FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0048751

Facility Name: Heartland Christian Village, LLC

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

County: Cumberland

Telephone Number: 217.895.2665 **Fax #** 217.895.3399

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314.587.7924
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2017 to 6/30/2018 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) Chuck Schmitz
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,695	11,539	3,880	22,114	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,695	11,539	3,880	22,114	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.33%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/12/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/12/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 3,466

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	155,145	14,122	11,262	180,529		180,529		180,529			1
2	Food Purchase		149,937		149,937		149,937		149,937			2
3	Housekeeping	78,132		18,358	96,490		96,490		96,490			3
4	Laundry	42,310		2,878	45,188		45,188		45,188			4
5	Heat and Other Utilities			94,897	94,897		94,897	795	95,692			5
6	Maintenance	74,113	39,272		113,385		113,385	1,644	115,029			6
7	Other (specify):* Trash			8,838	8,838		8,838		8,838			7
8	TOTAL General Services	349,700	203,331	136,233	689,264		689,264	2,439	691,703			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,559,085	74,784	5,767	1,639,636		1,639,636		1,639,636			10
10a	Therapy			351,744	351,744		351,744		351,744			10a
11	Activities	51,483	17,440	2,529	71,452		71,452		71,452			11
12	Social Services	114,897		4,140	119,037		119,037		119,037			12
13	CNA Training											13
14	Program Transportation			4,154	4,154		4,154		4,154			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,725,465	92,224	382,734	2,200,423		2,200,423		2,200,423			16
	C. General Administration											
17	Administrative	98,375		405,230	503,605		503,605	(364,103)	139,502			17
18	Directors Fees											18
19	Professional Services			20,146	20,146		20,146	29,026	49,172			19
20	Dues, Fees, Subscriptions & Promotions			33,911	33,911		33,911	(836)	33,075			20
21	Clerical & General Office Expenses	71,553	28,230	66,914	166,697		166,697	191,013	357,710			21
22	Employee Benefits & Payroll Taxes			442,869	442,869		442,869	40,247	483,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,683	4,683		4,683	16,796	21,479			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,021	58,021		58,021	466	58,487			26
27	Other (specify):* Marketing	46,553		32,852	79,405		79,405	(79,405)				27
28	TOTAL General Administration	216,481	28,230	1,064,626	1,309,337		1,309,337	(166,796)	1,142,541			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,291,646	323,785	1,583,593	4,199,024		4,199,024	(164,357)	4,034,667			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, LLC #0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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			249,145	249,145		249,145	17,013	266,158			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,267	110,267		110,267		110,267			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,617	11,617		11,617		11,617			35
36	Other (specify):* Sales Tax/Def Financing Cost			9,427	9,427		9,427		9,427			36
37	**TOTAL Ownership**			380,456	380,456		380,456	17,013	397,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,842	173,670	179,512		179,512	14,441	193,953			39
40	Barber and Beauty Shops			2,219	2,219		2,219		2,219			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			152,223	152,223		152,223		152,223			42
43	Other (specify):* Duplexes	4,476		93,068	97,544		97,544	(92,014)	5,530			43
44	**TOTAL Special Cost Centers**	4,476	5,842	421,180	431,498		431,498	(77,573)	353,925			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,296,122	329,627	2,385,229	5,010,978		5,010,978	(224,917)	4,786,061			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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,987)	21		24
25	Fund Raising, Advertising and Promotional	(79,405)	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	(100,622)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (191,014)		$	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)	(33,903)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,903)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,917)		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, LLC

ID# 0048751

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ (97,544)	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Lobbying Expense	(837)	20	3
4	Travel and Seminar	(2,241)	24	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(100,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	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	0	795	0	0	0	0	0	0	0	0	0	795	5
6	Maintenance	0	1,644	0	0	0	0	0	0	0	0	0	1,644	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	2,439	0	0	0	0	0	0	0	0	0	2,439	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	(364,103)	0	0	0	0	0	0	0	0	0	(364,103)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	29,026	0	0	0	0	0	0	0	0	0	29,026	19
20	Fees, Subscriptions & Promotions	(837)	0	0	0	0	0	0	0	0	0	0	(837)	20
21	Clerical & General Office Expenses	(10,987)	202,000	0	0	0	0	0	0	0	0	0	191,013	21
22	Employee Benefits & Payroll Taxes	0	40,247	0	0	0	0	0	0	0	0	0	40,247	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,241)	19,038	0	0	0	0	0	0	0	0	0	16,796	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	466	0	0	0	0	0	0	0	0	0	466	26
27	Other (specify):*	(79,405)	0	0	0	0	0	0	0	0	0	0	(79,405)	27
28	**TOTAL General Administration**	(93,470)	(73,326)	0	0	0	0	0	0	0	0	0	(166,796)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(93,470)	(70,887)	0	0	0	0	0	0	0	0	0	(164,357)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	17,013	0	0	0	0	0	0	0	0	0	17,013	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	17,013	0	0	0	0	0	0	0	0	0	17,013	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	14,441	0	0	0	0	0	0	0	0	0	14,441	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):*	(97,544)	5,530	0	0	0	0	0	0	0	0	0	(92,014)	43
44	**TOTAL Special Cost Centers**	(97,544)	19,971	0	0	0	0	0	0	0	0	0	(77,573)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(191,014)	(33,903)	0	0	0	0	0	0	0	0	0	(224,917)	45

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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. ☐ 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 Horizons	100.00%	$ 795	$ 795	1
2	V	6	Maintenance				1,644	1,644	2
3	V	17	Administrative	411,496			47,393	(364,103)	3
4	V	19	Professional Services				29,026	29,026	4
5	V	21	Clerical				181,130	181,130	5
6	V	22	Employee Benefits				40,247	40,247	6
7	V	21	Dues & Subscriptions				4,732	4,732	7
8	V	24	Travel and Seminars				19,038	19,038	8
9	V	26	Insurance				466	466	9
10	V	30	Depreciation				17,013	17,013	10
11	V	21	Other Administrative Expense				16,138	16,138	11
12	V	43	Independent Living				5,530	5,530	12
13	V	39	Pharmacy Services	136,212			150,653	14,441	13
14	Total			$ 547,708			$ 513,805	$ * (33,903)	14

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

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$ 3,381,662	7/01/2037	4.0500	$ 117,337	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Offset										(7,070)	6
7												7
8												8
9	TOTAL Facility Related				$30,948.00		$ 4,072,900	$ 3,381,662			$ 110,267	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	$ 3,381,662			$ 110,267	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 12,892 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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village, LLC 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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			3,601	2
3	TOTALS	34,909		$ 45,368	3

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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				32,300	1,127		1,127		26,479	8
	Improvement Type**										
9	1992 Fixed Assets			10/13/1992	59,471		Various				9
10	1993 Fixed Assets			12/31/1993	536		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	2002 Fixed Assets			12/31/2002	4,734		Various				15
16	2003 Fixed Assets			12/31/2003	5,476		Various				16
17	2004 Fixed Assets			12/31/2004	20,398		Various				17
18	2005 Fixed Assets			12/31/2005	23,620		Various				18
19	2007 Fixed Assets			12/31/2007	85,108		Various				19
20	2008 Fixed Assets			12/31/2008	6,243		Various				20
21	Parking lot			6/30/2009	13,895		10				21
22	Sprinkler System			12/12/2009	150,125		10				22
23	Compressor for Walkin Cooler			12/30/2009	3,745		10				23
24	Door Alarm System			4/1/2010	35,520		10				24
25	Dock Door w/Lock & handle			10/21/2010	5,402		10				25
26	Fire Alarm System			1/31/2011	65,344		10				26
27	89 gal water heater			1/31/2011	12,834		10				27
28	PTAC Units			1/31/2011	6,733		10				28
29	Refurb Activity & Therapy Room			1/31/2011	3,474		10				29
30	Paint Main Hall			5/31/2011	38,671		10				30
31	Main Hall - Flooring			6/30/2011	87,059		10				31
32	Flooring - Service Hallway Tekno			8/21/2011	5,490		10				32
33	PTAC Digismart, 15,000 BTU 30am			7/12/2011	2,113		10				33
34	Vinyl Flooring & Covebase Rm 115			10/25/2011	2,462		10				34
35	A/C Condensor			7/11/2012	2,375		15				35
36	90 gal water Heater			4/10/2013	6,250		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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	East Wing Shower	4/10/2013	$ 917	$	20	$	$	$	37
38	Rm 106 Toilet	4/10/2013	700		20				38
39	R&R Sliding Door	6/24/2013	7,398		10				39
40	R&R South Sliding Door	6/24/2013	8,802		10				40
41	Hall 2 - R&R Vinyl Floor & Covebase	5/1/2013	49,870		10				41
42	Unit #7 AC System	9/11/2013	3,883		10				42
43	Furnace	5/17/2014	3,294		15				43
44	Paint Resient & Bath Walls	4/24/2014	3,833		5				44
45	Install AC Unit in Laundry Room	6/23/2014	2,382		10				45
46	Paint All Resient Rooms Walls Only	4/24/2014	7,667		5				46
47	Install Leonard Mixing Valve	6/5/2014	3,485		10				47
48	Remodel Flooring Hall 1 & 3	10/31/2013	54,720		10				48
49	Storage Shed	6/1/2007	19,054		20				49
50	Tile Flooring 3 bathing rooms	7/1/2008	2,351		5				50
51	Land Improvement by Thomas Lawn Care	9/30/2009	22,690		10				51
52	Duplex #105 ADA Shower	11/10/2015	2,993		10				52
53	10 Bronze 31.5" Wide Chandeliers	8/28/2015	3,000		10				53
54	Replacement Glass For Windows	7/10/2015	3,889		10				54
55	18x21 Brown Carport	9/8/2015	1,587		10				55
56	Display Illuminated custom Sign 6x14	9/8/2015	21,947		10				56
57	Parking Lot 18x64 & 23x77	9/8/2015	12,226		10				57
58	Dining Room Drapes & Rods 115 x 93	6/27/2016	1,134		10				58
59	Unit 106 Shower/Drywall	7/17/2016	454		10				59
60	125kw Cummins Onan Generator	9/7/2016	32,331		10				60
61	New Commercial Furnace #6 Upstairs	3/31/2017	6,439		10				61
62	Resident Room Privacy Curtains (60)	8/1/2017	11,784		7				62
63	Flooring Conference Admin office	11/17/2017	2,246		10				63
64									64
65									65
66									66
67									67
68	Home Office Allocation		2,748	99		99		2,319	68
69	Other Building & Building Improvements Depreciation Exp.			144,277		144,277		2,428,144	69
70	TOTAL (lines 4 thru 69)		$ 3,702,553	$ 145,503		$ 145,503	$	$ 2,456,942	70

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

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$ 605,574	$ 78,519	$ 78,519	$	Various	$ 465,474	71
72	Current Year Purchases	16,878	2,568	2,568		Various	2,568	72
73	Fully Depreciated Assets	297,198	161	161		Various	297,198	73
74	Home Office Allocation	91,922	14,930	14,930			68,440	74
75	TOTALS	$ 1,011,572	$ 96,178	$ 96,178	$		$ 833,680	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	$ 23,621	$ 23,621	$	Various	$ 138,730	76
77										77
78										78
79	Home Office Allocation			5,172	2,876	2,876			4,690	79
80	TOTALS			$ 159,976	$ 26,497	$ 26,497	$		$ 143,421	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)	$ 4,919,468	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 268,177	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 268,177	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)	$ 3,434,043	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	794,513	23,012	530,653	87
88					88
89					89
90					90
91	TOTALS	$ 836,280	$ 23,012	$ 530,653	91

G. Construction-in-Progress

	Description	Cost	
92	Home Office Allocation	$ 20,562	92
93	CIP	36,037	93
94			94
95		$ 56,599	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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 24,496 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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	hrs	$	2,619	$ 130,497	$	2,619	$ 130,497	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,813	59,600		1,813	59,600	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		4,712	161,647		4,712	161,647	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				137,343		137,343	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					12,569		12,569	12
13	Other (specify): BILLABLE SUPPLIES	V39					29,600		29,600	13
14	TOTAL			$	9,143	$ 351,744	$ 179,512	9,143	$ 531,256	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, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2018 (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	$ 758,171	$	1
2	Cash-Patient Deposits	6,872		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,833)	548,974		3
4	Supply Inventory (priced at)	12,593		4
5	Short-Term Investments	143,984		5
6	Prepaid Insurance	42,124		6
7	Other Prepaid Expenses	18,763		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int Receivable	7,623		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,539,104	$	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	4,466,746		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,069,725		16
17	Accumulated Depreciation (book methods)	(3,862,768)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	741,527		21
22	Other Long-Term Assets (spe CIP	36,037		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,534,801	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,073,905	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 149,951	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,872		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,102		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Acc Liab/Def Financing Cost	(21,781)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 320,144	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,381,662		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,381,662	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,701,806	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 372,099	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,073,905	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 222,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 222,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	235,480	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) **Transfer to Related Party**	(93,970)	15
16	Other (describe) **Restricted Contribution Activity**	7,810	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 149,320	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	0	18
19	**Rounding**	2	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 372,099	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	$ 5,071,795	1
2	Discounts and Allowances for all Levels	(2,624,482)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,447,313	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,321,369	6
7	Oxygen	8,511	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,329,880	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	248,705	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,372	19
20	Radiology and X-Ray	9,202	20
21	Other Medical Services	58,351	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 332,630	23
	D. Non-Operating Revenue		
24	Contributions	58,801	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,801	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	76,465	28
28a	Misc Revenue	1,369	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,834	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,246,458	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	689,264	31
32	Health Care	2,200,423	32
33	General Administration	1,309,337	33
	B. Capital Expense		
34	Ownership	380,456	34
	C. Ancillary Expense		
35	Special Cost Centers	279,275	35
36	Provider Participation Fee	152,223	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,010,978	40
41	**Income before Income Taxes (line 30 minus line 40)****	235,480	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 235,480	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,178,573	44
45	Private Pay - Net Inpatient Revenue	2,031,125	45
46	Medicare - Net Inpatient Revenue	(356,047)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(76,141)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(330,197)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,447,313	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	1,872	2,334	$ 81,199	$ 34.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,464	13,494	379,111	28.09	3
4	Licensed Practical Nurses	17,273	19,342	396,047	20.48	4
5	CNAs & Orderlies	51,980	56,091	648,994	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,915	2,020	27,866	13.80	9
10	Activity Assistants	2,318	2,365	23,647	10.00	10
11	Social Service Workers	6,929	7,409	114,867	15.50	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,163	34,410	15.91	13
14	Head Cook	3,833	3,961	41,099	10.38	14
15	Cook Helpers/Assistants	7,332	7,510	79,637	10.60	15
16	Dishwashers					16
17	Maintenance Workers	4,415	4,564	74,113	16.24	17
18	Housekeepers	7,108	7,343	78,132	10.64	18
19	Laundry	3,382	3,490	42,310	12.12	19
20	Administrator	1,882	2,060	98,375	47.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,786	1,962	37,964	19.35	23
24	Clerical	1,944	2,079	62,239	29.94	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	1,599	1,684	25,084	14.90	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/IL	3,265	3,456	51,028	14.77	33
34	TOTAL (lines 1 - 33)	132,204	143,327	$ 2,296,122 *	$ 16.02	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	174	$ 9,261	V01-3	35
36	Medical Director	182	14,400	V09-3	36
37	Medical Records Consultant	32	2,230	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	364	1,899	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	37	2,529	V11-3	44
45	Social Service Consultant	39	2,528	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	828	$ 32,847		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	$ 98,375
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,375

B. Administrative - Other

Description	Amount
Management Fee	$ 405,230
TOTAL (agree to Schedule V, line 17, col. 3)	$ 405,230
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Plate Moran PLLC	Accounting	$ 10,750
National Research	Consulting	1,479
Davis & Campbell	Legal	7,918
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,146

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,311
Unemployment Compensation Insurance	(2,698)
FICA Taxes	169,844
Employee Health Insurance	178,187
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	8,465
Employee Expense	25,596
457 Plan Expense	8,483
Employee Uniforms	680
TOTAL (agree to Schedule V, line 22, col.8)	$ 483,116

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)	
Patient Background Checks	
License	2,632
Dues	14,120
Subscriptions	16,323
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,075

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,781
In-State Travel	1,386
Seminar Expense	1,269
Non Allowable Marketing Offset	(2,994)
Home Office Allocation	19,038
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,479

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Christian Village, LLC # 0048751 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 - $6,563.60**

(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. $ **17,131** 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. $ **152,223**
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