FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0048744

Facility Name: Shawnee Christian Nursing Center

Address: 1901 North 13th Street (Number) Herrin (City) 62948 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** 618-942-3369

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1980

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2009 to June 30, 2010 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) Tim Phillippe
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Allan B. Larson, CPA, Principal
(Firm Name & Address) LarsonAllen LLP, 600 Washington, Suite 1800 St. Louis, MO 63101
(Telephone) 314-925-4379 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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 _____

	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	159	Skilled (SNF)	159	58,035	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	159	TOTALS	159	58,035	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	26,460	8,447	10,796	45,703	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,460	8,447	10,796	45,703	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.75%

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)
None

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 9/1/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 159 and days of care provided 10,408

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: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	316,842	15,169	14,604	346,615		346,615		346,615			1
2	Food Purchase		258,991		258,991		258,991	(1,184)	257,807			2
3	Housekeeping	158,988	26,407		185,395		185,395		185,395			3
4	Laundry	108,162	5,310		113,472		113,472		113,472			4
5	Heat and Other Utilities			205,844	205,844		205,844	5,092	210,936			5
6	Maintenance	157,027	17,216	14,630	188,873		188,873	4,637	193,510			6
7	Other (specify):* Trash			5,461	5,461		5,461		5,461			7
8	TOTAL General Services	741,019	323,093	240,539	1,304,651		1,304,651	8,545	1,313,196			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,644,675	538,454	17,980	3,201,109	(331,552)	2,869,557		2,869,557			10
10a	Therapy			1,044,348	1,044,348		1,044,348		1,044,348			10a
11	Activities	101,523	40		101,563		101,563		101,563			11
12	Social Services	124,770	3,286	5,544	133,600		133,600	(1,111)	132,489			12
13	CNA Training											13
14	Program Transportation			4,021	4,021		4,021		4,021			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,870,968	541,780	1,095,893	4,508,641	(331,552)	4,177,089	(1,111)	4,175,978			16
	C. General Administration											
17	Administrative	114,118	577	526,315	641,010		641,010	(448,613)	192,397			17
18	Directors Fees											18
19	Professional Services			67,181	67,181		67,181	36,196	103,377			19
20	Dues, Fees, Subscriptions & Promotions			17,749	17,749		17,749		17,749			20
21	Clerical & General Office Expenses	126,951	12,798	197,139	336,888		336,888	198,505	535,393			21
22	Employee Benefits & Payroll Taxes			704,765	704,765		704,765	34,890	739,655			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,931	23,931		23,931	17,029	40,960			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			114,942	114,942		114,942	1,377	116,319			26
27	Other (specify):* Marketing	62,515	3,744	10,468	76,727		76,727	(76,727)				27
28	TOTAL General Administration	303,584	17,119	1,662,490	1,983,193		1,983,193	(237,343)	1,745,850			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,915,571	881,992	2,998,922	7,796,485	(331,552)	7,464,933	(229,909)	7,235,024			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 Shawnee Christian Nursing Center #0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			228,625	228,625		228,625	22,842	251,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			405,778	405,778		405,778	(16,565)	389,213			32
33	Real Estate Taxes			368	368		368		368			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,956	18,956		18,956		18,956			35
36	Other (specify):* Def Fin Costs, FIN 47 Accretion			10,436	10,436		10,436		10,436			36
37	TOTAL Ownership			664,163	664,163		664,163	6,277	670,440			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			107,508	107,508	331,552	439,060		439,060			39
40	Barber and Beauty Shops	14,996	1,096		16,092		16,092		16,092			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,053	87,053		87,053		87,053			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	14,996	1,096	194,561	210,653	331,552	542,205		542,205			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,930,567	883,088	3,857,646	8,671,301		8,671,301	(223,632)	8,447,669			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 Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	(2,129)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,742)	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	(25,051)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,767)	21		24
25	Fund Raising, Advertising and Promotional	(76,727)	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	(311)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,727)		$	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)	(111,905)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (111,905)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (223,632)		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	X		331,552	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 331,552		47

Shawnee Christian Nursing Center

ID# 0048744

Report Period Beginning: July 1, 2009

Ending: June 30, 2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 945	2	1
2	Activity	(1,111)	12	2
3	Late Fees, Finances Charges	(145)	21	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
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**	(311)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,184)	0	0	0	0	0	0	0	0	0	0	(1,184)	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	(3,742)	8,834	0	0	0	0	0	0	0	0	0	5,092	5
6	Maintenance	0	4,637	0	0	0	0	0	0	0	0	0	4,637	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,926)	13,471	0	0	0	0	0	0	0	0	0	8,545	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	(1,111)	0	0	0	0	0	0	0	0	0	0	(1,111)	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**	(1,111)	0	0	0	0	0	0	0	0	0	0	(1,111)	16
	C. General Administration													
17	Administrative	0	(448,613)	0	0	0	0	0	0	0	0	0	(448,613)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	36,196	0	0	0	0	0	0	0	0	0	36,196	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,912)	202,417	0	0	0	0	0	0	0	0	0	198,505	21
22	Employee Benefits & Payroll Taxes	0	34,890	0	0	0	0	0	0	0	0	0	34,890	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,029	0	0	0	0	0	0	0	0	0	17,029	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	1,377	0	0	0	0	0	0	0	0	0	1,377	26
27	Other (specify):*	(76,727)	0	0	0	0	0	0	0	0	0	0	(76,727)	27
28	**TOTAL General Administration**	(80,639)	(156,704)	0	0	0	0	0	0	0	0	0	(237,343)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(86,676)	(143,233)	0	0	0	0	0	0	0	0	0	(229,909)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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	22,842	0	0	0	0	0	0	0	0	0	22,842	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,051)	8,486	0	0	0	0	0	0	0	0	0	(16,565)	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**	(25,051)	31,328	0	0	0	0	0	0	0	0	0	6,277	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	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,727)	(111,905)	0	0	0	0	0	0	0	0	0	(223,632)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing of Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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. dba: Christian Homes, Inc.	100.00%	$ 8,834	$ 8,834	1
2	V	6	Maintenance				4,637	4,637	2
3	V	17	Administration	526,315			77,702	(448,613)	3
4	V	19	Professional Services				36,196	36,196	4
5	V	21	Clerical				202,417	202,417	5
6	V	22	Employee Benefits				34,890	34,890	6
7	V	24	Travel and Seminar				17,029	17,029	7
8	V	26	Insurance				1,377	1,377	8
9	V	30	Depreciation				22,842	22,842	9
10	V	32	Interest				8,486	8,486	10
11	V								11
12	V								12
13	V								13
14	Total			$ 526,315			$ 414,410	$ * (111,905)	14

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: ne 30, 2010

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 not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	HUD Sect. 232 Ins. Mortgage		X	Refinance Old Debt	$10,860.00	8/1/07	$ 6,634,900	$ 6,263,539	8/1/32	0.0588	$ 405,778	1
2	Baytree Leasing Company		X	Lease Satellite TV System	$455.00	9/29/08	19,930	12,833	10/1/13	N/A		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$11,315.00		$ 6,654,830	$ 6,276,372			$ 405,778	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,654,830	$ 6,276,372			$ 405,778	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 31,683 **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 Shawnee Christian Nursing Center **#** 0048744 **Report Period Beginning:** July 1, 2009 **Ending:** June 30, 2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Center COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0048744

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

TELEPHONE 217-732-5175 FAX #: 217-732-8686

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	Williams 1st SOL	$ 330.16	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 330.16	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,600 B. General Construction Type: Exterior Brick Frame Steel 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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			6,324	2
3	TOTALS	180,000		$ 77,495	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 44,338	$	$ 1,322,757	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				65,226	4,846		4,846		130,031	8
	Improvement Type**										
9	Storage Building			1981	6,510		20			6,510	9
10	Hearing & A/C System			1982	37,091		20			37,091	10
11											11
12											12
13	Building Improvements			1982	159,808	4,098	39	4,098		115,417	13
14	Building Improvements			1983	22,362	588	38	588		15,937	14
15	Smoke Alarm			1984	650		20			650	15
16	Building Improvements			1985	44,866	1,122	40	1,122		27,761	16
17	Windows			1985	39,252	981	40	981		24,287	17
18	Ceiling Tile			1985	4,232		20			4,232	18
19	Light Fixtures			1985	777		10			777	19
20	Ceiling Tile			1986	1,874		20			1,874	20
21	Duct Work			1986	1,600		20			1,600	21
22	Building Improvements			1986	4,103		10			4,103	22
23	Wiring			1987	891		20			891	23
24	Dining & Adminstration Wing			1987	688,723	17,639	40	17,639		399,123	24
25	Remodeling			1987	705		20			705	25
26	Ceiling Duct			1987	510		20			510	26
27	Duct Work			1987	635		20			635	27
28	Remodeling			1988	552		20			552	28
29	Electrical Supply			1988	373		20			373	29
30	Air Cleaner & Duct			1988	1,694		10			1,694	30
31	Mirror			1988	1,562		10			1,562	31
32	HVAC System			1988	4,675		20			4,675	32
33	Windows			1988	705	20	35	20		445	33
34	Baseboard			1988	739		20			739	34
35	Heat Pumps			1988	27,223		20			27,223	35
36	Floor Tile			1988	340		5			340	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 Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Duct Work	1988	$ 22,066	$ 184	20	$ 184	$	$ 22,066	37
38	Towel & Soap Dispenser	1988	1,976		10			1,976	38
39	Title Policy	1988	3,740	94	40	94		2,041	39
40	Hampton Settlement	1988	74,000	1,850	40	1,850		40,392	40
41	Wall Heat Pump	1989	1,300		10			1,300	41
42	Flourescent Light	1989	673		10			673	42
43	A/C Electrical Work	1989	6,950		8			6,950	43
44	Heat Pumps/Duct System	1989	39,940		20			39,940	44
45	Down Spouts	1989	600		15			600	45
46	Laundry Room Roof	1989	2,200		15			2,200	46
47	Heat Pumps	1989	63,466	1,587	20	1,587		63,466	47
48	Wander Guard (Current Year Disposal)	1989		285	20	285			48
49	Air Conditioning	1989	5,820		8			5,820	49
50	Ceiling Tile	1989	1,868		10			1,868	50
51	Trimming (1200")	1990	840		5			840	51
52	Remodel Rooms	1990	2,446	61	20	61		2,446	52
53	Baseboard (120')	1990	706		5			706	53
54	Shelving	1990	851		5			851	54
55	Floor Tile	1990	426		5			426	55
56	Water Heater	1990	386		15			386	56
57	Smoke Detectors	1990	890		5			890	57
58	Door & Hardware	1990	541		5			541	58
59	Wallpaper	1990	919		5			919	59
60	Relocate Sprinklers	1990	583		10			583	60
61	Brick A/C Holes	1990	1,352	34	40	34		682	61
62	Door Frames	1990	303		5			303	62
63	Paint & Wallpaper	1990	1,118		5			1,118	63
64	Heating Receivers (11)	1990	1,975		15			1,975	64
65	Kickplates	1990	763		10			763	65
66	Air Conditioner	1990	1,184		8			1,184	66
67	Door Alarm	1990	423		5			423	67
68	Doors & Lock	1990	35,817	1,791	20	1,791		35,668	68
69	Lights (13)	1990	590		10			590	69
70	TOTAL (lines 4 thru 69)		$ 3,167,919	$ 79,518		$ 79,518	$	$ 2,373,080	70

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		$ 3,167,919	$ 79,518		$ 79,518	$	$ 2,373,080	1
2	Door Kickplates (118)	1990	2,104		10			2,104	2
3	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		6,786	3
4	Remodeling	1991	2,733	137	20	137		2,665	4
5	Door Locks	1991	510	26	20	26		498	5
6	Floor Tile Install	1991	10,926		5			10,926	6
7	Cove Base	1991	1,763		10			1,763	7
8	Handrail, Drywall	1991	569		5			569	8
9	Exit Fixtures	1991	1,619		10			1,619	9
10	A/C Units (2)	1991	15,885		10			15,885	10
11	Wallcoverings	1991	483		5			483	11
12	Heat Pump	1991	5,267		15			5,267	12
13	Walk-in Freezer	1991	8,643		15			8,643	13
14	Water Heater	1991	867		10			867	14
15	Hall Lights	1992	2,091		10			2,091	15
16	Water Heaters	1992	3,164		15			3,164	16
17	Heat Pump	1992	653		15			653	17
18	Heat Pump	1992	7,265		15			7,265	18
19	4' Loop System	1992	3,723		10			3,723	19
20	Building Lighting	1992	1,142		10			1,142	20
21	Metal Door Frames	1992	840	42	20	42		753	21
22	Garbage Disposals/Folding Door Divider	1994	1,161		5			1,161	22
23									23
24	Building Remodeling	1993	6,103	305	20	305		5,213	24
25	Honeywell System	1993	5,031	252	20	252		4,297	25
26	Sink & Doors	1994	3,381		10			3,381	26
27	Storage Room Remodel	1994	2,020	101	20	101		1,667	27
28	Sewage Pump System	1994	4,256		10			4,256	28
29	Fire/Garage Door	1994	526		5			526	29
30	Handrails	1995	6,079		10			6,079	30
31	Remodeling (Side 1)	1995	7,992		5			7,992	31
32	Cabinets	1995	2,343	143	15	143		2,343	32
33	Therapy/Bath	1996	181,372	7,557	24	7,557		107,060	33
34	TOTAL (lines 1 thru 33)		$ 3,465,360	$ 88,428		$ 88,428	$	$ 2,593,921	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12B, Carried Forward		$ 3,465,360	$ 88,428		$ 88,428	$	$ 2,593,921	1
2	Fire Alarm System Relay	1996	2,596		10			2,596	2
3									3
4	Water Fountain	1997	502		5			502	4
5	Compressor	1997	973		3			973	5
6	Compressor Unit 1516	1997	2,377		3			2,377	6
7	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		28,943	7
8									8
9	Kitchen Heaters	1998	793		3			793	9
10	Compressor/Library #24	1999	2,972		3			2,972	10
11	Keyless locks	1999	1,423		5			1,423	11
12	Wallpaper dining room	1999	3,071		5			3,071	12
13	120 gal water heater	1999	3,000		10			3,000	13
14									14
15	Compressor	2000	1,133		3			1,133	15
16	Security control system	2000	940	31	10	31		940	16
17	Remodel admin office/wiring	2000	1,147		5			1,147	17
18	Rooftop cond unit	2000	3,373	309	10	309		3,373	18
19	4 ton A/C	2000	2,590		5			2,590	19
20	4 ton hest pumps	2000	4,780	438	10	438		4,780	20
21	4 Ton Heat Pumps	2000	2,692	269	10	269		2,647	21
22	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		2,159	22
23	Remodel Rooms 9-17	2001	2,657	266	10	266		2,524	23
24	Install Grease Trap	2001	886		5			886	24
25	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		534	25
26	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		7,120	26
27	Door Control System	1/1/2001	12,860	1,286	10	1,286		10,931	27
28	Countertop Nursing Station Side 1 (Current Year Disposal)	1/1/2002		46	15	46			28
29	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685		4			3,685	29
30	Install Dishwasher	5/24/2002	1,100	110	10	110		898	30
31	Countertop Nursing Station Side 2 (Current Year Disposal)	3/22/2002		46	15	46			31
32	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		1,831	32
33	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		1,813	33
34	TOTAL (lines 1 thru 33)		$ 3,575,110	$ 95,354		$ 95,354	$	$ 2,689,562	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12C, Carried Forward		$ 3,575,110	$ 95,354		$ 95,354	$	$ 2,689,562	1
2	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		604	2
3	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		7,000	3
4	Replacement Compressor in kitchen AC	8/31/2002	875		3			875	4
5	30 Position Nurse Call Station w Desig (Current Year Disposal)	10/2/2002		101	10	101			5
6	(10) Panic Bars/(41)Door Knobs	12/9/2002	746		5			746	6
7	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		1,756	7
8	(12) Wall Signs w/Letters	2/27/2003	789		5			789	8
9	Nurse Call Light System Side 1 (Current Year Disposal)	8/1/2003		89	10	89			9
10	New Roof - Side 1	8/4/2003	52,263	3,484	15	3,484		23,518	10
11					3				11
12	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571		5			571	12
13									13
14	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	1,896	10	1,896		12,009	14
15	Service Sink w/double pedal valves	6/3/2004	1,189	119	10	119		723	15
16	Heat Pump	6/16/2004	4,800	480	10	480		2,920	16
17									17
18	Cable for Resident Phone Lines	3/18/2005	1,460	195	5	195		1,460	18
19	Dining Room Remodeling	3/1/2005	3,493	466	5	466		3,493	19
20	Resident Rooms Lighting	3/31/2005	1,793	239	5	239		1,793	20
21									21
22	Carport	9/22/2000	1,363	136	10	136		1,340	22
23	Bus barn	3/1/2003	8,752	219	40	219		1,605	23
24	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	24
25	Parking lot and sewer	2/29/1988	4,658		20			4,658	25
26	Courtyard walks and projects	9/30/1989	18,906	85	20	85		18,906	26
27									27
28	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	942	20	942		17,789	28
29	Drainage, lanscaping & Gazebo	8/14/1991	12,452	41	20	41		12,406	29
30	100' Fence	12/5/1991	1,380		15			1,380	30
31	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		12,498	31
32	Sidewalk & Fence	8/30/1996	3,247		10			3,247	32
33	Enlarge parking	9/3/2002	2,386	119	20	119		934	33
34	TOTAL (lines 1 thru 33)		$ 3,822,366	$ 105,834		$ 105,834	$	$ 2,885,019	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12D, Carried Forward		$ 3,822,366	$ 105,834		$ 105,834	$	$ 2,885,019	1
2	Drainage culvert	3/28/2003	1,419	79	18	79		578	2
3	Dumpster fence	6/24/2003	769	77	10	77		545	3
4	Mini Blinds and Draperies	6/30/2006	3,348	670	5	670		2,734	4
5	Toilets and Tanks (4)	6/2/2006	716	72	10	72		293	5
6	New A/C and Heat Unit	6/30/2006	6,290	629	10	629		2,568	6
7	8 Alabaster Mini Blinds	3/29/2006	672	134	5	134		582	7
8	Water Heater	4/17/2006	4,174	417	10	417		1,774	8
9	A/C Unit Hallway	4/5/2006	6,820	682	10	682		2,899	9
10	Install New Nurse Call Light System (Current Year Disposal	4/20/2006		145	10	145			10
11	5 Toilets	1/13/2006	872	44	20	44		197	11
12	39" X 59" Cordless Mark I (6)	2/1/2006	648	130	5	130		573	12
13	39" X 59" Cordless Mark I (6)	2/23/2006	648	130	5	130		573	13
14	New Grease Trap	3/1/2006	7,750	775	10	775		3,358	14
15	New Roof	7/28/2006	25,044	1,670	15	1,670		8,348	15
16	39" X 59" Cordless Roller Mini (7)	10/13/2005	613	123	5	123		583	16
17	New Flooring - Kitchen	3/31/2006	1,995	200	10	200		865	17
18	Landscaping Materials	6/29/2006	1,030	103	10	103		421	18
19	3 Sidewalks	8/10/2005	3,344	334	10	334		1,644	19
20	Side 1 Shower room remodel	7/1/2006	4,756	476	10	476		1,903	20
21									21
22	Remodel Side 4 shower room	7/1/2006	3,331	333	10	333		1,332	22
23									23
24									24
25	Bryant 3 phase 35,000 BTU electric heat pump	5/8/2007	7,100	1,420	5	1,420		4,497	25
26	Reroof Maintenance Shop	10/3/2007	11,392	1,139	10	1,139		3,133	26
27	19 Resident Room Exhaust Fans	10/1/2007	1,790	179	10	179		492	27
28									28
29	Repour Portion of Front Parking Lot	11/27/2007	3,400	680	5	680		1,813	29
30	Asphalt back Parking Lot	6/11/2008	35,790	3,579	10	3,579		7,456	30
31	Stone work and paving of back parking lot	12/7/2007	10,277	2,055	5	2,055		5,309	31
32	Wallpaper - Side 1 Renovation	9/19/2008	3,992	399	10	399		732	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,970,346	$ 122,508		$ 122,508	$	$ 2,940,221	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12E, Carried Forward		$ 3,970,346	$ 122,508		$ 122,508	$	$ 2,940,221	1
2									2
3	Sprinkler head replacement	3/11/2009	7,174	717	10	717		957	3
4	Condensing fan and blower	6/4/2009	618	124	5	124		134	4
5	24 ton heat pump	6/8/2009	9,377	938	10	938		1,016	5
6	Accumulator - Side 4 dining room	6/24/2009	547	109	5	109		119	6
7	Therapy gym remodeling project	6/30/2009	369,504	18,475	20	18,475		20,015	7
8	Satellite TV system	10/31/2008	19,930	1,993	10	1,993		3,483	8
9	100 gallon fuel tank - above ground	6/27/2009	10,857	542	20	542		587	9
10	Floor tile for reclaim bath	11/9/2009	559	37	10	37		37	10
11	Flooring - Dining room	8/31/2009	33,070	3,031	10	3,031		3,031	11
12	Call Light System	7/31/2009	47,969	4,797	10	4,797		4,797	12
13	Roof Replacement - Dining room	6/23/2010	11,582	97	10	97		97	13
14	122 Ft Privacy Fence	6/10/2010	1,800	15	10	15		15	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	TOTAL (lines 1 thru 33)		$ 4,483,332	$ 153,383		$ 153,383	$	$ 2,974,509	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 321,943	$ 47,133	$ 47,133	$	Various	$ 142,479	71
72	Current Year Purchases	209,720	17,098	17,098		Various	17,098	72
73	Fully Depreciated Assets	357,421	2,179	2,179		Various	357,421	73
74	Home Office Allocation	209,109	15,535	15,535			31,817	74
75	TOTALS	$ 1,098,193	$ 81,945	$ 81,945	$		$ 548,815	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	$ 14,250	$	$	$	8	$ 14,250	76
77	Patient Transportation	2006 Ford Starcraft	2006	46,350	5,794	5,794		8	24,141	77
78										78
79	Home Office Allocation			33,133	2,461	2,461			11,700	79
80	TOTALS			$ 93,733	$ 8,255	$ 8,255	$		$ 50,091	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)	$ 5,752,753	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,583	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,583	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)	$ 3,573,415	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	Land	$ 10,800	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 10,800	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 47,271	92
93	Home Office Allocation	47,817	93
94			94
95		$ 95,088	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 Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			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. N/A
   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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 18,956 Description: See attached schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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.

   Only certified students were hired

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	6,213	$ 416,266	$	6,213	$ 416,266	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,577	214,856		2,577	214,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,269	413,226		6,269	413,226	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			$	15,059	$ 1,044,348	$	15,059	$ 1,044,348	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 Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2010 (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	$ 1,525,347	$	1
2	Cash-Patient Deposits	25,119		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 17,681)	940,540		3
4	Supply Inventory (priced at)	11,739		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,210		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int Rec	762		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,519,717	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	4,401,360		14
15	Leasehold Improvements, at Historical Cost	206,649		15
16	Equipment, at Historical Cost	949,684		16
17	Accumulated Depreciation (book methods)	(3,531,505)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	622,975		21
22	Other Long-Term Assets (spe CIP	47,271		22
23	Other(specify): Deferred Financing Costs	215,806		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,994,211	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,513,928	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,806	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,119		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	375,867		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	172		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bonuses, FIN 47, and other liabili	227,830		36
37	Due to Auxiliary	2,629		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 829,423	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,833		39
40	Mortgage Payable	6,263,539		40
41	Bonds Payable			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)**	$ 6,276,372	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,105,795	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,591,867)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,513,928	$	48

*(See instructions.)

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,080,303)	1
2	Restatements (describe):		2
3	Rounding Difference	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,080,306)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	488,439	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)**	$ 488,439	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,591,867)	24 *

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,151,135	1
2	Discounts and Allowances for all Levels	(1,451,438)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,699,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,201,981	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,201,981	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,460	13
14	Non-Patient Meals	2,129	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,686	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,463	19
20	Radiology and X-Ray	55,850	20
21	Other Medical Services	11,852	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 180,440	23
	D. Non-Operating Revenue		
24	Contributions	31,179	24
25	Interest and Other Investment Income***	27,711	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,890	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous/Unrealized Gain(Loss) on Investments	18,732	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,732	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,159,740	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,304,651	31
32	Health Care	4,508,641	32
33	General Administration	1,983,193	33
	B. Capital Expense		
34	Ownership	664,163	34
	C. Ancillary Expense		
35	Special Cost Centers	123,600	35
36	Provider Participation Fee	87,053	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,671,301	40
41	**Income before Income Taxes (line 30 minus line 40)****	488,439	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 488,439	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

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	3,534	3,534	$ 136,200	$ 38.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,848	13,112	352,126	26.86	3
4	Licensed Practical Nurses	40,339	43,940	700,190	15.94	4
5	CNAs & Orderlies	105,492	115,336	1,145,153	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,497	3,497	42,558	12.17	8
9	Activity Director	1,656	1,656	16,925	10.22	9
10	Activity Assistants	7,359	7,359	70,946	9.64	10
11	Social Service Workers	6,078	7,488	101,227	13.52	11
12	Dietician					12
13	Food Service Supervisor	2,104	2,104	36,437	17.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,417	30,293	280,406	9.26	15
16	Dishwashers					16
17	Maintenance Workers	9,548	10,136	157,027	15.49	17
18	Housekeepers	16,759	17,772	158,988	8.95	18
19	Laundry	10,236	10,985	108,162	9.85	19
20	Administrator	1,675	1,675	114,118	68.13	20
21	Assistant Administrator					21
22	Other Administrative	322	322	11,102	34.48	22
23	Office Manager	1,973	1,973	38,778	19.65	23
24	Clerical	5,439	6,134	68,898	11.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,964	1,964	29,204	14.87	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Ward Clerk, Direc	15,099	15,099	268,445	17.78	32
33	Other(specify) Comm. Liaison, V	3,621	3,743	93,677	25.03	33
34	TOTAL (lines 1 - 33)	276,960	298,122	$ 3,930,567 *	$ 13.18	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	299	$ 14,604	ln 1, col 3	35
36	Medical Director	120	24,000	ln 9, col 3	36
37	Medical Records Consultant	32	1,804	ln 10, col 3	37
38	Nurse Consultant	30	5,803	ln 10, col 3	38
39	Pharmacist Consultant	168	4,358	ln 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	93	5,544	ln 12, col 3	45
46	Other(specify) Administrator	393	19,134	ln 21, col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,134	$ 75,247		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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Neal	Administrator	0	$ 114,118
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,118

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 526,315
TOTAL (agree to Schedule V, line 17, col. 3)	$ 526,315
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LarsonAllen	Accounting	$ 16,995
My Inner View	Consulting	1,672
Asaturian Eaton & Associates	Consulting	4,120
Husch Blackwell Sanders	Legal	42,979
Davis & Campbell	Legal	1,415
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 67,181

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,356
Unemployment Compensation Insurance	39,764
FICA Taxes	285,107
Employee Health Insurance	262,031
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	6,630
Employee Expense	16,118
Employee Uniforms	759
Home Office Allocation	34,890
TOTAL (agree to Schedule V, line 22, col.8)	$ 739,655

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,906
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License	1,050
Dues	8,845
Subscriptions	900
Other	48
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,749

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18,507
Seminar Expense	5,424
Home Office Allocation	17,029
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 40,960

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This workpaper is not applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2009 Ending: June 30, 201

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. **Life Services Network - $8,923**

(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?

(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?

(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. $ **28,657** Line **10-2**

(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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **87,053**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,129**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.