FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048744

Facility Name: Shawnee Christian Nursing Center

Address: 1901 N. 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, 2010 to June 30, 2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Susan McGhee
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Chad D. Kunze, CPA, Pricipal
(Firm Name & Address) LarsonAllen LLP, 600 Washington, suite 1800 St. Louis, MO 63101
(Telephone) 314-925-4321 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, 2010 Ending: June 30, 2011

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	26,765	6,640	12,541	45,946	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,765	6,640	12,541	45,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.17%

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 12,541

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: 6/30/11 Fiscal Year: 6/30/11

* 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, 2010 Ending: June 30, 2011

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	332,174	17,205	15,482	364,861		364,861		364,861			1
2	Food Purchase		257,735		257,735		257,735	(8,848)	248,887			2
3	Housekeeping	165,468	24,524	1	189,993		189,993	(1)	189,992			3
4	Laundry	110,321	7,722		118,043		118,043		118,043			4
5	Heat and Other Utilities			204,490	204,490		204,490	(1,940)	202,550			5
6	Maintenance	157,865	12,473	11,211	181,549		181,549	19,137	200,686			6
7	Other (specify):* Trash			6,686	6,686		6,686		6,686			7
8	**TOTAL General Services**	765,828	319,659	237,870	1,323,357		1,323,357	8,348	1,331,705			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,689,357	232,838	33,537	2,955,732		2,955,732		2,955,732			10
10a	Therapy			1,149,087	1,149,087		1,149,087		1,149,087			10a
11	Activities	107,540	1,665	130	109,335		109,335		109,335			11
12	Social Services	120,061	1,020	5,368	126,449		126,449	667	127,116			12
13	CNA Training											13
14	Program Transportation			6,544	6,544		6,544	461	7,005			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,916,958	235,523	1,218,666	4,371,147		4,371,147	1,128	4,372,275			16
	C. General Administration											
17	Administrative	113,340	42	562,558	675,940		675,940	(488,094)	187,846			17
18	Directors Fees											18
19	Professional Services			94,454	94,454		94,454	26,969	121,423			19
20	Dues, Fees, Subscriptions & Promotions			17,662	17,662		17,662	6,285	23,947			20
21	Clerical & General Office Expenses	123,554	11,367	119,462	254,383		254,383	121,141	375,524			21
22	Employee Benefits & Payroll Taxes			705,732	705,732		705,732	39,160	744,892			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,321	4,321		4,321	12,550	16,871			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			369,375	369,375		369,375	1,073	370,448			26
27	Other (specify):* Marketing	67,176	(250)	15,097	82,023		82,023	(82,023)				27
28	**TOTAL General Administration**	304,070	11,159	1,888,661	2,203,890		2,203,890	(362,939)	1,840,951			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,986,856	566,341	3,345,197	7,898,394		7,898,394	(353,463)	7,544,931			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, 2010 Ending: June 30, 2011

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			252,519	252,519		252,519	22,606	275,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			396,959	396,959		396,959	(13,662)	383,297			32
33	Real Estate Taxes			354	354		354		354			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,614	18,614		18,614	5,086	23,700			35
36	Other (specify):* Def Fin Cost/ Admin			10,467	10,467		10,467		10,467			36
37	TOTAL Ownership			678,913	678,913		678,913	14,030	692,943			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			616,860	616,860		616,860	(54,440)	562,420			39
40	Barber and Beauty Shops	21,283	1,009		22,292		22,292		22,292			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	21,283	1,009	703,913	726,205		726,205	(54,440)	671,765			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,008,139	567,350	4,728,023	9,303,512		9,303,512	(393,873)	8,909,639			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, 2010 Ending: June 30, 2011

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	(3,846)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,190)	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	(14,456)	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	(46,073)	21		24
25	Fund Raising, Advertising and Promotional	(82,023)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,588)		$	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)	(228,535)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (228,535)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (379,123)		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

Shawnee Christian Nursing Center

ID# 0048744

Report Period Beginning: July 1, 2010

Ending: June 30, 2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (5,002)	2	1
2	Activity	667	12	2
3	Late Fees, Finance Charges	(275)	21	3
4	Shopping Cart Revenue	(70)	21	4
5	Transporation	461	14	5
6	Late Fees, Finance Charges	(1)	3	6
7	Fines and Penalties	(10,530)	21	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**	(14,750)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2010 **Ending:** June 30, 2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,848)	0	0	0	0	0	0	0	0	0	0	(8,848)	2
3	Housekeeping	(1)	0	0	0	0	0	0	0	0	0	0	(1)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,190)	2,250	0	0	0	0	0	0	0	0	0	(1,940)	5
6	Maintenance	0	19,137	0	0	0	0	0	0	0	0	0	19,137	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,039)	21,387	0	0	0	0	0	0	0	0	0	8,348	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	667	0	0	0	0	0	0	0	0	0	0	667	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	461	0	0	0	0	0	0	0	0	0	0	461	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	1,128	0	0	0	0	0	0	0	0	0	0	1,128	16
	C. General Administration													
17	Administrative	0	(488,094)	0	0	0	0	0	0	0	0	0	(488,094)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	26,969	0	0	0	0	0	0	0	0	0	26,969	19
20	Fees, Subscriptions & Promotions	0	6,285	0	0	0	0	0	0	0	0	0	6,285	20
21	Clerical & General Office Expenses	(56,948)	178,089	0	0	0	0	0	0	0	0	0	121,141	21
22	Employee Benefits & Payroll Taxes	0	39,160	0	0	0	0	0	0	0	0	0	39,160	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,550	0	0	0	0	0	0	0	0	0	12,550	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	1,073	0	0	0	0	0	0	0	0	0	1,073	26
27	Other (specify):*	(82,023)	0	0	0	0	0	0	0	0	0	0	(82,023)	27
28	**TOTAL General Administration**	(138,971)	(223,968)	0	0	0	0	0	0	0	0	0	(362,939)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(150,882)	(202,581)	0	0	0	0	0	0	0	0	0	(353,463)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2010 **Ending:** June 30, 2011

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	22,606	0	0	0	0	0	0	0	0	0	22,606	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,456)	794	0	0	0	0	0	0	0	0	0	(13,662)	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	5,086	0	0	0	0	0	0	0	0	0	5,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,456)	28,486	0	0	0	0	0	0	0	0	0	14,030	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	(54,440)	0	0	0	0	0	0	0	0	0	(54,440)	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	(54,440)	0	0	0	0	0	0	0	0	0	(54,440)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(165,338)	(228,535)	0	0	0	0	0	0	0	0	0	(393,873)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached 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%	$ 2,250	$ 2,250	1
2	V	6	Maintenance				19,137	19,137	2
3	V	17	Administration	562,558			74,464	(488,094)	3
4	V	19	Professional Services				26,969	26,969	4
5	V	21	Clerical				178,089	178,089	5
6	V	22	Employee Benefits				39,160	39,160	6
7	V	24	Travel and Seminar				12,550	12,550	7
8	V	26	Insurance				1,073	1,073	8
9	V	30	Depreciation				22,606	22,606	9
10	V	32	Interest				794	794	10
11	V	20	Dues and Subscriptions				6,285	6,285	11
12	V	35	Rental and Leasing				5,086	5,086	12
13	V	39	Pharmacy Services	551,574	Senior Care Pharmacy		497,134	(54,440)	13
14	Total			$ 1,114,132			$ 885,597	$ * (228,535)	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, 2010 Ending: June 30, 2011

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, 2010 Ending: ne 30, 2011

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, 2010 Ending: June 30, 2011

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	$49,528.00	8/1/2007	$ 6,634,900	$ 6,120,870	8/1/2032	5.8800	$ 396,959	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$49,528.00		$ 6,634,900	$ 6,120,870			$ 396,959	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,634,900	$ 6,120,870			$ 396,959	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 30,991 **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, 2010 **Ending:** June 30, 2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	Williams 1st SOL	$ 350.20	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 350.20	$

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, 2010 Ending: June 30, 2011

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			6,898	2
3	TOTALS	180,000		$ 78,069	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

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	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 44,338	$	$ 1,367,095	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				71,319	4,602		4,602		163,797	8
	Improvement Type**										
9	1981 Fixed Assets			12/31/1981	6,510		Various			6,510	9
10	1982 Fixed Assets			12/31/1982	259,336	4,098	Various	4,098		219,043	10
11	1983 Fixed Assets			12/31/1983	22,362	588	Various	588		16,525	11
12	1984 Fixed Assets			12/31/1984	650		Various			650	12
13	1985 Fixed Assets			12/31/1985	89,127	2,103	Various	2,103		59,160	13
14	1986 Fixed Assets			12/31/1986	7,577		Various			7,577	14
15	1987 Fixed Assets			12/31/1987	691,464	17,639	Various	17,639		419,503	15
16	1988 Fixed Assets			12/31/1988	139,355	1,964	Various	1,964		105,752	16
17	1989 Fixed Assets			12/31/1989	141,723		Various			141,723	17
18	1990 Fixed Assets			12/31/1990	74,448	1,269	Various	1,269		73,706	18
19	1991 Fixed Assets			12/31/1991	47,675	121	Various	121		47,670	19
20	1992 Fixed Assets			12/31/1992	32,538	726	Various	726		32,015	20
21	1993 Fixed Assets			12/31/1993	5,031	557	Various	557		4,549	21
22	1994 Fixed Assets			12/31/1994	11,344	101	Various	101		11,092	22
23	1995 Fixed Assets			12/31/1995	8,422		Various			8,422	23
24	1996 Fixed Assets			12/31/1996	187,215	7,557	Various	7,557		120,460	24
25	1997 Fixed Assets			12/31/1997	42,730	2,592	Various	2,592		35,387	25
26	1998 Fixed Assets			12/31/1998	793		Various			793	26
27	1999 Fixed Assets			12/31/1999	10,466		Various			10,466	27
28	2000 Fixed Assets			12/31/2000	17,431	123	Various	123		17,431	28
29	2001 Fixed Assets			12/31/2001	22,324	2,277	Various	2,277		21,615	29
30	2002 Fixed Assets			12/31/2002	23,218	1,634	Various	1,634		20,020	30
31	2003 Fixed Assets			12/31/2003	66,904	4,093	Various	4,093		33,455	31
32	2004 Fixed Assets			12/31/2004	24,951	2,495	Various	2,495		18,147	32
33	2005 Fixed Assets			12/31/2005	10,703	364	Various	364		9,337	33
34	2006 Fixed Assets			12/31/2006	68,094	6,255	Various	6,255		34,675	34
35	2007 Fixed Assets			12/31/2007	33,959	5,473	Various	5,473		20,717	35
36	Asphalt back Parking Lot			6/11/2008	35,790	3,579	10	3,579		11,035	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, 2010 Ending: June 30, 2011

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	Wallpaper - Side 1 Renovation	9/19/2008	$ 3,992	$ 399	10	$ 399	$	$ 1,131	37
38	Satellite TV system	10/31/2008	19,930	1,993	10	1,993		5,476	38
39	Sprinkler head replacement	3/11/2009	7,174	717	10	717		1,674	39
40	Condensing fan and blower	6/4/2009	618	124	5	124		258	40
41	24 ton heat pump	6/8/2009	9,377	938	10	938		1,954	41
42	Accumulator - Side 4 dining room	6/24/2009	547	109	5	109		228	42
43	100 gallon fuel tank - above ground	6/27/2009	10,857	542	20	542		1,129	43
44	Therapy gym remodeling project	6/30/2009	369,504	18,475	20	18,475		38,490	44
45	Call Light System	7/31/2009	47,969	4,797	10	4,797		9,594	45
46	Flooring - Dining room	8/31/2009	33,070	3,031	10	3,031		6,338	46
47	Floor tile for reclaim bath	11/9/2009	559	37	10	37		93	47
48	122 Ft Privacy Fence	6/10/2010	1,800	15	10	15		195	48
49	Roof Replacement - Dining room	6/23/2010	11,582	97	10	97		1,255	49
50	5 Ton A/C Compressor & Replacement Labor	7/7/2010	1,074	107	10	107		107	50
51	Carpet for Office and Conference Room	10/23/2010	4,638	348	10	348		348	51
52	Sprinkler System Upgrade	1/31/2011	5,048	252	10	252		252	52
53	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829	10	829		829	53
54	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883	10	1,883		1,883	54
55	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385	10	1,385		1,385	55
56	Roof Exhaust Fans	6/30/2011	1,905	16	10	16		16	56
57	Dietary - Floor Replacement	6/30/2011	19,467	162	10	162		162	57
58	Doors w/Smoke Gaskets	6/30/2011	8,402	70	10	70		70	58
59	Memory Lane - Painting	6/30/2011	3,226	27	10	27		27	59
60	Memory Lane/Shadybrook - Asbestos Remova	6/30/2011	22,100	184	10	184		184	60
61	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	647	10	647		647	61
62	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	30	10	30		30	62
63	Memory Lane/Shadybrook - Rails and guard	6/30/2011	15,044	125	10	125		125	63
64	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	122	10	122		122	64
65	Memory Lane - Light Fixtures	6/30/2011	1,039	9	10	9		9	65
66	Shadybrook - Light Fixtures	6/30/2011	1,039	9	10	9		9	66
67	Dietary Loading - Privacy Fence	6/30/2011	2,118	18	10	18		18	67
68	Restripe Parking Lots	6/30/2011	5,375	45	10	45		45	68
69	Lighting for Outdoor Sign	6/30/2011	889	7	10	7		7	69
70	TOTAL (lines 4 thru 69)		$ 4,672,088	$ 152,097		$ 152,097	$	$ 3,112,417	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, 2010 Ending: June 30, 2011

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	$ 508,278	$ 80,304	$ 80,304	$		$ 219,305	71
72	Current Year Purchases	122,020	8,491	8,491			8,491	72
73	Fully Depreciated Assets	288,504	1,452	1,452			288,504	73
74	Home Office Allocation	338,130	21,820	21,820			37,518	74
75	TOTALS	$ 1,256,932	$ 112,067	$ 112,067	$		$ 553,818	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	$ 14,250	$	$	$	8	$ 14,250	76
77	Patient Transportation	2006 Ford Starcraft	2006	46,350	5,794	5,794		8	29,934	77
78										78
79	Home Office Allocation			41,736	2,693	2,693			17,478	79
80	TOTALS			$ 102,336	$ 8,487	$ 8,487	$		$ 61,662	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)	$ 6,109,425	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 272,651	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 272,651	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)	$ 3,727,897	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	$ 9,850	92
93	Home office allocation	65,935	93
94			94
95		$ 75,785	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, 2010 Ending: June 30, 2011

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. 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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 18,569 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, 2010 Ending: June 30, 2011

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.

   Shawnee Christian Nursing Center only hires certified C N A s

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, 2010 Ending: June 30, 2011

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	$	9,526	$ 464,905	$	9,526	$ 464,905	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		5,477	241,084		5,477	241,084	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		13,628	443,098		13,628	443,098	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			$	28,631	$ 1,149,087	$	28,631	$ 1,149,087	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, 2010 Ending: June 30, 2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2011 (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	$ 996,827	$	1
2	Cash-Patient Deposits	44,865		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 49,216)	1,038,588		3
4	Supply Inventory (priced at)	22,792		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,146		6
7	Other Prepaid Expenses	14,391		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	684		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,123,293	$	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	4,579,298		14
15	Leasehold Improvements, at Historical Cost	211,374		15
16	Equipment, at Historical Cost	979,402		16
17	Accumulated Depreciation (book methods)	(3,648,229)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	512,172		21
22	Other Long-Term Assets (specify):	215,847		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,931,835	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,055,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 342,890	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	438,482		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	175		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	359,808		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,186,220	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,847		39
40	Mortgage Payable	6,120,870		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)**	$ 6,129,717	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,315,937	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,260,809)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,055,128	$	48

*(See instructions.)

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,591,867)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,591,867)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	369,188	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)**	$ 369,188	17
	B. Transfers (Itemize):		
18	**Equity Transfer to CHI**	(1,038,130)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,038,130)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,260,809)	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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,462,672	1
2	Discounts and Allowances for all Levels	(1,884,112)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,578,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,826,278	6
7	Oxygen	43,801	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,870,079	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	17,923	13
14	Non-Patient Meals	3,846	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	941,415	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,174	19
20	Radiology and X-Ray	66,553	20
21	Other Medical Services	53,558	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,162,469	23
	D. Non-Operating Revenue		
24	Contributions	35,435	24
25	Interest and Other Investment Income***	18,347	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,782	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	7,810	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,810	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,672,700	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,323,357	31
32	Health Care	4,371,147	32
33	General Administration	2,203,890	33
	B. Capital Expense		
34	Ownership	678,913	34
	C. Ancillary Expense		
35	Special Cost Centers	639,152	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)***	$ 9,303,512	40
41	**Income before Income Taxes (line 30 minus line 40)****	369,188	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 369,188	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, 2010 Ending: June 30, 2011

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	1,574	1,752	$ 57,835	$ 33.01	1
2	Assistant Director of Nursing	2,311	2,440	65,746	26.95	2
3	Registered Nurses	14,199	14,764	373,330	25.29	3
4	Licensed Practical Nurses	42,316	44,813	785,662	17.53	4
5	CNAs & Orderlies	109,099	116,818	1,175,632	10.06	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	1,636	1,698	17,363	10.23	9
10	Activity Assistants	7,445	8,259	77,365	9.37	10
11	Social Service Workers	7,700	8,362	132,873	15.89	11
12	Dietician	0	0			12
13	Food Service Supervisor	1,936	2,080	37,202	17.89	13
14	Head Cook	0	0			14
15	Cook Helpers/Assistants	28,448	30,310	294,972	9.73	15
16	Dishwashers	0	0			16
17	Maintenance Workers	8,638	9,513	157,865	16.60	17
18	Housekeepers	16,440	17,649	165,468	9.38	18
19	Laundry	9,515	10,403	110,321	10.60	19
20	Administrator	1,818	2,000	113,340	56.67	20
21	Assistant Administrator	0	0			21
22	Other Administrative	371	389	6,426	16.54	22
23	Office Manager	1,724	2,048	36,641	17.90	23
24	Clerical	5,465	5,706	63,754	11.17	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	3,776	4,034	50,781	12.59	31
32	Other Health C: MDS Coordinator	6,199	6,615	180,370	27.27	32
33	Other(specify) Marketing	3,729	4,048	105,193	25.99	33
34	TOTAL (lines 1 - 33)	274,336	293,701	$ 4,008,139 *	$ 13.65	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	340	$ 15,482	ln 1, col 3	35
36	Medical Director	120	24,000	ln 9, col 3	36
37	Medical Records Consultant	53	2,989	ln 10, col 3	37
38	Nurse Consultant	10	608	ln 10, col 3	38
39	Pharmacist Consultant	168	4,485	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	90	5,368	ln 12, col 3	45
46	Other(specify) Administrator	231	19,447	ln 21, col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,012	$ 72,379		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
Sherry Neal	Administrator	0	$ 113,340
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,340

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 562,558
TOTAL (agree to Schedule V, line 17, col. 3)	$ 562,558
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LarsonAllen LLP	Accounting	$ 15,345
My Innerview	Consulting	1,119
Davis and Campbell	Attorney	11,039
Husch Blackwell Sanders	Attorney	11,809
Armstrong Teasdale	Attorney	3,141
Adam Lawler	Grant	12,001
Accrued Legal Fees	Outstanding Lawsuit	40,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 94,454

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,444
Unemployment Compensation Insurance	14,357
FICA Taxes	292,450
Employee Health Insurance	281,352
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,909
Employee Expense	13,335
Employee Uniforms	385
457 Plan Expense	4,500
Home Office Allocation	39,160
TOTAL (agree to Schedule V, line 22, col.8)	$ 744,892

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,214
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License	829
Dues	8,974
Subscriptions	565
Other	80
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,662

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,469
In-State Travel	565
Seminar Expense	210
Home office Allocation	12,550
Other	77
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,871

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2010 Ending: June 30, 2011

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, 2010 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. **LSN & AAHSA $8,893.94**

(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. $ **46,769** 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. $ **3,846**

(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. $
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.