1,188,964		1,188,964	(121,373)	1,067,591			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,172,959	255,743	1,614,325	4,043,027		4,043,027	(124,482)	3,918,545			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.

Facility Name & ID Number Heartland Christian Village #0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			242,421	242,421		242,421	21,309	263,730			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,657	171,657		171,657	(13,074)	158,583			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,612	12,612		12,612		12,612			35
36	Other (specify):* **Deferred Financing Costs**			6,315	6,315		6,315		6,315			36
37	**TOTAL Ownership**			433,005	433,005		433,005	8,235	441,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			179,903	179,903		179,903	(4,481)	175,422			39
40	Barber and Beauty Shops	17,267	1,131		18,398		18,398		18,398			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,312	150,312		150,312		150,312			42
43	Other (specify):*			42,942	42,942		42,942	(42,942)				43
44	**TOTAL Special Cost Centers**	17,267	1,131	373,157	391,555		391,555	(47,423)	344,132			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,190,226	256,874	2,420,487	4,867,587		4,867,587	(163,670)	4,703,917			45

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	(440)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,388)	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	(13,074)	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	(23,960)	21		24
25	Fund Raising, Advertising and Promotional	(48,174)	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 See PG5A	(48,400)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,436)		$	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)			34
35	Other- Attach Schedule	(28,234)	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,234)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (163,670)		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

STATE OF ILLINOIS **Page 5A**

Heartland Christian Village

ID# 0048751

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apt/Congregate	$ (42,942)	43	1
2	Late Charges	(37)	21	2
3	Transportation	(2,800)	14	3
4				4
5	Activity Revenue	(2,181)	11	5
6	Miscellaneous Revenue	(440)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(48,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village **#** 0048751 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(440)	0	0	0	0	0	0	0	0	0	0	(440)	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	(1,388)	1,088	0	0	0	0	0	0	0	0	0	(300)	5
6	Maintenance	0	2,612	0	0	0	0	0	0	0	0	0	2,612	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,828)	3,700	0	0	0	0	0	0	0	0	0	1,872	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,181)	0	0	0	0	0	0	0	0	0	0	(2,181)	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	(2,800)	0	0	0	0	0	0	0	0	0	0	(2,800)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,981)	0	0	0	0	0	0	0	0	0	0	(4,981)	16
	C. General Administration													
17	Administrative	0	(250,157)	0	0	0	0	0	0	0	0	0	(250,157)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,719	0	0	0	0	0	0	0	0	0	22,719	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(24,437)	145,595	0	0	0	0	0	0	0	0	0	121,158	21
22	Employee Benefits & Payroll Taxes	0	25,550	0	0	0	0	0	0	0	0	0	25,550	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	13,530	0	0	0	0	0	0	0	0	0	13,530	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	(5,999)	0	0	0	0	0	0	0	0	0	(5,999)	26
27	Other (specify):*	(48,174)	0	0	0	0	0	0	0	0	0	0	(48,174)	27
28	**TOTAL General Administration**	(72,611)	(48,762)	0	0	0	0	0	0	0	0	0	(121,373)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,420)	(45,062)	0	0	0	0	0	0	0	0	0	(124,482)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Christian Village **#** 0048751 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	21,309	0	0	0	0	0	0	0	0	0	21,309	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,074)	0	0	0	0	0	0	0	0	0	0	(13,074)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,074)	21,309	0	0	0	0	0	0	0	0	0	8,235	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(4,481)	0	0	0	0	0	0	0	0	0	(4,481)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(42,942)	0	0	0	0	0	0	0	0	0	0	(42,942)	43
44	**TOTAL Special Cost Centers**	(42,942)	(4,481)	0	0	0	0	0	0	0	0	0	(47,423)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,436)	(28,234)	0	0	0	0	0	0	0	0	0	(163,670)	45

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Board of Directors Attachment						

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Midwest Christian Villages, Inc. d/b/a Christian Homes, Inc.	100.00%	$ 1,088	$ 1,088	1
2	V	6	Maintenance				2,612	2,612	2
3	V	17	Administrative	326,000			75,843	(250,157)	3
4	V	19	Professional Services				22,719	22,719	4
5	V	21	Clerical				145,130	145,130	5
6	V	22	Employee Benefits				25,550	25,550	6
7	V	21	Dues & Subscriptions				102	102	7
8	V	24	Travel and Seminars				13,530	13,530	8
9	V	26	Insurance				(5,999)	(5,999)	9
10	V	30	Depreciation				21,309	21,309	10
11	V	21	Other Administrative Expense				363	363	11
12	V	39	Pharmacy Services	144,542	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	140,061	(4,481)	12
13	V								13
14	Total			$ 470,542			$ 442,308	$ * (28,234)	14

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 N/A								$		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: 7/1/14 Ending: 6/30/15

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mortgage Payable		X	HUD Financing	$32,080.00	10/28/11	$ 4,072,900	$ 3,715,845	07/01/2037	4.0500	$ 152,758	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,080.00		$ 4,072,900	$ 3,715,845			$ 152,758	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,072,900	$ 3,715,845			$ 152,758	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 18,899** **Line #** **32**

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

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 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 ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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? [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 IL 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 41,767	1
2	Home Office Allocation			3,942	2
3	TOTALS			$ 45,709	3

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$		$	$	$	4
5			1995	1995	119,926						5
6											6
7											7
8	Home Office Allocation				38,230	4,111		4,111		28,344	8
	Improvement Type**										
9	1992 Fixed Assets			10/13/1992	65,757		Various				9
10	1993 Fixed Assets			12/31/1993	1,392		Various				10
11	1994 Fixed Assets			10/24/1994	908		Various				11
12	1995 Fixed Assets			7/31/1995	2,602		Various				12
13	1998 Fixed Assets			12/31/1998	3,689		Various				13
14	1999 Fixed Assets			12/13/1999	1,126		Various				14
15	2000 Fixed Assets			1/3/2000	500		Various				15
16	2002 Fixed Assets			12/31/2002	4,734		Various				16
17	2003 Fixed Assets			12/31/2003	7,806		Various				17
18	2004 Fixed Assets			12/31/2004	20,398		Various				18
19	2005 Fixed Assets			12/31/2005	23,620		Various				19
20	2007 Fixed Assets			12/31/2007	85,108		Various				20
21	Bldg supplies for bathroom Hall 2			4/1/2008	2,944		10				21
22	Pushbutton Door locks			5/14/2008	3,299		10				22
23	Parking lot			6/30/2009	13,895		10				23
24	Sprinkler System			12/12/2009	150,125		10				24
25	Compressor for Walkin Cooler			12/30/2009	3,745		10				25
26	Door Alarm System			4/1/2010	35,520		10				26
27	Dock Door w/Lock & handle			10/21/2010	5,402		10				27
28	Fire Alarm System			1/31/2011	65,344		10				28
29	89 gal water heater			1/31/2011	12,834		10				29
30	PTAC Units			1/31/2011	6,733		10				30
31	Refurb Activity & Therapy Room			1/31/2011	3,474		10				31
32	Paint Main Hall			5/31/2011	38,671		10				32
33	Main Hall - Flooring			6/30/2011	87,059		10				33
34	Flooring - Service Hallway Tekno			8/21/2011	5,490		10				34
35	PTAC Digismart, 15,000 BTU 30am			7/12/2011	2,113		10				35
36	Vinyl Flooring & Covebase RM 115			10/25/2011	2,462		10				36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	A/C Condensor	7/11/2012	$ 2,375		15	$	$	$	37
38	R&R Generator	1/18/2013	3,419		12				38
39	90 gal water Heater	4/10/2013	6,250		10				39
40	East Wing Shower	4/10/2013	917		20				40
41	Rm 106 Toilet	4/10/2013	700		20				41
42	R&R Sliding Door	6/24/2013	7,398		10				42
43	R&R South Sliding Door	6/24/2013	8,802		10				43
44	Hall 2 - R&R Vinyl Floor & Covebase	5/1/2013	49,870		10				44
45	Unit #7 AC System	9/11/2013	3,883		10				45
46	Furnace	5/17/2014	3,294		15				46
47	Paint Resient & Bath Walls	4/24/2014	3,833		5				47
48	Install AC Unit in Laundry Room	6/23/2014	2,382		10				48
49	Paint All Resient Rooms Walls Only	4/24/2014	7,667		5				49
50	Install Leonard Mixing Valve	6/5/2014	3,485		10				50
51	Remodel Flooring Hall 1 & 3	10/31/2013	54,720		10				51
52	Storage Shed	6/1/2007	19,054		20				52
53	Tile Flooring 3 bathing rooms	7/1/2008	2,351		5				53
54	Land Improvement by Thomas Lawn Care	9/30/2009	22,690		10				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	Other Building & Building Improvements Depreciation Exp.			142,230		142,230		2,002,884	69
70	TOTAL (lines 4 thru 69)		$ 3,619,095	$ 146,341		$ 146,341	$	$ 2,031,228	70

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 510,618	$ 75,380	$ 75,380	$		$ 240,780	71
72	Current Year Purchases	37,320	6,129	6,129			13,048	72
73	Fully Depreciated Assets	355,623	7,007	7,007			355,623	73
74	Home Office Allocation	153,495	16,503	16,503			104,752	74
75	TOTALS	$ 1,057,056	$ 105,019	$ 105,019	$		$ 714,203	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		93 CHEVY VAN WLIFT	1996	$ 16,383	$	$	$	8	$ 16,383	76
77		2009 Chrysler Town & Country T	2009	43,935				4	43,935	77
78		2014 Ford Starcraft	2014	59,315	9,886	9,886		4	9,886	78
79	Home Office Allocation			6,461	695	695			4,468	79
80	TOTALS			$ 126,094	$ 10,581	$ 10,581	$		$ 74,672	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,847,954	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 261,941	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 261,941	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)	$ 2,820,103	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplex Land	$ 41,767	$	$	86
87	Duplex Building/Land Improvements	744,529	20,614	475,489	87
88					88
89					89
90					90
91	TOTALS	$ 786,296	$ 20,614	$ 475,489	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 25,031	92
93	Home Office Allocation	59	93
94			94
95		$ 25,090	95

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

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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:				$			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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,612 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.

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   HLCV only hires certified CNAs

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 ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	2,977	$ 152,142	$	2,977	$ 152,142	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,832	105,603		1,832	105,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,877	204,947		6,877	204,947	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			$	11,686	$ 462,692	$	11,686	$ 462,692	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.

STATE OF ILLINOIS

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 84,844	$	1
2	Cash-Patient Deposits	1,308,397		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,295)	540,237		3
4	Supply Inventory (priced at)	13,580		4
5	Short-Term Investments	31,298		5
6	Prepaid Insurance	15,188		6
7	Other Prepaid Expenses	18,651		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/AR - Other	20,056		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,032,251	$	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	4,149,042		14
15	Leasehold Improvements, at Historical Cost	178,822		15
16	Equipment, at Historical Cost	1,034,097		16
17	Accumulated Depreciation (book methods)	(3,156,525)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	687,077		21
22	Other Long-Term Assets (spe CIP	25,031		22
23	Other(specify): Deferred Financing Costs	138,404		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,139,482	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,171,733	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,223	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,614		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,575		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	Accrued Liabilities/Due to Auxiliary	142,482		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 569,894	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,715,845		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposit Payable	5,000		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,720,845	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,290,739	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 880,994	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,171,733	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,300,645	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,300,645	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,098	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)**	$ 394,098	17
	B. Transfers (Itemize):		
18	**Equity Transfers between Affiliates**	(813,749)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (813,749)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 880,994	24 *

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,337,386	1
2	Discounts and Allowances for all Levels	(1,503,672)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,833,714	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,936,149	6
7	Oxygen	697	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,936,846	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	17,431	13
14	Non-Patient Meals	440	14
15	Telephone, Television and Radio	1,388	15
16	Rental of Facility Space		16
17	Sale of Drugs	246,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,663	19
20	Radiology and X-Ray	17,852	20
21	Other Medical Services	13,902	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 322,581	23
	D. Non-Operating Revenue		
24	Contributions	95,779	24
25	Interest and Other Investment Income***	19,659	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115,438	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	66,598	28
28a	Miscellaneous	(13,492)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53,106	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,261,685	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	639,439	31
32	Health Care	2,214,624	32
33	General Administration	1,188,964	33
	B. Capital Expense		
34	Ownership	433,005	34
	C. Ancillary Expense		
35	Special Cost Centers	241,243	35
36	Provider Participation Fee	150,312	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,867,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	394,098	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 394,098	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,087,030	44
45	Private Pay - Net Inpatient Revenue	1,797,125	45
46	Medicare - Net Inpatient Revenue	(60,827)	46
47	Other-(specify) HMO/HMO Ancillary/Medicare Advantage	(31,286)	47
48	Other-(specify) Nursing	41,672	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,833,714	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,929	2,201	$ 80,390	$ 36.52	1
2	Assistant Director of Nursing	-	-	-		2
3	Registered Nurses	12,397	13,580	308,359	22.71	3
4	Licensed Practical Nurses	16,837	18,311	342,278	18.69	4
5	CNAs & Orderlies	51,616	54,603	634,283	11.62	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	2,195	2,273	27,047	11.90	9
10	Activity Assistants	2,290	2,540	23,661	9.32	10
11	Social Service Workers	7,037	7,929	118,871	14.99	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	1,854	2,080	32,218	15.49	13
14	Head Cook	5,502	6,014	57,054	9.49	14
15	Cook Helpers/Assistants	6,135	6,492	59,608	9.18	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	4,661	4,999	70,723	14.15	17
18	Housekeepers	7,289	7,584	76,172	10.04	18
19	Laundry	3,492	4,349	42,464	9.76	19
20	Administrator	1,848	2,100	92,908	44.24	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	2,112	2,360	43,847	18.58	23
24	Clerical	1,883	1,986	22,497	11.33	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	2,128	2,251	39,530	17.56	31
32	Other Health Care(specify)	3,857	4,294	101,051	23.53	32
33	Other(specify)	1,260	1,356	17,265	12.73	33
34	TOTAL (lines 1 - 33)	136,322	147,302	$ 2,190,226 *	$ 14.87	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	136	$ 7,208	V01-3	35
36	Medical Director	208	14,400	V09-3	36
37	Medical Records Consultant	32	2,462	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	312	1,875	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,506	V11-3	44
45	Social Service Consultant	25	1,450	V12-3	45
46	Other(specify) FOREFRONT TELE	201	4,959	V10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	954	$ 34,860		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Letizia	Administrator	0	$ 92,954
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,954

B. Administrative - Other

Description	Amount
Management Fee	$ 326,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 326,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen	Accounting	$ 13,841
National Research	Consulting	923
Davis & Campbell	Legal	3,498
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 18,261

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,658
Unemployment Compensation Insurance	2,675
FICA Taxes	158,899
Employee Health Insurance	174,050
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	5,143
Employee Expense	15,853
457 Plan Expense	8,250
Employee Uniforms	35
Home Office Allocation	25,550
TOTAL (agree to Schedule V, line 22, col.8)	$ 475,114

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	322
Health Care Worker Background Check	
(Indicate # of checks performed 15)	525
Patient Background Checks 192	1,920
License	3,435
Dues	17,854
Subscriptions	369
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,425

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,474
In-State Travel	4,555
Seminar Expense	4,695
Home Office Allocation	13,530
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,255

**See instructions.

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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 N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN - $5,594.47**

(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. $ **19,573** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **150,312**
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. $ **440**

(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? **YES**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.