1. IDPH Facility ID Number: 0025619
    Facility Name: Shawnee Christian Nursing Ctr
    Address: 1901 North 13th P.O. Box 680 Herrin 62948-0680
    County: Williamson
    Telephone Number: (618) 942-7391 Fax # (____ )
    IDPA ID Number: 37-0841562005
    Date of Initial License for Current Owners: 09-01-80
    Type of Ownership:
    VOLUNTARY, NON-PROFIT
    CHARITABLE CORP.
    IRS Exemption Code

2. 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, 2000 to June 30, 2001 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: Mark Havrilka (Signed) (Date)
   Type or Print Name: Chief Financial Officer
   Title: (Signed) (Date)
   Paid Preparer: William O. Buskirk, CPA (Print Name)
   and Title:
   (Firm Name) Eck, Schafer & Punke, LLP
   & Address: 600 E. Adams Springfield, IL 62701-1624
   (Telephone) 217-525-1111 Fax 217-525-1120

   MAIL TO: OFFICE OF HEALTH FINANCE
   ILLINOIS DEPARTMENT OF PUBLIC AID
   201 S. Grand Avenue East
   Springfield, IL 62763-0001 Phone # (217) 782-1630
### 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

<table>
<thead>
<tr>
<th></th>
<th>Beds at Beginning of Report Period</th>
<th>Licensure Level of Care</th>
<th>Beds at End of Report Period</th>
<th>Licensed Bed Days During Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>159</td>
<td>Skilled (SNF)</td>
<td>159</td>
<td>58,035</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Skilled Pediatric (SNF/PED)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Intermediate (ICF)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Intermediate/DD</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Sheltered Care (SC)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>ICF/DD 16 or Less</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>159</td>
<td>TOTALS</td>
<td>159</td>
<td>58,035</td>
</tr>
</tbody>
</table>

#### B. Census—For the entire report period.

<table>
<thead>
<tr>
<th></th>
<th>Level of Care</th>
<th>Patient Days by Level of Care and Primary Source of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Public Aid Recipient</td>
</tr>
<tr>
<td>8</td>
<td>SNF</td>
<td>12,810</td>
</tr>
<tr>
<td>9</td>
<td>SNF/PED</td>
<td>19,069</td>
</tr>
<tr>
<td>10</td>
<td>ICF/DD</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>SC</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>DD 16 OR LESS</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>TOTALS</td>
<td>31,879</td>
</tr>
</tbody>
</table>

C. Percent Occupancy, (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.40%

#### D. How many bed-hold days during this year were paid by Public Aid?

0 (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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

#### H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

#### I. On what date did you start providing long term care at this location?

Date started 9/1/80

#### J. Was the facility purchased or leased after January 1, 1978?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Date 9/1/80</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### K. Was the facility certified for Medicare during the reporting year?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If YES, enter number of beds certified and days of care provided</th>
</tr>
</thead>
</table>

Medicare Intermediary N/A

#### IV. ACCOUNTING BASIS

<table>
<thead>
<tr>
<th>Accrual</th>
<th>Cash*</th>
<th>Cash*</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is your fiscal year identical to your tax year?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

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

Tax Year: 6/30/01  Fiscal Year: 6/30/01
### V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassification</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR OHH USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage 1</td>
<td>Supplies 2</td>
<td>Other 3</td>
<td>Total 4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td><strong>A. General Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Dietary</td>
<td>180,872</td>
<td>25,709</td>
<td>12,365</td>
<td>218,946</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Food Purchase</td>
<td>183,800</td>
<td></td>
<td></td>
<td>183,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Housekeeping</td>
<td>115,840</td>
<td>18,789</td>
<td></td>
<td>134,629</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Laundry</td>
<td>73,552</td>
<td>12,762</td>
<td></td>
<td>86,314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Heat and Other Utilities</td>
<td>123,325</td>
<td>214</td>
<td>123,325</td>
<td>123,325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Maintenance</td>
<td>37,799</td>
<td>16,181</td>
<td>18,852</td>
<td>72,832</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8 TOTAL General Services</strong></td>
<td>408,063</td>
<td>257,241</td>
<td>154,542</td>
<td>819,846</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Health Care and Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Medical Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6,500</td>
<td></td>
</tr>
<tr>
<td>10 Nursing and Medical Records</td>
<td>1,527,992</td>
<td>99,179</td>
<td>58,700</td>
<td>1,685,871</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10a Therapy</td>
<td></td>
<td></td>
<td>23,254</td>
<td>23,254</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Activities</td>
<td>51,211</td>
<td>1,648</td>
<td></td>
<td>52,859</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Social Services</td>
<td>59,335</td>
<td>4,595</td>
<td>4,089</td>
<td>68,019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Nurse Aide Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Program Transportation</td>
<td></td>
<td></td>
<td>1,734</td>
<td>1,734</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16 TOTAL Health Care and Programs</strong></td>
<td>1,638,538</td>
<td>107,156</td>
<td>92,543</td>
<td>1,838,237</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. General Administration</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Administrative</td>
<td>50,551</td>
<td>2,764</td>
<td>92,018</td>
<td>145,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Directors Fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Professional Services</td>
<td></td>
<td></td>
<td>1,039</td>
<td>1,039</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Dues, Fees, Subscriptions &amp; Promotions</td>
<td>21,827</td>
<td>21,827</td>
<td>656</td>
<td>22,483</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Clerical &amp; General Office Expenses</td>
<td>47,044</td>
<td>6,329</td>
<td>75,665</td>
<td>145,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Employee Benefits &amp; Payroll Taxes</td>
<td>376,626</td>
<td>376,626</td>
<td>371,365</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Inservice Training &amp; Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Travel and Seminar</td>
<td></td>
<td></td>
<td>6,336</td>
<td>6,336</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Other Admin, Staff Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Insurance-Prop.Liab.Malpractice</td>
<td>20,858</td>
<td>20,858</td>
<td>20,858</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>28 TOTAL General Administration</strong></td>
<td>97,595</td>
<td>9,093</td>
<td>540,996</td>
<td>647,684</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>29 TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</strong></td>
<td>2,144,196</td>
<td>373,490</td>
<td>788,081</td>
<td>3,305,767</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.
### V. COST CENTER EXPENSES (continued)

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>Reclassified</th>
<th>Adjustments</th>
<th>Adjusted</th>
<th>FOR OHH USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>D. Ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>151,703</td>
</tr>
<tr>
<td>Amortization of Pre-Op. &amp; Org.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>490,186</td>
</tr>
<tr>
<td>Interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>299</td>
</tr>
<tr>
<td>Real Estate Taxes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>299</td>
</tr>
<tr>
<td>Rent-Facility &amp; Grounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6,643</td>
</tr>
<tr>
<td>Rent-Equipment &amp; Vehicles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6,643</td>
</tr>
<tr>
<td>Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6,643</td>
</tr>
<tr>
<td>TOTAL Ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>648,831</td>
</tr>
<tr>
<td>E. Special Cost Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>648,831</td>
</tr>
<tr>
<td>Ancillary Expense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>648,831</td>
</tr>
<tr>
<td>Ancillary Service Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>648,831</td>
</tr>
<tr>
<td>Barber and Beauty Shops</td>
<td>18,745</td>
<td>1,316</td>
<td>20,061</td>
<td>20,061</td>
<td></td>
</tr>
<tr>
<td>Coffee and Gift Shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87,053</td>
</tr>
<tr>
<td>Provider Participation Fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87,053</td>
</tr>
<tr>
<td>Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87,053</td>
</tr>
<tr>
<td>TOTAL Special Cost Centers</td>
<td>18,745</td>
<td>1,316</td>
<td>89,165</td>
<td>109,226</td>
<td>109,226</td>
</tr>
<tr>
<td>GRAND TOTAL COST</td>
<td>2,162,941</td>
<td>374,806</td>
<td>4,063,824</td>
<td>4,063,824</td>
<td>(6,390)</td>
</tr>
</tbody>
</table>

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
### 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. Reference the line on which the particular cost was included. (See instructions.)

<table>
<thead>
<tr>
<th>NON-LIABLE EXPENSES</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Care</td>
<td>$</td>
<td>Reference</td>
<td>$</td>
</tr>
<tr>
<td>2 Other Care for Outpatients</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Governmental Sponsored Special Programs</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Non-Patient Meals</td>
<td>(87)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>5 Telephone, TV &amp; Radio in Resident Rooms</td>
<td>(398)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6 Rented Facility Space</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Sale of Supplies to Non-Patients</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Laundry for Non-Patients</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Non-Straightline Depreciation</td>
<td>2,290</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>10 Interest and Other Investment Income</td>
<td>(5,933)</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>11 Discounts, Allowances, Rebates &amp; Refunds</td>
<td>316</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>12 Non-Working Officer's or Owner's Salary</td>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Sales Tax</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Non-Care Related Interest</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 Non-Care Related Owner's Transactions</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Personal Expenses (Including Transportation)</td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Non-Care Related Fees</td>
<td>(299)</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>18 Fines and Penalties</td>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Entertainment</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Contributions</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21 Owner or Key-Man Insurance</td>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Special Legal Fees &amp; Legal Retainers</td>
<td></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23 Malpractice Insurance for Individuals</td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24 Bad Debt</td>
<td>(12,409)</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>25 Fund Raising, Advertising and Promotional</td>
<td></td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26 Income Taxes and Illinois Personal</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27 Property Replacement Tax</td>
<td></td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 Nurse Aide Training for Non-Employees</td>
<td></td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29 Other-Attach Schedule</td>
<td>(10,141)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30 SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$ (26,661)</td>
<td>$ 30</td>
<td></td>
</tr>
</tbody>
</table>

**OHF 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.)

| 31 Non-Paid Workers-Attach Schedule* | $ | Reference |
| 32 Donated Goods-Attach Schedule* | $ | 32 |
| 33 Amortization of Organization & Pre-Operating Expense | | 33 |
| 34 Adjustments for Related Organization Costs (Schedule VII) | $ 20,271 | 34 |
| 35 Other-Attach Schedule | | 35 |
| 36 SUBTOTAL (B): (Sum of lines 31-35) | $ 20,271 | 36 |
| 37 TOTAL ADJUSTMENTS (A and B) | $ (6,390) | 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.)

<p>| 38 Medically Necessary Transport. | Yes | No | $ | Reference |
| 39 | | | | |
| 40 Gift and Coffee Shops | | | | |
| 41 Barber and Beauty Shops | | | | |
| 42 Laboratory and Radiology | | | | |
| 43 Prescription Drugs | | | | |
| 44 Exceptional Care Program | | | | |
| 45 Other-Attach Schedule | | | | |
| 46 Other-Attach Schedule | | | | |
| 47 TOTAL (C): (Sum of lines 38-46) | $ | 47 |</p>
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## STATE OF ILLINOIS

### Facility Name & ID Number
Shawnee Christian Nursing Ctr  # 0025619

### Report Period
Beginning: July 1, 2000     Ending: June 30, 2001

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## STATE OF ILLINOIS

### Summary B

**Facility Name & ID Number**: Shawnee Christian Nursing Ctr # 0025619  
**Report Period Beginning**: July 1, 2000  
**Ending**: June 30, 2001

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

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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>36 Other (specify)*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>37 TOTAL Ownership</td>
<td>(3,942)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

### Ancillary Expense

| E. Special Cost Centers | 38 | Medically Necessary Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| 39 Ancillary Service Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| 40 Barber and Beauty Shops | 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 | 41 |
| 42 Provider Participation Fee | 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 | 43 |
| 44 TOTAL Special Cost Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 44 |

### GRAND TOTAL COST

| 45 (sum of lines 29, 37 & 44) | (26,661) | 20,271 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (6,390) |

**SUMMARY TOTALS** (to Sch V, col.7)
VII. RELATED PARTIES

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

<table>
<thead>
<tr>
<th>OWNERS</th>
<th>RELATED NURSING HOMES</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Ownership %</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Schedule V</th>
<th>Line</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>V 2</td>
<td>Utilities</td>
<td>$612</td>
<td></td>
<td>$612</td>
<td>$612</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>V 6</td>
<td>Maintenance</td>
<td>8,974</td>
<td></td>
<td>8,974</td>
<td>8,974</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>V 7</td>
<td>Administrative</td>
<td>75,420</td>
<td></td>
<td>36,922</td>
<td>36,922</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>V 8</td>
<td>Directors</td>
<td>4</td>
<td></td>
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<td></td>
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<tr>
<td>5</td>
<td>V 9</td>
<td>Professional Services</td>
<td></td>
<td></td>
<td>13,370</td>
<td>13,370</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>V 20</td>
<td>Fees, Subscriptions</td>
<td>656</td>
<td></td>
<td>656</td>
<td>656</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>V 21</td>
<td>Clerical</td>
<td>28,738</td>
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<td>28,738</td>
<td>28,738</td>
<td>7</td>
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<tr>
<td>8</td>
<td>V 22</td>
<td>Employee Benefits</td>
<td>11,835</td>
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<td>11,835</td>
<td>11,835</td>
<td>8</td>
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<tr>
<td>9</td>
<td>V 23</td>
<td>Inservice Training</td>
<td>9</td>
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<tr>
<td>10</td>
<td>V 24</td>
<td>Travel &amp; Seminar</td>
<td>3,750</td>
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<td>3,750</td>
<td>3,750</td>
<td>10</td>
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<tr>
<td>11</td>
<td>V 26</td>
<td>Insurance</td>
<td>1,575</td>
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<td>1,575</td>
<td>1,575</td>
<td>11</td>
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<tr>
<td>12</td>
<td>V 27</td>
<td>Depreciation</td>
<td>5,987</td>
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<td>V 28</td>
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<tr>
<td>14</td>
<td>Total</td>
<td></td>
<td>$92,018</td>
<td></td>
<td>$112,289</td>
<td>*</td>
<td>20,271</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Hours</th>
<th>Percent</th>
<th>Description</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Applicable</td>
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</tbody>
</table>

* 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 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.
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.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Schedule V Line Reference</td>
<td>Item</td>
<td>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</td>
<td>Total Units</td>
<td>Number of Subunits Being Allocated Among</td>
<td>Total Indirect Cost Being Allocated</td>
<td>Amount of Salary Cost Contained in Column 6</td>
<td>Facility Units</td>
<td>Allocation (col.8/col.4)x col.6</td>
</tr>
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<td>Not Applicable</td>
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<tr>
<td>25 TOTALS</td>
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<td>25</td>
</tr>
</tbody>
</table>
### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

#### A. Interest:
(Complete details must be provided for each loan - attach a separate schedule if necessary.)

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate (4 Digits)</th>
<th>Reporting Period</th>
<th>Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td>Original</td>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A. Directly Facility Related</strong></td>
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<td></td>
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</tr>
<tr>
<td>1 CHI Revolving Loan Fund</td>
<td>x</td>
<td>Bldg &amp; Equipment</td>
<td>$1,081.78</td>
<td>7/1/80</td>
<td>$164,317</td>
<td>$125,531</td>
<td>11/1/07</td>
<td>0.0200</td>
<td>$26,030</td>
</tr>
<tr>
<td>2 City of Herrin</td>
<td>x</td>
<td>Refinance Debt</td>
<td>$19,308.33</td>
<td>9/1/93</td>
<td>2,720,000</td>
<td>2,310,000</td>
<td>9/1/18</td>
<td>0.0700</td>
<td>163,742</td>
</tr>
<tr>
<td>3 GR Bonds (91C, 96A, 99A &amp; 00A)</td>
<td>x</td>
<td>Redeem/Refinance Debt</td>
<td>$29,371.40</td>
<td>Various</td>
<td>4,937,500</td>
<td>3,951,704</td>
<td>Various</td>
<td>Various</td>
<td>265,580</td>
</tr>
<tr>
<td>4 CHI BondFund</td>
<td>x</td>
<td>Refinance Debt</td>
<td>$4,176.54</td>
<td>12/31/97</td>
<td>1,600,166</td>
<td>112,077</td>
<td>5/1/48</td>
<td>0.0850</td>
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<td><strong>B. Non-Facility Related</strong></td>
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<tr>
<td><strong>A. Directly Facility Related</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 CHI Revolving Loan Fund</td>
<td>x</td>
<td>Bldg &amp; Equipment</td>
<td>$1,081.78</td>
<td>7/1/80</td>
<td>$164,317</td>
<td>$125,531</td>
<td>11/1/07</td>
<td>0.0200</td>
<td>$26,030</td>
</tr>
<tr>
<td>2 City of Herrin</td>
<td>x</td>
<td>Refinance Debt</td>
<td>$19,308.33</td>
<td>9/1/93</td>
<td>2,720,000</td>
<td>2,310,000</td>
<td>9/1/18</td>
<td>0.0700</td>
<td>163,742</td>
</tr>
<tr>
<td>3 GR Bonds (91C, 96A, 99A &amp; 00A)</td>
<td>x</td>
<td>Redeem/Refinance Debt</td>
<td>$29,371.40</td>
<td>Various</td>
<td>4,937,500</td>
<td>3,951,704</td>
<td>Various</td>
<td>Various</td>
<td>265,580</td>
</tr>
<tr>
<td>4 CHI BondFund</td>
<td>x</td>
<td>Refinance Debt</td>
<td>$4,176.54</td>
<td>12/31/97</td>
<td>1,600,166</td>
<td>112,077</td>
<td>5/1/48</td>
<td>0.0850</td>
<td>34,835</td>
</tr>
<tr>
<td>TOTAL Facility Related</td>
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<td></td>
<td>$53,938.05</td>
<td></td>
<td>$9,421,983</td>
<td>$6,499,312</td>
<td></td>
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<td>$490,186</td>
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</tbody>
</table>

* 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.)
### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
#### B. Real Estate Taxes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Real Estate Tax accrual used on 2000 report.</td>
<td>$1</td>
</tr>
<tr>
<td><strong>2.</strong> 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.)</td>
<td>$2</td>
</tr>
<tr>
<td><strong>3.</strong> Under or (over) accrual (line 2 minus line 1).</td>
<td>$3</td>
</tr>
<tr>
<td><strong>4.</strong> Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)</td>
<td>$4</td>
</tr>
<tr>
<td><strong>5.</strong> 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.)</td>
<td>$5</td>
</tr>
<tr>
<td><strong>6.</strong> 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 19 Tax Year. (Attach a copy of the real estate tax appeal board’s decision.)</td>
<td>$6</td>
</tr>
<tr>
<td><strong>7.</strong> Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.</td>
<td>$7</td>
</tr>
</tbody>
</table>

**Real Estate Tax History:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Real Estate Tax Bill for Calendar Year:</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>8</td>
</tr>
<tr>
<td>1997</td>
<td>9</td>
</tr>
<tr>
<td>1998</td>
<td>10</td>
</tr>
<tr>
<td>1999</td>
<td>11</td>
</tr>
<tr>
<td>2000</td>
<td>12</td>
</tr>
</tbody>
</table>

**FOR OHF USE ONLY**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13 FROM R. E. TAX STATEMENT FOR 2000</td>
<td>$13</td>
</tr>
<tr>
<td>14 PLUS APPEAL COST FROM LINE 5</td>
<td>$14</td>
</tr>
<tr>
<td>15 LESS REFUND FROM LINE 6</td>
<td>$15</td>
</tr>
<tr>
<td>16 AMOUNT TO USE FOR RATE CALCULATION</td>
<td>$16</td>
</tr>
</tbody>
</table>

**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.
# 2000 Long Term Care Real Estate Tax Statement

## A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

<table>
<thead>
<tr>
<th>Tax Index Number</th>
<th>Property Description</th>
<th>Total Tax</th>
<th>Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>02-18-429-008 Williams 1st SOL N 75</td>
<td>$295.14</td>
<td>$295.14</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td></td>
<td>$295.14</td>
<td>$295.14</td>
</tr>
</tbody>
</table>

## B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.
X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100
B. General Construction Type: Exterior Brick Frame Steel
C. Does the Operating Entity?
   - (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?
   - (a) Own the Equipment
   - (b) Rent equipment from a Related Organization.
   - (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, nurse aide training facilities, etc.)

   List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
   - YES
   - 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:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Land.</td>
<td>Use</td>
<td>Square Feet</td>
<td>Year Acquired</td>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Facility</td>
<td>180,000</td>
<td>1980</td>
<td>$71,171</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Home Office Allocation</td>
<td></td>
<td></td>
<td>6,682</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>TOTALS</td>
<td>180,000</td>
<td></td>
<td>$77,853</td>
<td>3</td>
</tr>
</tbody>
</table>
### XI. OWNERSHIP COSTS (continued)

#### B. Building Depreciation-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Acquired</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storage Building</td>
<td>1981</td>
<td></td>
<td>6,010</td>
<td>235</td>
<td>20</td>
<td>326</td>
<td>91</td>
<td>6,310</td>
</tr>
<tr>
<td>Roof Repair</td>
<td>1983</td>
<td></td>
<td>4,238</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>4,238</td>
</tr>
<tr>
<td>Smoke Alarm</td>
<td>1984</td>
<td></td>
<td>650</td>
<td>33</td>
<td>20</td>
<td>33</td>
<td>(1)</td>
<td>377</td>
</tr>
<tr>
<td>Building Improvements</td>
<td>1985</td>
<td></td>
<td>34,866</td>
<td>1,855</td>
<td>20</td>
<td>1,855</td>
<td>(0)</td>
<td>35,711</td>
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<tr>
<td>Roof Replacement</td>
<td>1985</td>
<td></td>
<td>192,600</td>
<td>5,503</td>
<td>35</td>
<td>5,503</td>
<td>(0)</td>
<td>88,048</td>
</tr>
<tr>
<td>Windows</td>
<td>1985</td>
<td></td>
<td>39,252</td>
<td>981</td>
<td>40</td>
<td>981</td>
<td>0</td>
<td>15,451</td>
</tr>
<tr>
<td>Ceiling Tile</td>
<td>1985</td>
<td></td>
<td>4,232</td>
<td>212</td>
<td>20</td>
<td>212</td>
<td>(0)</td>
<td>3,304</td>
</tr>
<tr>
<td>A/C System</td>
<td>1985</td>
<td></td>
<td>4,200</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>4,200</td>
</tr>
<tr>
<td>Light Fixtures</td>
<td>1985</td>
<td></td>
<td>777</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>777</td>
</tr>
<tr>
<td>Ceiling Tile</td>
<td>1986</td>
<td></td>
<td>1,874</td>
<td>94</td>
<td>20</td>
<td>94</td>
<td>(0)</td>
<td>1,371</td>
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<tr>
<td>Duct Work</td>
<td>1986</td>
<td></td>
<td>1,200</td>
<td>80</td>
<td>20</td>
<td>80</td>
<td>0</td>
<td>1,100</td>
</tr>
<tr>
<td>Building Improvements</td>
<td>1986</td>
<td></td>
<td>4,103</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>4,103</td>
</tr>
<tr>
<td>Wiring</td>
<td>1987</td>
<td></td>
<td>891</td>
<td>45</td>
<td>20</td>
<td>45</td>
<td>(0)</td>
<td>653</td>
</tr>
<tr>
<td>Dining &amp; Administration Wing</td>
<td>1988</td>
<td></td>
<td>698,723</td>
<td>17,218</td>
<td>40</td>
<td>17,218</td>
<td>0</td>
<td>283,718</td>
</tr>
<tr>
<td>Landscaping</td>
<td>1987</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Remodeling</td>
<td>1987</td>
<td></td>
<td>705</td>
<td>35</td>
<td>20</td>
<td>35</td>
<td>0</td>
<td>487</td>
</tr>
<tr>
<td>Ceiling Duct</td>
<td>1987</td>
<td></td>
<td>510</td>
<td>26</td>
<td>20</td>
<td>26</td>
<td>(1)</td>
<td>502</td>
</tr>
<tr>
<td>Duct Work</td>
<td>1987</td>
<td></td>
<td>1,435</td>
<td>32</td>
<td>20</td>
<td>32</td>
<td>(0)</td>
<td>1,435</td>
</tr>
<tr>
<td>Energy System</td>
<td>1987</td>
<td></td>
<td>11,000</td>
<td>733</td>
<td>15</td>
<td>733</td>
<td>0</td>
<td>10,779</td>
</tr>
</tbody>
</table>

*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.
### B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 Remodeling</td>
<td>1988</td>
<td>$552</td>
<td>$28</td>
<td>20</td>
<td>$28</td>
<td>(0)</td>
<td>$373</td>
</tr>
<tr>
<td>38 Electrical Supply</td>
<td>1988</td>
<td>$373</td>
<td>19</td>
<td>20</td>
<td>19</td>
<td>(0)</td>
<td>253</td>
</tr>
<tr>
<td>39 Air Cleaner &amp; Duct</td>
<td>1988</td>
<td>1,694</td>
<td>10</td>
<td></td>
<td>1,694</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>40 Mirror</td>
<td>1988</td>
<td>$562</td>
<td></td>
<td>10</td>
<td>$562</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>41 HV Ac System</td>
<td>1988</td>
<td>4,675</td>
<td>234</td>
<td>20</td>
<td>234</td>
<td>(0)</td>
<td>3,081</td>
</tr>
<tr>
<td>42 Windows</td>
<td>1988</td>
<td>705</td>
<td>20</td>
<td>35</td>
<td>20</td>
<td>0</td>
<td>262</td>
</tr>
<tr>
<td>43 Baseboard</td>
<td>1988</td>
<td>757</td>
<td>37</td>
<td>20</td>
<td>37</td>
<td>(0)</td>
<td>484</td>
</tr>
<tr>
<td>44 Sewer</td>
<td>1988</td>
<td></td>
<td></td>
<td>20</td>
<td></td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>45 HVAC System</td>
<td>1988</td>
<td>2,423</td>
<td>1,103</td>
<td>20</td>
<td>1,103</td>
<td>0</td>
<td>1,703</td>
</tr>
<tr>
<td>46 HVAC System</td>
<td>1988</td>
<td>2,406</td>
<td>1,103</td>
<td>20</td>
<td>1,103</td>
<td>0</td>
<td>14,155</td>
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<tr>
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<td>1988</td>
<td>1,254</td>
<td>84</td>
<td>15</td>
<td>84</td>
<td>(0)</td>
<td>1,092</td>
</tr>
<tr>
<td>48 HVAC System</td>
<td>1988</td>
<td>1,576</td>
<td></td>
<td>10</td>
<td></td>
<td>1,576</td>
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<tr>
<td>49 HVAC System</td>
<td>1988</td>
<td>3,740</td>
<td>94</td>
<td>40</td>
<td>94</td>
<td>(1)</td>
<td>1,206</td>
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<td>1988</td>
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<td>1,850</td>
<td>40</td>
<td>1,850</td>
<td></td>
<td>23,742</td>
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<tr>
<td>51 HVAC System</td>
<td>1988</td>
<td>3,200</td>
<td>10</td>
<td></td>
<td></td>
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<td>3,200</td>
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<tr>
<td>52 HVAC System</td>
<td>1988</td>
<td>673</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>673</td>
</tr>
<tr>
<td>53 HVAC System</td>
<td>1988</td>
<td>6,950</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>6,950</td>
</tr>
<tr>
<td>54 HVAC System</td>
<td>1988</td>
<td>39,940</td>
<td>1,997</td>
<td>20</td>
<td>1,997</td>
<td></td>
<td>23,968</td>
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<td>55 HVAC System</td>
<td>1988</td>
<td>3,400</td>
<td>147</td>
<td>15</td>
<td>147</td>
<td>(0)</td>
<td>1,739</td>
</tr>
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<td>56 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>57 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>61 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>66 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>68 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69 HVAC System</td>
<td>1988</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>70 TOTAL (lines 4 thru 69)</td>
<td></td>
<td>$3,343,684</td>
<td>$89,982</td>
<td></td>
<td>$98,707</td>
<td></td>
<td>$8,725</td>
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</tbody>
</table>

**Improvement type must be detailed in order for the cost report to be considered complete.
<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year Constructed</td>
<td>Cost</td>
<td>Current Book Depreciation</td>
<td>Life in Years</td>
<td>Straight Line Depreciation</td>
<td>Accumulated Depreciation</td>
</tr>
<tr>
<td>1990</td>
<td>$840</td>
<td>5</td>
<td>20</td>
<td>$840</td>
<td>58</td>
</tr>
<tr>
<td>39 Trimming (120'*)</td>
<td>$2,446</td>
<td>122</td>
<td>20</td>
<td>122</td>
<td>0</td>
</tr>
<tr>
<td>40 Baseboard (120'*)</td>
<td>$706</td>
<td>5</td>
<td>20</td>
<td>706</td>
<td>40</td>
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<tr>
<td>41 Shelving</td>
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<td>5</td>
<td>20</td>
<td>851</td>
<td>41</td>
</tr>
<tr>
<td>42 Floor Tile</td>
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**Improvement type must be detailed in order for the cost report to be considered complete.
### B. Building Depreciation-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

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<th>Straight Line Depreciation</th>
<th>Depreciation Adjustments</th>
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**Improvement type must be detailed in order for the cost report to be considered complete.
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<td>Kombuch cool unit</td>
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</tr>
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<td>1 ton ac</td>
<td>2000</td>
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</tr>
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<td>1 ton heat pumps</td>
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<td>See attachment pg 1202(3)</td>
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<td>Remodel rooms 12, 24, 24, 24</td>
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<td>Remodel rooms 9, 15</td>
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<td>$2,490</td>
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<td>Install grease trap</td>
<td>2001</td>
<td>$886</td>
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<tr>
<td>68</td>
<td>Less disposables in 2001</td>
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<td>$1,750</td>
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<td>(177)</td>
<td>(177)</td>
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<td>(177)</td>
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<td>TOTAL: (lines 4 thru 69)</td>
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<td>$3,796,056</td>
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</table>

*Improvement type must be detailed in order for the cost report to be considered complete.*
<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>$</td>
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<td></td>
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<td></td>
<td></td>
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<td>70 TOTAL (lines 4 thru 69)</td>
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<td>$3,062,859</td>
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<td>$87,571</td>
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<td>$1,489,083</td>
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**Improvement type must be detailed in order for the cost report to be considered complete.
XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation—Excluding Transportation. (See instructions.)

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>Description &amp; Year Acquired</th>
<th>Model, Make and Year</th>
<th>Year Acquired</th>
<th>Current Book Cost</th>
<th>Current Book Depreciation</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Life in Years</th>
<th>Accumulated Depreciation</th>
<th>Accumulated Adjustments</th>
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<tbody>
<tr>
<td>71</td>
<td>Purchased in Prior Years</td>
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<td></td>
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<td></td>
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<td>$306,788</td>
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<td>$30,825</td>
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<td>Various</td>
<td>$213,066</td>
<td></td>
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<td>Current Year Purchases</td>
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<td></td>
<td>$38,082</td>
<td>$1,361</td>
<td>$1,361</td>
<td></td>
<td>Various</td>
<td>$1,361</td>
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</tr>
<tr>
<td>73</td>
<td>Fully Depreciated Assets</td>
<td></td>
<td></td>
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<td>$225,203</td>
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<tr>
<td>74</td>
<td>HO Allocation</td>
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<td>$41,621</td>
<td>$4,296</td>
<td>$4,296</td>
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<td>TOTALS</td>
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<td></td>
<td>$611,694</td>
<td>$36,482</td>
<td>$36,482</td>
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<td>$473,472</td>
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D. Vehicle Depreciation (See instructions.)*

<table>
<thead>
<tr>
<th>Model, Make and Year</th>
<th>Year Acquired</th>
<th>Current Book Cost</th>
<th>Current Book Depreciation</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Life in Years</th>
<th>Accumulated Depreciation</th>
<th>Accumulated Adjustments</th>
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</thead>
<tbody>
<tr>
<td>76</td>
<td>Patient Transportation</td>
<td>1992 Van &amp; Letter Painting</td>
<td>1992</td>
<td>$14,250</td>
<td>$8</td>
<td>3</td>
<td>$14,250</td>
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<td>77</td>
<td>Patient Transportation</td>
<td>2000 Motor for Bus</td>
<td>2000</td>
<td>$3,323</td>
<td>3</td>
<td>1,477</td>
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<td>78</td>
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<td>$1,937</td>
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<td>80</td>
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<td>$26,636</td>
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E. Summary of Care-Related Assets

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<tr>
<th>Reference</th>
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<td>$153,993</td>
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<tr>
<td>85</td>
<td>$2,332,401</td>
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</table>

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

<table>
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<tr>
<th>Description &amp; Year Acquired</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
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<td>86</td>
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<td>91</td>
<td>227,815</td>
<td>4,173</td>
<td>109,624</td>
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</tbody>
</table>

G. Construction-in-Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>92</td>
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<td>94</td>
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<tr>
<td>95</td>
<td></td>
<td>95</td>
</tr>
</tbody>
</table>

* 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.
XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES NO

<table>
<thead>
<tr>
<th></th>
<th>1 Year Constructed</th>
<th>2 Number of Beds</th>
<th>3 Date of Lease</th>
<th>4 Rental Amount</th>
<th>5 Total Years of Lease</th>
<th>6 Total Years Renewal Option*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
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</tr>
</tbody>
</table>

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:

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

<table>
<thead>
<tr>
<th>1 Use</th>
<th>2 Model Year and Make</th>
<th>3 Monthly Lease Payment</th>
<th>4 Rental Expense for this Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
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<td>$</td>
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<tr>
<td>20</td>
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</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$</td>
<td>$ 21</td>
</tr>
</tbody>
</table>

* 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 Ctr # 0025619

Report Period: July 1, 2000 to June 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<table>
<thead>
<tr>
<th>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</th>
<th>2. CLASSROOM PORTION:</th>
<th>3. CLINICAL PORTION:</th>
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</thead>
<tbody>
<tr>
<td>YES</td>
<td>IN-HOUSE PROGRAM</td>
<td>IN-HOUSE PROGRAM</td>
</tr>
<tr>
<td>NO</td>
<td>IN OTHER FACILITY</td>
<td>IN OTHER FACILITY</td>
</tr>
</tbody>
</table>

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

<table>
<thead>
<tr>
<th>Allocation of Costs (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility</th>
<th>Drop-outs</th>
<th>Completed</th>
<th>Contract</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community College Tuition</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Books and Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classroom Wages</td>
<td>(a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Wages</td>
<td>(b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-House Trainer Wages</td>
<td>(c)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractual Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Aide Competency Tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

C. CONTRACTUAL INCOME

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

D. NUMBER OF AIDES TRAINED

<table>
<thead>
<tr>
<th>COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From this facility</td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DROP-OUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From this facility</td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
</tr>
</tbody>
</table>

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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Schedule V Line &amp; Column Reference</th>
<th>Staff Units</th>
<th>Cost</th>
<th>Outside Practitioner Units (other than consultant)</th>
<th>Supplies (Actual or Allocated)</th>
<th>Total Units (Column 2 + 4)</th>
<th>Total Cost (Col. 3 + 5 + 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Licensed Occupational Therapist</td>
<td>Not Applicable</td>
<td>hrs</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>2. Licensed Speech and Language Development Therapist</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3. Licensed Recreational Therapist</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4. Licensed Physical Therapist</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5. Physician Care</td>
<td></td>
<td>visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>6. Dental Care</td>
<td></td>
<td>visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>7. Work Related Program</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>8. Habilitation</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>9. Pharmacy</td>
<td># of prescripts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>10. Psychological Services</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>11. Academic Education</td>
<td></td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>12. Exceptional Care Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>13. Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>14. TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**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 nurse aides, who help with the above activities should not be listed on this schedule.
### Facility Name & ID Number
Shawnee Christian Nursing Ctr # 0025619

### Report Period
Beginning: July 1, 2000
Ending: June 30, 2001

### As of
June 30, 2001
(last day of reporting year)

### XV. BALANCE SHEET - Unrestricted Operating Fund

This report must be completed even if financial statements are attached.

<table>
<thead>
<tr>
<th>A. Current Assets</th>
<th>1</th>
<th>Operating</th>
<th>2</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cash on Hand and in Banks</td>
<td>$74,474</td>
<td>$74,474</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Cash-Patient Deposits</td>
<td>16,242</td>
<td>16,242</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>332,190</td>
<td>332,190</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Supply Inventory (priced at)</td>
<td>8,366</td>
<td>8,366</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5 Short-Term Investments</td>
<td>1,154</td>
<td>1,154</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Prepaid Insurance</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Other Prepaid Expenses</td>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Accounts Receivable (owners or related parties)</td>
<td></td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Other(specify): Accrued Int Receivable</td>
<td>654</td>
<td>654</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Assets</strong> (sum of lines 1 thru 9)</td>
<td>$433,080</td>
<td>$433,080</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Long-Term Assets</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10 TOTAL Long-Term Assets (sum of lines 1 thru 9)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Current Liabilities</th>
<th>1</th>
<th>Operating</th>
<th>2</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Accounts Payable</td>
<td>$58,157</td>
<td>$58,157</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27 Officer's Accounts Payable</td>
<td></td>
<td></td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 Accounts Payable-Patient Deposits</td>
<td>16,242</td>
<td>16,242</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29 Short-Term Notes Payable</td>
<td></td>
<td></td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30 Accrued Salaries Payable</td>
<td>112,787</td>
<td>112,787</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>31 Accrued Taxes Payable (excluding real estate taxes)</td>
<td></td>
<td></td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>32 Accrued Real Estate Taxes(Sch.IX-B)</td>
<td>443</td>
<td>443</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>33 Accrued Interest Payable</td>
<td></td>
<td></td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>34 Deferred Compensation</td>
<td></td>
<td></td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>35 Federal and State Income Taxes</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Liabilities</strong> (sum of lines 26 thru 37)</td>
<td>$312,078</td>
<td>$312,078</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Long-Term Liabilities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>39 TOTAL Long-Term Liabilities (sum of lines 26 thru 37)</td>
<td>$312,078</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Other Long-Term Liabilities(specify):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</td>
<td>$6,624,599</td>
</tr>
<tr>
<td>41 TOTAL LIABILITIES (sum of lines 38 and 45)</td>
<td>$6,936,677</td>
</tr>
<tr>
<td>42 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</td>
<td>$2,847,963</td>
</tr>
</tbody>
</table>

*(See instructions.)*

### TOTAL ASSETS
(sum of lines 10 and 24) $2,847,963 $2,847,963 25
### STATE OF ILLINOIS

Facility Name & ID Number: Shawnee Christian Nursing Ctr # 0025619


#### XVI. STATEMENT OF CHANGES IN EQUITY

<table>
<thead>
<tr>
<th></th>
<th>1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Balance at Beginning of Year, as Previously Reported</td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5)</td>
</tr>
</tbody>
</table>

**A. Additions (deductions):**

<table>
<thead>
<tr>
<th></th>
<th>1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>NET Income (Loss) (from page 19, line 43)</td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners</td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>17</td>
<td>TOTAL Additions (deductions) (sum of lines 7-16)</td>
</tr>
</tbody>
</table>

**B. Transfers (Itemize):**

<table>
<thead>
<tr>
<th></th>
<th>1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>TOTAL Transfers (sum of lines 18-22)</td>
</tr>
<tr>
<td>24</td>
<td>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</td>
</tr>
</tbody>
</table>

* This must agree with page 17, line 47.
Facility Name & ID Number: Shawnee Christian Nursing Ctr # 0025619

**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.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient Care</td>
<td></td>
<td>A. Operating Expenses</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Gross Revenue – All Levels of Care</td>
<td>$4,133,230</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Discounts and Allowances for all Levels</td>
<td>(496,074)</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>SUBTOTAL Inpatient Care (line 1 minus line 2)</td>
<td>$3,637,156</td>
<td>3</td>
</tr>
<tr>
<td>B. Ancillary Revenue</td>
<td></td>
<td>B. Capital Expense</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Day Care</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Other Care for Outpatients</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Therapy</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Oxygen</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</td>
<td>$843</td>
<td>12</td>
</tr>
<tr>
<td>C. Other Operating Revenue</td>
<td></td>
<td>D. Other Expenses (specify):</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Payments for Education</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>Other Government Grants</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Nurses Aide Training Reimbursements</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>Gift and Coffee Shop</td>
<td>$18,620</td>
<td>13</td>
</tr>
<tr>
<td>13</td>
<td>Barber and Beauty Care</td>
<td>$18,620</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Non-Patient Meals</td>
<td>$98</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>Telephone, Television and Radio</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>Rental of Facility Space</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>Sale of Drugs</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td>Sale of Supplies to Non-Patients</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>Laboratory</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td>Radiology and X-Ray</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>Other Medical Services</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td>Laundry</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</td>
<td>$19,261</td>
<td>23</td>
</tr>
<tr>
<td>D. Non-Operating Revenue</td>
<td></td>
<td>E. Other Revenue (specify):****</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Contributions</td>
<td>$25,752</td>
<td>24</td>
</tr>
<tr>
<td>25</td>
<td>Interest and Other Investment Income***</td>
<td>$12,582</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</td>
<td>$38,334</td>
<td>26</td>
</tr>
<tr>
<td>E. Other Revenue (specify):****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Settlement Income (Insurance, Legal, Etc.)</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>28</td>
<td>Activity Revenue</td>
<td>(412)</td>
<td>28</td>
</tr>
<tr>
<td>28a</td>
<td>Gain/Loss on Sale of Equip &amp; Investments</td>
<td>$661</td>
<td>28a</td>
</tr>
<tr>
<td>29</td>
<td>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</td>
<td>$249</td>
<td>29</td>
</tr>
<tr>
<td>30</td>
<td>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</td>
<td>$3,694,999</td>
<td>30</td>
</tr>
<tr>
<td>31</td>
<td>TOTAL EXPENSES (sum of lines 31 thru 39)*</td>
<td>$4,063,824</td>
<td>40</td>
</tr>
<tr>
<td>41</td>
<td>Income before Income Taxes (line 30 minus line 40)**</td>
<td>(368,825)</td>
<td>41</td>
</tr>
<tr>
<td>42</td>
<td>Income Taxes</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>43</td>
<td>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</td>
<td>$ (368,825)</td>
<td>43</td>
</tr>
</tbody>
</table>

* 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.
### XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

<table>
<thead>
<tr>
<th># of Hrs. Actually Worked</th>
<th># of Hrs. Paid and Accrued</th>
<th>Reporting Period Total Salaries, Wages</th>
<th>Average Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Director of Nursing</td>
<td>2,114</td>
<td>2,114 $ 47,818</td>
<td>$ 22.62</td>
</tr>
<tr>
<td>2 Assistant Director of Nursing</td>
<td>2,167</td>
<td>2,167 $ 44,896</td>
<td>$ 20.73</td>
</tr>
<tr>
<td>3 Registered Nurses</td>
<td>12,405</td>
<td>12,482 $ 240,803</td>
<td>$ 19.00</td>
</tr>
<tr>
<td>4 Licensed Practical Nurses</td>
<td>21,278</td>
<td>23,218 $ 276,195</td>
<td>$ 11.90</td>
</tr>
<tr>
<td>5 Nurse Aides &amp; Orderlies</td>
<td>99,816</td>
<td>110,785 $ 865,449</td>
<td>$ 7.81</td>
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<tr>
<td>6 Nurse Aide Trainees</td>
<td>6</td>
<td></td>
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<tr>
<td>7 Licensed Therapist</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8 Rehab/Therapy Aides</td>
<td>3,255</td>
<td>3,255 $ 28,160</td>
<td>$ 8.65</td>
</tr>
<tr>
<td>9 Activity Director</td>
<td>2,739</td>
<td>2,936 $ 35,398</td>
<td>$ 12.06</td>
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<tr>
<td>10 Activity Assistants</td>
<td></td>
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<tr>
<td>11 Social Service Workers</td>
<td>8,375</td>
<td>8,977 $ 75,148</td>
<td>$ 8.37</td>
</tr>
<tr>
<td>12 Dietician</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13 Food Service Supervisor</td>
<td>1,845</td>
<td>1,972 $ 22,473</td>
<td>$ 11.40</td>
</tr>
<tr>
<td>14 Head Cook</td>
<td></td>
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<td></td>
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<tr>
<td>15 Cook Helpers/Assistants</td>
<td>19,382</td>
<td>20,712 $ 158,399</td>
<td>$ 7.65</td>
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<tr>
<td>16 Dishwashers</td>
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<td></td>
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<tr>
<td>17 Maintenance Workers</td>
<td>3,435</td>
<td>3,732 $ 37,799</td>
<td>$ 10.13</td>
</tr>
<tr>
<td>18 Housekeepers</td>
<td>17,760</td>
<td>18,119 $ 115,840</td>
<td>$ 6.34</td>
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<tr>
<td>19 Laundry</td>
<td>8,886</td>
<td>9,497 $ 73,552</td>
<td>$ 7.74</td>
</tr>
<tr>
<td>20 Administrator</td>
<td>1,497</td>
<td>1,699 $ 50,551</td>
<td>$ 29.75</td>
</tr>
<tr>
<td>21 Assistant Administrator</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>22 Other Administrative</td>
<td>1,886</td>
<td>2,141 $ 24,841</td>
<td>$ 11.23</td>
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<tr>
<td>23 Office Manager</td>
<td>1,600</td>
<td>1,816 $ 23,003</td>
<td>$ 12.67</td>
</tr>
<tr>
<td>24 Clerical</td>
<td>3,194</td>
<td>3,194 $ 24,669</td>
<td>$ 7.72</td>
</tr>
<tr>
<td>25 Vocational Instruction</td>
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</tr>
<tr>
<td>26 Academic Instruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Qualified MR Prof. (QMRP)</td>
<td>1,724</td>
<td>1,836 $ 18,745</td>
<td>$ 10.21</td>
</tr>
<tr>
<td>29 Resident Services Coordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Habilitation Aides (DD Homes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Medical Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Other Health Care(specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 Other(specify) Beauty Shop</td>
<td>1,724</td>
<td>1,836 $ 18,745</td>
<td>$ 10.21</td>
</tr>
<tr>
<td>34 TOTAL (lines 1 - 33)</td>
<td>207,358</td>
<td>226,652 $ 2,162,941</td>
<td>$ 9.54</td>
</tr>
</tbody>
</table>

### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>Number of Hrs. of Consultant Services</th>
<th>Total Consultant Cost for Reporting Period</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 Dietary Consultant</td>
<td>$ 12,365</td>
<td>35</td>
</tr>
<tr>
<td>36 Medical Director</td>
<td>$ 6,500</td>
<td>36</td>
</tr>
<tr>
<td>37 Medical Records Consultant</td>
<td>$ 203</td>
<td>37</td>
</tr>
<tr>
<td>38 Nurse Consultant</td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>39 Pharmacist Consultant</td>
<td>$ 780</td>
<td>39</td>
</tr>
<tr>
<td>40 Physical Therapy Consultant</td>
<td>$ 19,988</td>
<td>40</td>
</tr>
<tr>
<td>41 Occupational Therapy Consultant</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>42 Respiratory Therapy Consultant</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>43 Speech Therapy Consultant</td>
<td>$ 2,831</td>
<td>43</td>
</tr>
<tr>
<td>44 Activity Consultant</td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>45 Social Service Consultant</td>
<td>$ 4,089</td>
<td>45</td>
</tr>
<tr>
<td>46 Other(specify) Dental Consultant</td>
<td>$ 49</td>
<td>46</td>
</tr>
<tr>
<td>47</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>48</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>49 TOTAL (lines 35 - 48)</td>
<td>$ 46,805</td>
<td>49</td>
</tr>
</tbody>
</table>

### C. CONTRACT NURSES

<table>
<thead>
<tr>
<th>Number of Hrs. of Contract Wages</th>
<th>Total Contract Wages</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 Registered Nurses</td>
<td>$</td>
<td>50</td>
</tr>
<tr>
<td>51 Licensed Practical Nurses</td>
<td>$</td>
<td>51</td>
</tr>
<tr>
<td>52 Nurse Aides</td>
<td>$</td>
<td>52</td>
</tr>
<tr>
<td>53 TOTAL (lines 50 - 52)</td>
<td>$</td>
<td>53</td>
</tr>
</tbody>
</table>

* This total must agree with page 4, column 1, line 45. ** See instructions.
## STATE OF ILLINOIS
### Facility Name & ID Number: Shawnee Christian Nursing Ctr
### # 0025619
### Report Period Beginning: July 1, 2000
### Ending: June 30, 2001

### XIX. SUPPORT SCHEDULES

<table>
<thead>
<tr>
<th>A. Administrative Salaries</th>
<th>Ownership</th>
<th>Name</th>
<th>Function</th>
<th>%</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Burvell</td>
<td>Administrator</td>
<td>$50,551</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Employee Benefits and Payroll Taxes</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers' Compensation Insurance</td>
<td></td>
<td>$78,300</td>
</tr>
<tr>
<td>Unemployment Compensation Insurance</td>
<td></td>
<td>$4,800</td>
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<tr>
<td>FICA Taxes</td>
<td></td>
<td>$165,761</td>
</tr>
<tr>
<td>Employee Health Insurance</td>
<td></td>
<td>$101,400</td>
</tr>
<tr>
<td>Employee Meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Expense</td>
<td></td>
<td>$6,684</td>
</tr>
<tr>
<td>Employee Physicals</td>
<td></td>
<td>$1,724</td>
</tr>
</tbody>
</table>

### B. Administrative - Other

<table>
<thead>
<tr>
<th>Description</th>
<th>Management Fee</th>
<th>Marketing Exp</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$75,420</td>
<td>$16,598</td>
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</tbody>
</table>

### C. Professional Services

<table>
<thead>
<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craig/Bartels Meyer</td>
<td>Legal</td>
<td>$208</td>
</tr>
<tr>
<td>V. Ostrand/E. Kelley</td>
<td>Legal</td>
<td>$661</td>
</tr>
<tr>
<td>Booth &amp; Antolione</td>
<td>Legal</td>
<td>$170</td>
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</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-State Travel</td>
<td>$</td>
</tr>
<tr>
<td>In-State Travel</td>
<td>$3,785</td>
</tr>
<tr>
<td>Seminar Expense</td>
<td>$1,935</td>
</tr>
<tr>
<td>Other Costs</td>
<td>$616</td>
</tr>
<tr>
<td>HO Allocation</td>
<td>$3,750</td>
</tr>
</tbody>
</table>

### G. Schedule of Travel and Seminar**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (agree to Schedule V, line 24, col. 8)</td>
<td>$10,086</td>
</tr>
</tbody>
</table>

### Notes:
- *Attach copy of IMRF notifications
- **See instructions.
### XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

<table>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Applicable</td>
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<td>20</td>
<td>TOTALS</td>
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</tr>
</tbody>
</table>

(See instructions.)
XX. GENERAL INFORMATION:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Are nursing employees (RN, LPN, NA) represented by a union?</td>
<td>No</td>
</tr>
<tr>
<td>(2) Are there any dues to nursing home associations included on the cost report?</td>
<td>Yes</td>
</tr>
<tr>
<td>If YES, give association name and amount.</td>
<td>LS N $5502.09</td>
</tr>
<tr>
<td>(3) Did the nursing home make political contributions or payments to a political action organization?</td>
<td>No If YES, have these costs been properly adjusted out of the cost report?</td>
</tr>
<tr>
<td>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?</td>
<td>No If YES, what is the capacity?</td>
</tr>
<tr>
<td>(5) Have you properly capitalized all major repairs and equipment purchases?</td>
<td>Yes What was the average life used for new equipment added during this period?</td>
</tr>
<tr>
<td>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.</td>
<td>$ 8,069 Line 10.2</td>
</tr>
<tr>
<td>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?</td>
<td>Yes If NO, attach a complete explanation.</td>
</tr>
<tr>
<td>(8) Are you presently operating under a sale and leaseback arrangement?</td>
<td>NO</td>
</tr>
<tr>
<td>If YES, give effective date of lease.</td>
<td></td>
</tr>
<tr>
<td>(9) Are you presently operating under a sublease agreement?</td>
<td>YES X NO</td>
</tr>
<tr>
<td>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?</td>
<td>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.</td>
</tr>
<tr>
<td>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.</td>
<td>$ 87,053 This amount is to be recorded on line 42 of Schedule V.</td>
</tr>
<tr>
<td>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?</td>
<td>NO If YES, attach an explanation of the allocation.</td>
</tr>
<tr>
<td>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?</td>
<td>Yes</td>
</tr>
<tr>
<td>(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?</td>
<td>Yes For example, 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.</td>
</tr>
</tbody>
</table>
| (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? | No Indicate the amount. $ 
| (16) Travel and Transportation a. Are there costs included for out-of-state travel? | No |
| b. Do you have a separate contract with the Department to provide medical transportation for residents? | Yes If YES, please indicate the amount of income earned from such a program during this reporting period. $ 10,553 |
| c. What percent of all travel expense relates to transportation of nurses and patients? | 100% |
| 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. $ 0 |
| (17) Has an audit been performed by an independent certified public accounting firm? | Yes Firm Name: Eck, Schaefer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? | No If NO, please explain. To be provided when completed. |
| (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 $2,500, have legal invoices and a summary of services performed been attached to this cost report? | N/A Attach invoices and a summary of services for all architect and appraisal fees. |