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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2015 to 6/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Susan McGhee

(Title) CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Kenna Hudson Telephone Number: 314-587-7924
Email Address:

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: 7/1/2015 Ending: 6/30/2016

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	25,986	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	25,986	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	7,461	12,979	3,236	23,676	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,461	12,979	3,236	23,676	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.11%

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 2,847

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: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	151,957	17,056	8,389	177,402		177,402		177,402			1
2	Food Purchase		142,029		142,029		142,029		142,029			2
3	Housekeeping	78,436	15,216		93,652		93,652		93,652			3
4	Laundry	40,293	3,544	(232)	43,605		43,605		43,605			4
5	Heat and Other Utilities			91,069	91,069		91,069	(604)	90,465			5
6	Maintenance	72,623	5,569	24,144	102,336		102,336	2,317	104,653			6
7	Other (specify):* Trash			9,035	9,035		9,035		9,035			7
8	TOTAL General Services	343,309	183,414	132,405	659,128		659,128	1,713	660,841			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,530,350	73,150	13,818	1,617,318		1,617,318	(3,381)	1,613,937			10
10a	Therapy			377,180	377,180		377,180		377,180			10a
11	Activities	51,073	4,269	2,888	58,230		58,230	(679)	57,551			11
12	Social Services	88,789	399	1,531	90,719		90,719		90,719			12
13	CNA Training											13
14	Program Transportation			2,730	2,730		2,730	(2,789)	(59)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,670,212	77,818	412,547	2,160,577		2,160,577	(6,849)	2,153,728			16
	C. General Administration											
17	Administrative	94,443		424,000	518,443		518,443	(345,666)	172,777			17
18	Directors Fees											18
19	Professional Services			27,081	27,081		27,081	63,851	90,932			19
20	Dues, Fees, Subscriptions & Promotions			26,686	26,686		26,686	(817)	25,869			20
21	Clerical & General Office Expenses	63,533	7,863	102,809	174,205		174,205	188,410	362,615			21
22	Employee Benefits & Payroll Taxes			512,905	512,905		512,905	32,174	545,079			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,902	4,902		4,902	26,218	31,120			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,564	46,564		46,564	17,254	63,818			26
27	Other (specify):* Marketing	43,209	14,939	3,315	61,463		61,463	(61,463)				27
28	TOTAL General Administration	201,185	22,802	1,148,262	1,372,249		1,372,249	(80,039)	1,292,210			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,214,706	284,034	1,693,214	4,191,954		4,191,954	(85,175)	4,106,779			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: 7/1/2015 Ending: 6/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			247,044	247,044		247,044	22,746	269,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,203	125,203		125,203	(3,938)	121,265			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,925	14,925		14,925		14,925			35
36	Other (specify):* Deferred Financing Costs			4,730	4,730		4,730		4,730			36
37	**TOTAL Ownership**			391,902	391,902		391,902	18,808	410,710			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			132,546	132,546		132,546	(4,693)	127,853			39
40	Barber and Beauty Shops	18,233	1,247		19,480		19,480		19,480			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,214	166,214		166,214		166,214			42
43	Other (specify):* Apt/Duplex			95,687	95,687		95,687	(95,687)				43
44	**TOTAL Special Cost Centers**	18,233	1,247	394,447	413,927		413,927	(100,380)	313,547			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,232,939	285,281	2,479,563	4,997,783		4,997,783	(166,747)	4,831,036			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: 7/1/2015 Ending: 6/30/2016

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	(1,637)	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	(3,938)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,381)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,860)	21		24
25	Fund Raising, Advertising and Promotional	(61,463)	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	(106,193)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (196,472)		$	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)	29,725	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 29,725		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (166,747)		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

Heartland Christian Village

ID# 0048751

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apt/Congregate	$ (101,908)	43	1
2	Transportation	(2,730)	14	2
3	Activity Revenue	(679)	11	3
4	Vending Revenue	(59)	14	4
5	Lobbying Expense	(817)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(106,193)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,637)	1,033	0	0	0	0	0	0	0	0	0	(604)	5
6	Maintenance	0	2,317	0	0	0	0	0	0	0	0	0	2,317	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,637)	3,350	0	0	0	0	0	0	0	0	0	1,713	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	(3,381)	0	0	0	0	0	0	0	0	0	0	(3,381)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(679)	0	0	0	0	0	0	0	0	0	0	(679)	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	(2,789)	0	0	0	0	0	0	0	0	0	0	(2,789)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,849)	0	0	0	0	0	0	0	0	0	0	(6,849)	16
	C. General Administration													
17	Administrative	0	(345,666)	0	0	0	0	0	0	0	0	0	(345,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	63,851	0	0	0	0	0	0	0	0	0	63,851	19
20	Fees, Subscriptions & Promotions	(817)	0	0	0	0	0	0	0	0	0	0	(817)	20
21	Clerical & General Office Expenses	(19,860)	208,270	0	0	0	0	0	0	0	0	0	188,410	21
22	Employee Benefits & Payroll Taxes	0	32,174	0	0	0	0	0	0	0	0	0	32,174	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	26,218	0	0	0	0	0	0	0	0	0	26,218	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	17,254	0	0	0	0	0	0	0	0	0	17,254	26
27	Other (specify):*	(61,463)	0	0	0	0	0	0	0	0	0	0	(61,463)	27
28	TOTAL General Administration	(82,140)	2,101	0	0	0	0	0	0	0	0	0	(80,039)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,626)	5,451	0	0	0	0	0	0	0	0	0	(85,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Christian Village **#** 0048751 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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	22,746	0	0	0	0	0	0	0	0	0	22,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,938)	0	0	0	0	0	0	0	0	0	0	(3,938)	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**	(3,938)	22,746	0	0	0	0	0	0	0	0	0	18,808	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	(4,693)	0	0	0	0	0	0	0	0	0	(4,693)	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):*	(101,908)	6,221	0	0	0	0	0	0	0	0	0	(95,687)	43
44	**TOTAL Special Cost Centers**	(101,908)	1,528	0	0	0	0	0	0	0	0	0	(100,380)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(196,472)	29,725	0	0	0	0	0	0	0	0	0	(166,747)	45

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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%	$ 1,033	$ 1,033	1
2	V	6	Maintenance				2,317	2,317	2
3	V	17	Administrative	424,000			78,334	(345,666)	3
4	V	19	Professional Services				63,851	63,851	4
5	V	21	Clerical				178,061	178,061	5
6	V	22	Employee Benefits				32,174	32,174	6
7	V	21	Dues & Subscriptions				3,758	3,758	7
8	V	24	Travel and Seminars				26,218	26,218	8
9	V	26	Insurance				17,254	17,254	9
10	V	30	Depreciation				22,746	22,746	10
11	V	21	Other Administrative Expense				26,451	26,451	11
12	V	43	Independent Living				6,221	6,221	12
13	V	39	Pharmacy Services	124,492	Midwest Senior Ministries d/b/a Senior Care Pharmacy	0.00%	119,799	(4,693)	13
14	Total			$ 548,492			$ 578,217	$ * 29,725	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: 7/1/2015 Ending: 6/30/2016

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: 7/1/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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: 7/1/2015 Ending: 6/30/2016

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	$30,948.00	10/28/11	$ 4,072,900	$ 3,608,923	07/01/2037	4.0500	$ 111,246	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$30,948.00		$ 4,072,900	$ 3,608,923			$ 111,246	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	$ 3,608,923			$ 111,246	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 13,957 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:** 7/1/2015 **Ending:** 6/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/1/2015 Ending: 6/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,909 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	34,909	Various	$ 41,767	1
2	Home Office Allocation			4,493	2
3	TOTALS	34,909		$ 46,260	3

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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				44,450	1,782		1,782		34,087	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				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: 7/1/2015 Ending: 6/30/2016

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	Duplex #105 ADA Shower	11/10/2015	2,993		10				55
56	10 Bronze 31.5" Wide Chandeliers	8/28/2015	3,000		10				56
57	Replacement Glass For Windows	7/10/2015	3,889		10				57
58	18x21 Brown Carport	9/8/2015	1,587		10				58
59	Display Illuminated custom Sign 6x14	9/8/2015	21,947		10				59
60	Parking Lot 18x64 & 23x77	9/8/2015	12,226		10				60
61	Dining Room Drapes & Rods 115 x 93	6/27/2016	1,134		10				61
62					various				62
63									63
64									64
65									65
66									66
67									67
68									68
69	Other Building & Building Improvements Depreciation Exp.			144,752		144,752		2,147,636	69
70	TOTAL (lines 4 thru 69)		$ 3,672,091	$ 146,534		$ 146,534	$	$ 2,181,723	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: 7/1/2015 Ending: 6/30/2016

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	$ 542,338	$ 76,952	$ 76,952	$		$ 311,428	71
72	Current Year Purchases	22,519	2,928	2,928			2,928	72
73	Fully Depreciated Assets	325,354	1,128	1,128			325,354	73
74	Home Office Allocation	163,565	19,557	19,557			120,743	74
75	TOTALS	$ 1,053,776	$ 100,565	$ 100,565	$		$ 760,453	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		All Vehicles - See Attached	Various	$ 154,803	$ 21,284	$ 21,284	$	Various	$ 91,488	76
77										77
78										78
79	Home Office Allocation			6,455	1,407	1,407			4,760	79
80	TOTALS			$ 161,258	$ 22,691	$ 22,691	$		$ 96,248	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)	$ 4,933,385	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,790	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 269,790	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)	$ 3,038,424	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 Imp/Equip	745,109	21,077	494,206	87
88					88
89					89
90					90
91	TOTALS	$ 786,876	$ 21,077	$ 494,206	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 2,860	92
93			93
94			94
95		$ 2,860	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: 7/1/2015 Ending: 6/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 14,925 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 Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	$	2,309	$ 116,618	$	2,309	$ 116,618	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,937	105,060		1,937	105,060	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		4,675	155,502		4,675	155,502	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			$	8,921	$ 377,180	$	8,921	$ 377,180	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:** 7/1/2015 **Ending:** 6/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2016 **(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	$ 682,235	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 48,115)	565,805		3
4	Supply Inventory (priced at)	19,370		4
5	Short-Term Investments	32,617		5
6	Prepaid Insurance	14,595		6
7	Other Prepaid Expenses	14,927		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	365		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,329,914	$	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	4,162,895		14
15	Leasehold Improvements, at Historical Cost	214,582		15
16	Equipment, at Historical Cost	1,040,288		16
17	Accumulated Depreciation (book methods)	(3,373,040)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	750,115		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing Costs	132,089		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,010,463	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,340,377	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,251	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,891		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,140		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	Accrued Liabilities/Due to Auxiliary	140,670		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 485,952	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,608,923		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposit Payable	5,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,614,423	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,100,375	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 240,002	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,340,377	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 880,994	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 880,994	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	237,277	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)**	$ 237,277	17
	B. Transfers (Itemize):		
18	**Equity Transfer to Christian Homes**	(872,953)	18
19	**Changes in Temporarily Restricted Net Assets**	(5,316)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (878,269)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 240,002	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	$ 4,552,061	1
2	Discounts and Allowances for all Levels	(2,059,714)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,492,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,329,682	6
7	Oxygen	2,051	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,331,733	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	21,314	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,637	15
16	Rental of Facility Space		16
17	Sale of Drugs	187,108	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,393	19
20	Radiology and X-Ray	15,509	20
21	Other Medical Services	7,025	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 257,986	23
	D. Non-Operating Revenue		
24	Contributions	65,454	24
25	Interest and Other Investment Income***	3,938	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69,392	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	74,275	28
28a	Miscellaneous	9,327	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 83,602	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,235,060	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	659,128	31
32	Health Care	2,160,577	32
33	General Administration	1,372,249	33
	B. Capital Expense		
34	Ownership	391,902	34
	C. Ancillary Expense		
35	Special Cost Centers	247,713	35
36	Provider Participation Fee	166,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,997,783	40
41	**Income before Income Taxes (line 30 minus line 40)****	237,277	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 237,277	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,224,764	44
45	Private Pay - Net Inpatient Revenue	2,222,911	45
46	Medicare - Net Inpatient Revenue	(793,470)	46
47	Other-(specify) HMO/HMO Ancillary/Medicare Advantage	(118,166)	47
48	Other-(specify) Nursing	(43,692)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,492,347	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	1,949	2,210	$ 81,536	$ 36.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,034	15,350	405,348	26.41	3
4	Licensed Practical Nurses	16,383	17,970	358,462	19.95	4
5	CNAs & Orderlies	54,077	56,424	650,752	11.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,089	24,876	11.91	9
10	Activity Assistants	2,547	2,671	26,196	9.81	10
11	Social Service Workers	4,892	5,381	88,789	16.50	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,150	32,367	15.05	13
14	Head Cook	4,880	5,377	50,047	9.31	14
15	Cook Helpers/Assistants	6,708	7,221	69,543	9.63	15
16	Dishwashers					16
17	Maintenance Workers	4,502	4,956	72,623	14.65	17
18	Housekeepers	7,186	7,469	78,436	10.50	18
19	Laundry	3,406	3,746	40,293	10.76	19
20	Administrator	1,780	2,120	94,443	44.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,990	2,198	40,065	18.23	23
24	Clerical	1,827	2,010	23,468	11.68	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	1,740	1,927	34,252	17.77	31
32	Other Health C: Marketing/Beauty	3,293	4,388	61,443	14.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,935	145,657	$ 2,232,939 *	$ 15.33	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	564	$ 6,588	V01-3	35
36	Medical Director	182	14,400	V09-3	36
37	Medical Records Consultant	32	2,396	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	364	1,968	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	49	2,888	V11-3	44
45	Social Service Consultant	26	1,531	V12-3	45
46	Other(specify) Forefront Telecare	142	3,514	V10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,359	$ 33,285		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	$ 94,443
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,443

B. Administrative - Other

Description	Amount
Management Fee	$ 424,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 424,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen	Accounting	$ 16,098
National Research	Consulting	791
Davis & Campbell	Legal	8,517
Lancaster Pollard	Legal	1,675
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 27,081

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,067
Unemployment Compensation Insurance	4,865
FICA Taxes	162,427
Employee Health Insurance	224,419
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	9,226
Employee Expense	17,798
457 Plan Expense	8,494
Employee Uniforms	(1,391)
TOTAL (agree to Schedule V, line 22, col.8)	$ 545,079

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 161)	
Patient Background Checks	1,610
License	3,377
Dues	10,370
Subscriptions	10,512
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,276
In-State Travel	2,696
Seminar Expense	930
Home Office Allocation	26,218
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 31,120

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Christian Village # 0048751 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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. **Leading Age - $2,840.45**

(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. $ **22,718** 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. $ **166,214**
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? **NO** Indicate the amount. $

(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: **Plante Moran PLLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

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