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: 0050682

Facility Name: Hickory Point Christian Vlg

Address: 565 West Marion Ave (Number) Forsyth (City) 62535 (Zip Code)

County: Macon

Telephone Number: 217-872-1122 **Fax #** 217-875-0600

HFS ID Number:

Date of Initial License for Current Owners: 9/22/11

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 Hickory Point Christian Vlg # 0050682 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	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	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	507	5,328	15,377	21,212	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	507	5,328	15,377	21,212	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.80%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 07/15/2011

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 13,329

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 Hickory Point Christian Vlg # 0050682 **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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	286,462	20,080	17,825	324,367		324,367		324,367			1
2	Food Purchase		285,616		285,616		285,616	(1,041)	284,575			2
3	Housekeeping	111,090	32,239	16	143,345		143,345		143,345			3
4	Laundry	25,616	299		25,915		25,915		25,915			4
5	Heat and Other Utilities			99,221	99,221		99,221	2,381	101,602			5
6	Maintenance	136,629	12,900	77,744	227,273		227,273	5,687	232,960			6
7	Other (specify):*			3,765	3,765		3,765		3,765			7
8	**TOTAL General Services**	559,797	351,134	198,571	1,109,502		1,109,502	7,027	1,116,529			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,129,474	124,231	9,031	2,262,736		2,262,736		2,262,736			10
10a	Therapy		260	1,496,997	1,497,257		1,497,257		1,497,257			10a
11	Activities	71,197	1,331	250	72,778		72,778		72,778			11
12	Social Services	88,345	2,609	3,349	94,303		94,303		94,303			12
13	CNA Training											13
14	Program Transportation			10,367	10,367		10,367		10,367			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,289,016	128,431	1,537,994	3,955,441		3,955,441		3,955,441			16
	C. General Administration											
17	Administrative	99,064		540,000	639,064		639,064	(373,964)	265,100			17
18	Directors Fees											18
19	Professional Services			3,816	3,816		3,816	49,737	53,553			19
20	Dues, Fees, Subscriptions & Promotions			35,223	35,223		35,223		35,223			20
21	Clerical & General Office Expenses	134,519	11,193	62,883	208,595		208,595	317,968	526,563			21
22	Employee Benefits & Payroll Taxes			553,614	553,614		553,614	55,935	609,549			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,936	13,936		13,936	29,620	43,556			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			125,997	125,997		125,997	(13,134)	112,863			26
27	Other (specify):* MARKETING	42,871	643	22,872	66,386		66,386	(66,386)				27
28	**TOTAL General Administration**	276,454	11,836	1,358,341	1,646,631		1,646,631	(224)	1,646,407			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,125,267	491,401	3,094,906	6,711,574		6,711,574	6,803	6,718,377			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 Hickory Point Christian Vlg #0050682 **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			518,149	518,149		518,149	46,651	564,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			875,192	875,192		875,192	(447,044)	428,148			32
33	Real Estate Taxes			175,689	175,689		175,689	(70,000)	105,689			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,936	32,936		32,936		32,936			35
36	Other (specify):*			11,322	11,322		11,322		11,322			36
37	**TOTAL Ownership**			1,613,288	1,613,288		1,613,288	(470,393)	1,142,895			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			611,869	611,869		611,869	(16,407)	595,462			39
40	Barber and Beauty Shops		317	16,369	16,686		16,686	(8,727)	7,959			40
41	Coffee and Gift Shops			580	580		580		580			41
42	Provider Participation Fee			83,800	83,800		83,800		83,800			42
43	Other (specify):* APT/CONGREGA	484,212		1,101,786	1,585,998		1,585,998	(1,585,998)				43
44	**TOTAL Special Cost Centers**	484,212	317	1,814,404	2,298,933		2,298,933	(1,611,132)	687,801			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,609,479	491,718	6,522,598	10,623,795		10,623,795	(2,074,722)	8,549,073			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 Hickory Point Christian Vlg # 0050682 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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(8,410)	40		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,036)	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	(441,008)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(66,386)	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	(1,658,151)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,179,991)		$	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	105,269	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 105,269		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,074,722)		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**

Hickory Point Christian Vlg

ID# **0050682**

Report Period Beginning: **7/1/14**

Ending: **6/30/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment/Congregate	$ (1,585,998)	43	1
2	Vending Revenue	(1,041)	2	2
3	Late Fee	(17)	21	3
4	Late Fee	(23)	6	4
5	Miscellaneous Revenue	(755)	21	5
6	Non-Care Real Estate Tax	(70,000)	33	6
7	Barber & Beauty Supplies	(317)	40	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,658,151)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 **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	(1,041)	0	0	0	0	0	0	0	0	0	0	(1,041)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,381	0	0	0	0	0	0	0	0	0	2,381	5
6	Maintenance	(23)	5,710	0	0	0	0	0	0	0	0	0	5,687	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,064)	8,091	0	0	0	0	0	0	0	0	0	7,027	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(373,964)	0	0	0	0	0	0	0	0	0	(373,964)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	49,737	0	0	0	0	0	0	0	0	0	49,737	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(772)	318,740	0	0	0	0	0	0	0	0	0	317,968	21
22	Employee Benefits & Payroll Taxes	0	55,935	0	0	0	0	0	0	0	0	0	55,935	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	29,620	0	0	0	0	0	0	0	0	0	29,620	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	(13,134)	0	0	0	0	0	0	0	0	0	(13,134)	26
27	Other (specify):*	(66,386)	0	0	0	0	0	0	0	0	0	0	(66,386)	27
28	**TOTAL General Administration**	(67,158)	66,934	0	0	0	0	0	0	0	0	0	(224)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(68,222)	75,025	0	0	0	0	0	0	0	0	0	6,803	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 **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	46,651	0	0	0	0	0	0	0	0	0	46,651	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(447,044)	0	0	0	0	0	0	0	0	0	0	(447,044)	32
33	Real Estate Taxes	(70,000)	0	0	0	0	0	0	0	0	0	0	(70,000)	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**	(517,044)	46,651	0	0	0	0	0	0	0	0	0	(470,393)	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	(16,407)	0	0	0	0	0	0	0	0	0	(16,407)	39
40	Barber and Beauty Shops	(8,727)	0	0	0	0	0	0	0	0	0	0	(8,727)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,585,998)	0	0	0	0	0	0	0	0	0	0	(1,585,998)	43
44	**TOTAL Special Cost Centers**	(1,594,725)	(16,407)	0	0	0	0	0	0	0	0	0	(1,611,132)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,179,991)	105,269	0	0	0	0	0	0	0	0	0	(2,074,722)	45

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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 Attached Board of Directors Listing						

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 [X] 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%	$ 2,381	$ 2,381	1
2	V	6	Maintenance				5,710	5,710	2
3	V	17	Administrative	540,000			166,036	(373,964)	3
4	V	19	Professional Services				49,737	49,737	4
5	V	21	Clerical				317,722	317,722	5
6	V	22	Employee Benefits				55,935	55,935	6
7	V	21	Dues & Subscriptions				223	223	7
8	V	24	Travel and Seminars				29,620	29,620	8
9	V	26	Insurance				(13,134)	(13,134)	9
10	V	30	Depreciation				46,651	46,651	10
11	V	21	Other Administrative Expense				795	795	11
12	V	39	Pharmacy Services	529,262	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	512,855	(16,407)	12
13	V								13
14	Total			$ 1,069,262			$ 1,174,531	$ * 105,269	14

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

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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 Hickory Point Christian Vlg # 0050682 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 Hickory Point Christian Vlg # 0050682 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	IL Finance Authority - 2010 Series		X	47 Bed SNF		7/29/10	$ 7,200,000	$ 7,090,661	5/15/2027	6.1300	$ 434,184	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,200,000	$ 7,090,661			$ 434,184	9
	B. Non-Facility Related*											
10			X	Refinance Debt		6/28/07	7,730,977	8,359,855	5/15/2031	5.6700	441,008	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 7,730,977	$ 8,359,855			$ 441,008	14
15	TOTALS (line 9+line14)						$ 14,930,977	$ 15,450,516			$ 875,192	15

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

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

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

Facility Name & ID Number Hickory Point Christian Vlg **#** 0050682 **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 Hickory Point Christian Vlg COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0050682

CONTACT PERSON REGARDING THIS REPORT Kenna Hudson

TELEPHONE 314-587-7924 FAX #: 217-732-8686

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.	07-07-15-452-019	See Attachment	$ 6,853.26	$
2.	07-07-15-452-018	See Attachment	$ 4,505.50	$
3.	07-07-15-451-006	See Attachment	$ 300,834.46	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 312,193.22	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Hickory Point Christian Vlg # 0050682 Report Period Beginning: 7/1/14 Ending: 6/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,326 B. General Construction Type: Exterior Siding/Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [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).

Apartments
Congregate

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	Facility			$ 188,520	1
2	Home Office Allocation			8,630	2
3	TOTALS			$ 197,150	3

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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	47		2011	2011	$ 6,531,557	$ 217,719	30	$ 217,719	$	$ 870,875	4
5			2011	2011	342,749	11,425	30	11,425		45,700	5
6	17		2014	2014	1,966,535	43,346	40	43,346		68,281	6
7											7
8	Home Office Allocation				83,694	8,999		8,999		62,052	8
	Improvement Type**										
9	Landscaping for HPCV GradingSeeding			2006	52,728	2,636	10	2,636		24,826	9
10	Irrigation system			2006	31,650	1,583	10	1,583		14,902	10
11	Land Improvement			2006	185,674	9,284	10	9,284		87,421	11
12	Landscaping front entrance flagpole			2006	14,200	1,420	10	1,420		13,372	12
13	Vinyl Fence Panels			2010	770	77	15	77		391	13
14	2010 Landscaping			2010	9,793	979	10	979		4,815	14
15	Ansul fire suppression system rebuild			2011	1,016	102	10	102		390	15
16	Slit Seed Landscaping			2011	3,350	335	10	335		1,396	16
17	Pavement sealing & crackfilling &marki			2011	4,850	606	10	606		2,375	17
18	Elopement Accutech IS Haven House Wing			2012	30,500	3,050	15	3,050		8,388	18
19	AC Unit Warming Kitchen			2012	12,026	1,203	40	1,203		3,508	19
20	R&R Economizer for RTU #4			2012	4,935	494	10	494		1,357	20
21	Electronic Locks for SNF			2012	7,599	760	10	760		1,963	21
22	Set up Door Alarm w Key Pad Entry (SNF			2012	1,538	154	10	154		461	22
23	Cabinets Upper & Base Laminate			2012	3,300	330	10	330		990	23
24	R&R Water Main from Laundry & Main Bld			2013	2,681	179	20	179		402	24
25	870 Hope R&R Carpet & Vinyl			2013	4,441	444	20	444		925	25
26	Nursing Narcotic Cabinet			2013	14,432	722	20	722		1,924	26
27	Signage			2013	16,828	1,683	10	1,683		2,945	27
28	Full wall panel for lobby			2013	2,124	212	10	212		372	28
29	Accent lighting near receptionist			2013	1,150	115	10	115		211	29
30	HH room 321 carpet heven			2013	771	77	10	77		391	30
31	Landscape Renovations			2013	31,150	3,894	8	3,894		5,451	31
32	Shrubs, Tress Landscape			2013	12,000	2,300	10	2,300		2,300	32
33	Retaining wall uility road trees			2013	4,630	810	10	810		810	33
34	New sidewalk & driveway			2013	4,650	446	10	446		446	34
35	Repave Marion Av front enterance way			2014	44,726	2,609	20	2,609		2,609	35
36	Pendant System (Lighting damage)			2014	16,440	1,370	10	1,370		1,370	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 Hickory Point Christian Vlg # 0050682 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	Panelboard surge device	2015	$ 59,400	$ 2,970	10	$ 2,970	$	$ 2,970	37
38	Awning / Carport	2015	3,995	100	10	100		100	38
39	Landscaping project Rear foundation	2014	21,260	1,417	10	1,417		1,417	39
40	Asphalt paving @ Marion	2014	49,875	4,676	8	4,676		4,676	40
41	Concrete driveway & sidewalk	2015	7,282	182	10	182		182	41
42	Gate & Concrete dumpster area	2015	3,264	54	10	54		54	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,589,563	$ 328,760		$ 328,760	$	$ 1,243,017	70

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

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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	$ 1,339,237	$ 177,997	$ 177,997	$		$ 457,025	71
72	Current Year Purchases	52,481	8,800	8,800			8,800	72
73	Fully Depreciated Assets	56,901					56,901	73
74	Home Office Allocation	336,035	36,131	36,131			229,325	74
75	TOTALS	$ 1,784,654	$ 222,928	$ 222,928	$		$ 752,051	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2006 Ford Startrans Senator		$ 45,963	$	$	$	4	$ 45,963	76
77		2014 Ford Starcraft Allstar E350		55,637	11,591	11,591		4	11,591	77
78										78
79	Home Office Allocation			14,146	1,521	1,521			9,782	79
80	TOTALS			$ 115,746	$ 13,112	$ 13,112	$		$ 67,336	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,687,113	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 564,800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 564,800	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)	$ 2,062,404	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	A/L Building & Equipment	$ 7,971,426	$ 276,221	$ 2,324,236	86
87	Duplex Building/Equipment/Land Imp.	6,916,926	197,445	3,498,583	87
88	Land	668,388			88
89					89
90					90
91	TOTALS	$ 15,556,740	$ 473,666	$ 5,822,819	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 32,151	92
93	Home Office Allocation	128	93
94			94
95		$ 32,279	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 Hickory Point Christian Vlg # 0050682 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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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 ☒ NO
16. Rental Amount for movable equipment: $ 32,936 Description: See Attachment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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.

   HPCV 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 Hickory Point Christian Vlg # 0050682 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	$	11,648	$ 646,985	$	11,648	$ 646,985	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,915	84,648		2,915	84,648	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		16,474	765,364		16,474	765,364	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			$	31,037	$ 1,496,997	$	31,037	$ 1,496,997	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 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	$ (3,713,405)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,206,679		3
4	Supply Inventory (priced at)	3,966		4
5	Short-Term Investments	40,471		5
6	Prepaid Insurance	15,539		6
7	Other Prepaid Expenses	24,496		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	11,365		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,410,889)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	856,908		13
14	Buildings, at Historical Cost	22,307,044		14
15	Leasehold Improvements, at Historical Cost	1,139,672		15
16	Equipment, at Historical Cost	2,497,725		16
17	Accumulated Depreciation (book methods)	(7,584,063)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,212,151		21
22	Other Long-Term Assets (specify):	224,631		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,654,068	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,243,179	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,124	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,383		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,678		32
33	Accrued Interest Payable	114,676		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37		384,038		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,015,899	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	15,450,516		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	1,636,748		43
44	Interest Rate Swap Agreement			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 17,087,264	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 18,103,163	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 140,016	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,243,179	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (257,905)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (257,905)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	397,926	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(5)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 397,921	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)**	$ 140,016	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	$ 6,228,627	1
2	Discounts and Allowances for all Levels	(5,489,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 738,647	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,502,388	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,502,388	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	190	12
13	Barber and Beauty Care	16,140	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,410	16
17	Sale of Drugs	888,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,527	19
20	Radiology and X-Ray	47,195	20
21	Other Medical Services	105,745	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,143,658	23
	D. Non-Operating Revenue		
24	Contributions	18,596	24
25	Interest and Other Investment Income***	6,036	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,632	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,542,879	28
28a		69,517	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,612,396	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,021,721	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,109,502	31
32	Health Care	3,955,441	32
33	General Administration	1,646,631	33
	B. Capital Expense		
34	Ownership	1,683,288	34
	C. Ancillary Expense		
35	Special Cost Centers	2,145,133	35
36	Provider Participation Fee	83,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,623,795	40
41	**Income before Income Taxes (line 30 minus line 40)****	397,926	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 397,926	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 91,888	44
45	Private Pay - Net Inpatient Revenue	1,585,912	45
46	Medicare - Net Inpatient Revenue	(544,883)	46
47	Other-(specify) HMO/HMO Ancillary/Medicare Advantage	(33,339)	47
48	Other-(specify) Nursing/Outpatient Part B	(360,931)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 738,647	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	1,864	2,080	$ 71,373	$ 34.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,186	22,621	578,333	25.57	3
4	Licensed Practical Nurses	19,962	21,465	431,584	20.11	4
5	CNAs & Orderlies	73,805	79,034	872,052	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,766	3,936	49,663	12.62	9
10	Activity Assistants	3,180	3,445	60,802	17.65	10
11	Social Service Workers	3,291	3,658	88,345	24.15	11
12	Dietician					12
13	Food Service Supervisor	1,901	2,080	42,707	20.53	13
14	Head Cook	3,729	4,086	36,684	8.98	14
15	Cook Helpers/Assistants	22,039	23,755	205,324	8.64	15
16	Dishwashers					16
17	Maintenance Workers	7,719	8,560	136,629	15.96	17
18	Housekeepers	12,426	13,365	111,307	8.33	18
19	Laundry	2,472	2,605	21,613	8.30	19
20	Administrator	1,104	1,523	99,064	65.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,802	2,017	44,481	22.05	23
24	Clerical	8,906	9,576	120,428	12.58	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	1,965	2,101	26,693	12.70	31
32	Other Health C: Community Liason	8,346	9,135	227,178	24.87	32
33	Other(specify) Assisted Living	28,681	31,129	385,219	12.37	33
34	TOTAL (lines 1 - 33)	228,144	246,171	$ 3,609,479 *	$ 14.66	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	304	$ 15,713	V01-3	35
36	Medical Director	208	18,000	V09-3	36
37	Medical Records Consultant	24	2,427	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	26	1,623	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				44
45	Social Service Consultant	43	3,349	V12-3	45
46	Other(specify) Clerical		313	V21.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	605	$ 41,425		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
STEPHANIE TAYLOR	ADMINISTRATOR	0	$ 72,003
LAURIE BROWN	ADMINISTRATOR	0	27,061
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,064

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 540,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 540,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NATIONAL RESEARCH	SURVEY	$ 1,073
DAVIS & CAMPBELL	LEGAL	2,743
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 3,816

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,616
Unemployment Compensation Insurance	15,639
FICA Taxes	264,172
Employee Health Insurance	130,095
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	5,341
Employee Uniforms	(187)
Employee Expense	12,188
457 Plan Expense	10,750
Home Office Allocation	55,935
TOTAL (agree to Schedule V, line 22, col.8)	$ 609,549

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	5,086
Health Care Worker Background Check	
(Indicate # of checks performed 30)	1,050
Patient Background Checks 447	4,470
LICENSE	2,290
DUES	16,909
SUBSCRIPTIONS	5,418
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,223

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,265
In-State Travel	3,933
Seminar Expense	3,738
Home Office Allocation	29,620
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 43,556

**See instructions.

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 Report Period Beginning: 7/1/14 Ending: 6/30/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hickory Point Christian Vlg # 0050682 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 - $5,484.38**

(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. $ **25,431** 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. $ **83,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CliftonLarsonAllen, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.