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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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, 2011 to June 30, 2012 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) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Avenue, 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, 2011 Ending: June 30, 2012

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	58,194	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	58,194	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	25,104	7,777	10,175	43,056	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,104	7,777	10,175	43,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.99%

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 9,821

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: 6/30/2012 Fiscal Year: 6/30/2012

* 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, 2011 Ending: June 30, 2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	329,769	13,365	20,061	363,195		363,195		363,195			1
2	Food Purchase		236,211		236,211		236,211	686	236,897			2
3	Housekeeping	149,711	24,574	316	174,601		174,601		174,601			3
4	Laundry	108,786	4,875		113,661		113,661		113,661			4
5	Heat and Other Utilities			159,027	159,027		159,027	(3,817)	155,210			5
6	Maintenance	131,783	14,469	26,049	172,301		172,301	3,245	175,546			6
7	Other (specify):*											7
8	**TOTAL General Services**	720,049	293,494	205,453	1,218,996		1,218,996	114	1,219,110			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,637,577	303,713	219,471	3,160,761		3,160,761	(124)	3,160,637			10
10a	Therapy			1,044,506	1,044,506		1,044,506		1,044,506			10a
11	Activities	101,016	3,047	565	104,628		104,628		104,628			11
12	Social Services	112,011	1,382	6,073	119,466		119,466	998	120,464			12
13	CNA Training											13
14	Program Transportation			6,727	6,727		6,727		6,727			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,850,604	308,142	1,301,342	4,460,088		4,460,088	874	4,460,962			16
	C. General Administration											
17	Administrative	79,723	2,067	618,538	700,328		700,328	(534,672)	165,656			17
18	Directors Fees											18
19	Professional Services			89,526	89,526		89,526	44,229	133,755			19
20	Dues, Fees, Subscriptions & Promotions			21,563	21,563		21,563		21,563			20
21	Clerical & General Office Expenses	142,529	22,055	231,976	396,560		396,560	107,042	503,602			21
22	Employee Benefits & Payroll Taxes			837,284	837,284		837,284	41,777	879,061			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,956	13,956		13,956	15,302	29,258			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,488	92,488		92,488	(9,047)	83,441			26
27	Other (specify):* **Marketing**	58,919	2,215	23,283	84,417		84,417	(84,417)				27
28	**TOTAL General Administration**	281,171	26,337	1,928,614	2,236,122		2,236,122	(419,786)	1,816,336			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,851,824	627,973	3,435,409	7,915,206		7,915,206	(418,798)	7,496,408			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, 2011 Ending: June 30, 2012

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			281,140	281,140		281,140	30,597	311,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			387,605	387,605		387,605	1,523	389,128			32
33	Real Estate Taxes			368	368		368		368			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,861	22,861		22,861		22,861			35
36	Other (specify):* Def Fin Cost/Admin			10,500	10,500		10,500		10,500			36
37	**TOTAL Ownership**			702,474	702,474		702,474	32,120	734,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			428,833	428,833		428,833	(26,984)	401,849			39
40	Barber and Beauty Shops	19,453	1,347	110	20,910		20,910		20,910			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			332,526	332,526		332,526		332,526			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	19,453	1,347	761,469	782,269		782,269	(26,984)	755,285			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,871,277	629,320	4,899,352	9,399,949		9,399,949	(413,662)	8,986,287			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, 2011 Ending: June 30, 2012

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	(2,782)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,323)	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	(12,483)	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	(118,543)	21		24
25	Fund Raising, Advertising and Promotional	(84,417)	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	(4,150)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (227,698)		$	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)	(185,964)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (185,964)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (413,662)		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, 2011

Ending: June 30, 2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 3,468	2	1
2	Activity	998	12	2
3	Late Fees, Finance Charges	(568)	6	3
4	Late Fees, Finance Charges	(124)	10	4
5	Fines and Penalties	(2,925)	21	5
6	Discounts	(4,437)	21	6
7	Miscellaneous Revenue	(551)	21	7
8	Late Fees, Finance Charges	(11)	21	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**	(4,150)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2011 **Ending:** June 30, 2012

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	686	0	0	0	0	0	0	0	0	0	0	686	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	(5,323)	1,506	0	0	0	0	0	0	0	0	0	(3,817)	5
6	Maintenance	(568)	3,813	0	0	0	0	0	0	0	0	0	3,245	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,205)	5,319	0	0	0	0	0	0	0	0	0	114	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	(124)	0	0	0	0	0	0	0	0	0	0	(124)	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	998	0	0	0	0	0	0	0	0	0	0	998	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**	874	0	0	0	0	0	0	0	0	0	0	874	16
	C. General Administration													
17	Administrative	0	(534,672)	0	0	0	0	0	0	0	0	0	(534,672)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	44,229	0	0	0	0	0	0	0	0	0	44,229	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(126,467)	233,509	0	0	0	0	0	0	0	0	0	107,042	21
22	Employee Benefits & Payroll Taxes	0	41,777	0	0	0	0	0	0	0	0	0	41,777	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	15,302	0	0	0	0	0	0	0	0	0	15,302	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	(9,047)	0	0	0	0	0	0	0	0	0	(9,047)	26
27	Other (specify):*	(84,417)	0	0	0	0	0	0	0	0	0	0	(84,417)	27
28	**TOTAL General Administration**	(210,884)	(208,902)	0	0	0	0	0	0	0	0	0	(419,786)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(215,215)	(203,583)	0	0	0	0	0	0	0	0	0	(418,798)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 **Report Period Beginning:** July 1, 2011 **Ending:** June 30, 2012

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	30,597	0	0	0	0	0	0	0	0	0	30,597	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,483)	14,006	0	0	0	0	0	0	0	0	0	1,523	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	(12,483)	44,603	0	0	0	0	0	0	0	0	0	32,120	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	(26,984)	0	0	0	0	0	0	0	0	0	(26,984)	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	(26,984)	0	0	0	0	0	0	0	0	0	(26,984)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(227,698)	(185,964)	0	0	0	0	0	0	0	0	0	(413,662)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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. ☐ 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%	$ 1,506	$ 1,506	1
2	V	6	Maintenance				3,813	3,813	2
3	V	17	Administration	618,538			83,866	(534,672)	3
4	V	19	Professional Services				44,229	44,229	4
5	V	21	Clerical				195,747	195,747	5
6	V	22	Employee Benefits				41,777	41,777	6
7	V	24	Travel and Seminar				15,302	15,302	7
8	V	26	Insurance				(9,047)	(9,047)	8
9	V	30	Depreciation				30,597	30,597	9
10	V	32	Interest				14,006	14,006	10
11	V	21	Other Administrative Expenses				37,762	37,762	11
12	V	39	Pharmacy Services	329,070	Senior Care Pharmacy		302,086	(26,984)	12
13	V								13
14	Total			$ 947,608			$ 761,644	$ * (185,964)	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, 2011 Ending: June 30, 2012

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, 2011 Ending: ne 30, 2012

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, 2011 Ending: June 30, 2012

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	$42,264.00	8/1/2007	$ 6,634,900	$ 5,969,583	8/1/2032	5.8800	$ 387,605	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$42,264.00		$ 6,634,900	$ 5,969,583			$ 387,605	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	$ 5,969,583			$ 387,605	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 30,256** **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, 2011 Ending: June 30, 2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	Williams 1st SOL	$ 367.72	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 367.72	$

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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, 2011 Ending: June 30, 2012

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			6,416	2
3	TOTALS	180,000		$ 77,587	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	$	$ 1,411,433	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				62,872	7,136		7,136		38,741	8
	Improvement Type**										
9	1981 Fixed Assets			1981	6,510		Various			6,510	9
10	1982 Fixed Assets			1982	259,336	4,098	Various	4,098		223,141	10
11	1983 Fixed Assets			1983	22,362	588	Various	588		17,113	11
12	1985 Fixed Assets			1985	89,127	2,103	Various	2,103		61,263	12
13	1986 Fixed Assets			1986	7,577		Various			7,577	13
14	1987 Fixed Assets			1987	690,759	17,639	Various	17,639		436,437	14
15	1988 Fixed Assets			1988	139,015	1,964	Various	1,964		107,376	15
16	1989 Fixed Assets			1989	140,423		Various			140,423	16
17	1990 Fixed Assets			1990	73,558	284	Various	284		73,100	17
18	1991 Fixed Assets			1991	47,675	39	Various	39		47,675	18
19	1992 Fixed Assets			1992	32,538	520	Various	520		32,535	19
20	1993 Fixed Assets			1993	5,031	557	Various	557		4,801	20
21	1994 Fixed Assets			1994	11,344	101	Various	101		11,193	21
22	1995 Fixed Assets			1995	8,422		Various			8,422	22
23	1996 Fixed Assets			1996	184,619	7,557	Various	7,557		125,421	23
24	1997 Fixed Assets			1997	42,730	2,592	Various	2,592		37,979	24
25	1998 Fixed Assets			1998	793		Various			793	25
26	1999 Fixed Assets			1999	10,466		Various			10,466	26
27	2000 Fixed Assets			2000	17,431		Various			17,431	27
28	2001 Fixed Assets			2001	22,324	842	Various	842		22,324	28
29	2002 Fixed Assets			2002	23,218	1,594	Various	1,594		21,614	29
30	2003 Fixed Assets			2003	66,904	4,093	Various	4,093		37,548	30
31	2004 Fixed Assets			2004	24,951	2,495	Various	2,495		20,642	31
32	2005 Fixed Assets			2005	10,703	334	Various	334		9,671	32
33	2006 Fixed Assets			2006	68,094	5,401	Various	5,401		40,076	33
34	2007 Fixed Assets			2007	33,959	5,236	Various	5,236		25,953	34
35	2008 Fixed Assets			2008	59,712	5,971	Various	5,971		23,613	35
36	Sprinkler head replacement			2009	7,174	717	10	717		2,391	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, 2011 Ending: June 30, 2012

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	Condensing fan and blower	6/4/2009	$ 618	$ 124	5	$ 124	$	$ 382	37
38	24 ton heat pump	6/8/2009	9,377	938	10	938		2,892	38
39	Accumulator - Side 4 dining room	6/24/2009	547	109	5	109		337	39
40	100 gallon fuel tank - above ground	6/27/2009	10,857	542	20	542		1,671	40
41	Therapy gym remodeling project	6/30/2009	369,504	18,475	20	18,475		56,965	41
42	Call Light System	7/31/2009	47,969	4,797	10	4,797		14,391	42
43	Flooring - Dining room	8/31/2009	33,070	3,307	10	3,307		9,645	43
44	Floor tile for reclaim bath	11/9/2009	559	56	10	56		149	44
45	122 Ft Privacy Fence	6/10/2010	1,800	180	10	180		375	45
46	Roof Replacement - Dining room	6/23/2010	11,582	1,158	10	1,158		2,413	46
47	5 Ton A/C Compressor & Replacement Labor	7/7/2010	1,074	107	10	107		214	47
48	Carpet for Office and Conference Room	10/23/2010	4,638	464	10	464		812	48
49	Sprinkler System Upgrade	1/31/2011	5,048	505	10	505		757	49
50	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829	10	829		1,658	50
51	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883	10	1,883		3,766	51
52	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385	10	1,385		2,770	52
53	Roof Exhaust Fans	6/30/2011	1,905	190	10	190		206	53
54	Dietary - Floor Replacement	6/30/2011	19,467	1,947	10	1,947		2,109	54
55	Doors w/Smoke Gaskets	6/30/2011	8,402	840	10	840		910	55
56	Memory Lane - Painting	6/30/2011	3,226	323	10	323		350	56
57	Memory Lane/Shadybrook - Asbestos Remova	6/30/2011	22,100	2,210	10	2,210		2,394	57
58	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	7,761	10	7,761		8,408	58
59	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	358	10	358		388	59
60	Memory Lane/Shadybrook - Rails and guard	6/30/2011	15,044	1,504	10	1,504		1,629	60
61	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	1,460	10	1,460		1,582	61
62	Memory Lane - Light Fixtures	6/30/2011	1,039	104	10	104		113	62
63	Shadybrook - Light Fixtures	6/30/2011	1,039	104	10	104		113	63
64	Dietary Loading - Privacy Fence	6/30/2011	2,118	212	10	212		230	64
65	Restripe Parking Lots	6/30/2011	5,375	537	10	537		582	65
66	Lighting for Outdoor Sign	6/30/2011	889	89	10	89		96	66
67	Fire Alarm System, Addressable 3 Year Warranty	1/9/2012	83,728	3,476	10	3,476		3,476	67
68	Fire Alarm System & Door Closures Installation	1/23/2012	5,907	247	10	247		247	68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,746,795	$ 172,420		$ 172,420	$	$ 3,145,692	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, 2011 Ending: June 30, 2012

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	$ 592,441	$ 92,950	$ 92,950	$	Various	$ 290,889	71
72	Current Year Purchases	10,381	1,676	1,676		Various	1,676	72
73	Fully Depreciated Assets	318,361				Various	318,361	73
74	Home Office Allocation	254,163	21,294	21,294			108,765	74
75	TOTALS	$ 1,175,346	$ 115,920	$ 115,920	$		$ 719,691	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	35,728	77
78										78
79	Home Office Allocation			19,094	2,167	2,167			7,097	79
80	TOTALS			$ 79,694	$ 7,961	$ 7,961	$		$ 57,075	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)	$ 6,079,422	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,301	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 296,301	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)	$ 3,922,458	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	Home Office Allocation	$ 88,893	92
93			93
94			94
95		$ 88,893	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, 2011 Ending: June 30, 2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 22,861 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, 2011 Ending: June 30, 2012

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.

   SCNC only hires certified CNAs.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	9,806	$ 429,442	$	9,806	$ 429,442	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,941	231,029		3,941	231,029	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		12,867	384,035		12,867	384,035	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			$	26,614	$ 1,044,506	$	26,614	$ 1,044,506	14

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2012 (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	$ 260,624	$	1
2	Cash-Patient Deposits	44,665		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 178,676)	1,412,024		3
4	Supply Inventory (priced at)	15,558		4
5	Short-Term Investments			5
6	Prepaid Insurance	700		6
7	Other Prepaid Expenses	13,965		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	658		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,748,194	$	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	4,662,452		14
15	Leasehold Improvements, at Historical Cost	211,374		15
16	Equipment, at Historical Cost	981,783		16
17	Accumulated Depreciation (book methods)	(3,914,887)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	576,945		21
22	Other Long-Term Assets (spe Def Fin Costs	196,187		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,795,825	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,544,019	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 203,028	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,665		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,658		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	630,171		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,132,697	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,861		39
40	Mortgage Payable	5,969,583		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)**	$ 5,974,444	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,107,141	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,563,122)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,544,019	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,260,809)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,260,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(302,313)	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)**	$ (302,313)	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)**	$ (2,563,122)	24 *

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,306,244	1
2	Discounts and Allowances for all Levels	(2,136,336)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,169,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,986,999	6
7	Oxygen	39,435	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,026,434	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	14,453	13
14	Non-Patient Meals	2,782	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	664,951	17
18	Sale of Supplies to Non-Patients	10,803	18
19	Laboratory	47,457	19
20	Radiology and X-Ray	49,956	20
21	Other Medical Services	44,571	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 834,973	23
	D. Non-Operating Revenue		
24	Contributions	52,524	24
25	Interest and Other Investment Income***	13,656	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66,180	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	141	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 141	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,097,636	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,218,996	31
32	Health Care	4,460,088	32
33	General Administration	2,236,122	33
	B. Capital Expense		
34	Ownership	702,474	34
	C. Ancillary Expense		
35	Special Cost Centers	449,743	35
36	Provider Participation Fee	332,526	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,399,949	40
41	**Income before Income Taxes (line 30 minus line 40)****	(302,313)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (302,313)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,058,878	44
45	Private Pay - Net Inpatient Revenue	1,098,269	45
46	Medicare - Net Inpatient Revenue	68,747	46
47	Other-(specify) HMO/Medicare Advantage	(64,553)	47
48	Other-(specify) Special Contracts	8,567	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,169,908	49

* **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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	888	1,087	$ 35,827	$ 32.96	1
2	Assistant Director of Nursing	2,477	2,636	68,882	26.13	2
3	Registered Nurses	20,278	21,266	455,482	21.42	3
4	Licensed Practical Nurses	35,254	36,215	584,152	16.13	4
5	CNAs & Orderlies	125,820	138,877	1,472,345	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,976	2,101	23,934	11.39	9
10	Activity Assistants	6,908	7,718	77,082	9.99	10
11	Social Service Workers	6,296	7,151	112,011	15.66	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,148	38,327	17.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,234	31,123	291,442	9.36	15
16	Dishwashers					16
17	Maintenance Workers	6,967	7,835	131,783	16.82	17
18	Housekeepers	13,670	15,530	149,711	9.64	18
19	Laundry	9,691	10,690	108,786	10.18	19
20	Administrator	1,548	1,882	79,723	42.36	20
21	Assistant Administrator	2,384	2,486	30,011	12.07	21
22	Other Administrative	1,847	2,135	33,664	15.77	22
23	Office Manager	1,992	2,108	37,772	17.92	23
24	Clerical	3,596	3,843	41,082	10.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,809	1,948	20,889	10.72	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing and Be	4,804	5,484	78,372	14.29	33
34	TOTAL (lines 1 - 33)	278,391	304,263	$ 3,871,277 *	$ 12.72	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	420	$ 20,061	ln 1, col 3	35
36	Medical Director	120	24,000	ln 9, col 3	36
37	Medical Records Consultant	32	1,893	ln 10, col 3	37
38	Nurse Consultant	2	100	ln 10, col 3	38
39	Pharmacist Consultant	156	4,275	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	102	6,056	ln 12, col 3	45
46	Other(specify) Administrator	473	31,648	ln 21, col 3	46
47	MDS Consultant	1,344	112,469	ln 10, col 3	47
48	Nurse Consultant	1,071	94,873	ln 10, col 3	48
49	TOTAL (lines 35 - 48)	3,720	$ 295,375		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	$ 33,280
Roland Busher	Administrator	0	46,443
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,723

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 618,538
TOTAL (agree to Schedule V, line 17, col. 3)	$ 618,538
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CliftonLarsonAllen LLP	Accounting	$ 13,225
My Innerview	Consulting	1,560
CM Management Corp, Inc.	Placement Services	15,750
Adam Lawler Law Firm	Attorney	2,854
Armstrong Teasdale	Attorney	17,482
David & Campbell	Attorney	4,684
Swanson, Martin & Bell, LLP	Attorney	33,971
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 89,526

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,725
Unemployment Compensation Insurance	99,007
FICA Taxes	294,279
Employee Health Insurance	258,210
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Net Earned PTO	63,092
Employee Physicals	15,660
Employee Expense and Uniforms	8,847
Sales Tax	464
Home Office Allocation	41,777
TOTAL (agree to Schedule V, line 22, col.8)	$ 879,061

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	11,524
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses, Dues, and Subscriptions - See Attac	10,039
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,563

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 933
In-State Travel	11,295
Seminar Expense	1,728
Home Office Allocation	15,302
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 29,258

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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, 2011 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 & Leading Age - $6,724.80**

(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. $ **65,314** 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. $ **332,526**
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. $ **2,782**

(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: **CliftonLarsonAllen 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.