

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0025619

Facility Name: Shawnee Christian Nursing Center

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

County: Williamson

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

HFS ID Number: 37-0841562005

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Brenda S. Lavin **Telephone Number:** 217-732-5136

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, 2005 to June 30, 2006 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) <u>Tim Phillippe</u>	
	(Title) <u>Chief Executive Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Deborah Elsey</u> <u>Principal</u>	
	(Firm Name & Address) <u>Larson, Allen, Weishair & Co.</u> <u>220 South 6th Street, #300, Minneapolis, MN 55402</u>	
	(Telephone) <u>612-376-4642</u> Fax # <u>612-376-4850</u>	
	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# 0025619 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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 bedsn/a

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>159</u>	Skilled (SNF)	<u>159</u>	<u>58,035</u>	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	<u>159</u>	TOTALS	<u>159</u>	<u>58,035</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>29,693</u>	<u>8,919</u>	<u>11,704</u>	<u>50,316</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,693</u>	<u>8,919</u>	<u>11,704</u>	<u>50,316</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.70%

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)

NoneF. 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 NO

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

YES 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 Date 9/1/1980 NO

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

YES NO If YES, enter number of beds certified 159 and days of care provided 9,522Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	252,431	22,751	15,416	290,598		290,598		290,598			1
2	Food Purchase		208,785		208,785		208,785	362	209,147			2
3	Housekeeping	138,222	39,091	27	177,340		177,340		177,340			3
4	Laundry	99,396			99,396		99,396		99,396			4
5	Heat and Other Utilities			110,567	110,567		110,567	8,937	119,504			5
6	Maintenance	58,985	35,782	35,709	130,476		130,476	11,965	142,441			6
7	Other (specify):* Trash			3,721	3,721		3,721		3,721			7
8	TOTAL General Services	549,034	306,409	165,440	1,020,883		1,020,883	21,264	1,042,147			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,949,945	502,389	157,834	2,610,168		2,610,168	(343,319)	2,266,849			10
10a	Therapy			668,754	668,754		668,754		668,754			10a
11	Activities	12,519			12,519		12,519		12,519			11
12	Social Services	145,016	1,782	7,618	154,416		154,416	(685)	153,731			12
13	CNA Training											13
14	Program Transportation			3,632	3,632		3,632	(3,632)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,107,480	504,171	843,838	3,455,489		3,455,489	(347,636)	3,107,853			16
	C. General Administration											
17	Administrative	111,998	256	410,292	522,546		522,546	(321,947)	200,599			17
18	Directors Fees											18
19	Professional Services			32,318	32,318		32,318	12,013	44,331			19
20	Dues, Fees, Subscriptions & Promotions			61,469	61,469		61,469	(20,606)	40,863			20
21	Clerical & General Office Expenses	165,634	5,270	119,339	290,243		290,243	3,250	293,493			21
22	Employee Benefits & Payroll Taxes			570,848	570,848		570,848	22,339	593,187			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,707	9,707		9,707	14,959	24,666			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			133,553	133,553		133,553	3,149	136,702			26
27	Other (specify):*											27
28	TOTAL General Administration	277,632	5,526	1,337,526	1,620,684		1,620,684	(286,843)	1,333,841			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,934,146	816,106	2,346,804	6,097,056		6,097,056	(613,215)	5,483,841			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.

STATE OF ILLINOIS

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Facility Name & ID Number Shawnee Christian Nursing Center

#0025619

Report Period Beginning: July 1, 2005 Ending: June 30, 2006

June 30, 2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			200,475	200,475	200,475	27,421	227,896				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			445,250	445,250	445,250	(9,201)	436,049				32
33	Real Estate Taxes			447	447	447	(309)	138				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Deferred Bond Cost			1,291	1,291	1,291		1,291				36
37	TOTAL Ownership			647,463	647,463	647,463	17,911	665,374				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			23,143	23,143	23,143		23,143				39
40	Barber and Beauty Shops	18,197	597		18,794	18,794		18,794				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,053	87,053	87,053		87,053				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	18,197	597	110,196	128,990	128,990		128,990				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,952,343	816,703	3,104,463	6,873,509	6,873,509	(595,304)	6,278,205				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

0025619

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(139)	2		4
5	Telephone, TV & Radio in Resident Rooms	(594)	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	(9,570)	32		10
11	Discounts, Allowances, Rebates & Refunds	(497)	21		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)	(3,632)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,600)	21		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	(54,074)	21		24
25	Fund Raising, Advertising and Promotional	(18,531)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(447,091)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (536,728)		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (536,728)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Shawnee Christian Nursing Center

ID# 0025619

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ 501	2	1
2	Activity	(685)	12	2
3	Ambulance	(6,173)	10	3
4	Miscellaneous	(112)	21	4
5	Marketing Supplies	(2,075)	20	5
6	Marketing Salary	(87,768)	21	6
7	Marketing Printing	(538)	21	7
8	Marketing Finance Charges	(83)	21	8
9	Marketing Benefits	(3,408)	22	9
10	Marketing Travel	(1,354)	24	10
11	Real Estate Tax Adjustment to Actual	(309)	33	11
12	Pharmacy Chargeable	(21)	10	12
13	Pharmacy Chargeable	(302,169)	10	13
14	Pharmacy Non-Chargeable	(34,956)	10	14
15	Legal Fees (Related to Civil Penalty)	(7,941)	19	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	(447,091)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005

Ending:

June 30, 2006

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	362	0	0	0	0	0	0	0	0	0	0	362	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	(594)	9,531	0	0	0	0	0	0	0	0	0	8,937	5
6	Maintenance	0	11,965	0	0	0	0	0	0	0	0	0	11,965	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(232)	21,496	0	21,264	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	(343,319)	0	0	0	0	0	0	0	0	0	0	(343,319)	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	(685)	0	0	0	0	0	0	0	0	0	0	(685)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,632)	0	0	0	0	0	0	0	0	0	0	(3,632)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(347,636)	0	0	0	0	0	0	0	0	0	0	(347,636)	16
	C. General Administration													
17	Administrative	0	(321,947)	0	0	0	0	0	0	0	0	0	(321,947)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,941)	19,954	0	0	0	0	0	0	0	0	0	12,013	19
20	Fees, Subscriptions & Promotions	(20,606)	0	0	0	0	0	0	0	0	0	0	(20,606)	20
21	Clerical & General Office Expenses	(145,672)	148,922	0	0	0	0	0	0	0	0	0	3,250	21
22	Employee Benefits & Payroll Taxes	(3,408)	25,747	0	0	0	0	0	0	0	0	0	22,339	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,354)	16,313	0	0	0	0	0	0	0	0	0	14,959	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	3,149	0	0	0	0	0	0	0	0	0	3,149	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(178,981)	(107,862)	0	(286,843)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(526,849)	(86,366)	0	(613,215)	29								

STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nursing Center

0025619 Report Period Beginning:

July 1, 2005 Ending:

Summary B
June 30, 2006

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	27,421	0	0	0	0	0	0	0	0	0	27,421	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,570)	369	0	0	0	0	0	0	0	0	0	(9,201)	32
33	Real Estate Taxes	(309)	0	0	0	0	0	0	0	0	0	0	(309)	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	(9,879)	27,790	0	17,911	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(536,728)	(58,576)	0	(595,304)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule.						

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes Inc.	100.00%	\$ 9,531	\$ 9,531
2	V	6 Maintenance				11,965	11,965
3	V	17 Administrative	410,292			88,345	(321,947)
4	V	19 Professional Services				19,954	19,954
5	V	21 Clerical				148,922	148,922
6	V	22 Employee Benefits				25,747	25,747
7	V	24 Travel & Seminar				16,313	16,313
8	V	26 Insurnace				3,149	3,149
9	V	30 Depreciation				27,421	27,421
10	V	32 Interest				369	369
11	V						
12	V						
13	V						
14	Total		\$ 410,292			\$ 351,716	\$ * (58,576)

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

Facility Name & ID Number

Shawnee Christian Nursing Center

0025619

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619 Report Period Beginning: July 1, 2005

Ending: ne 30, 2006

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 Christian Homes, Inc.
 Street Address 200 N. Postville Dr.
 City / State / Zip Code Lincoln, IL 62656
 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					\$	\$		\$	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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	1993 Tax Exempt		x	Refinance Debt	\$19,388.00	9/1/1993	\$ 2,720,000	\$ 1,895,000	9/1/2018	0.0700	\$ 135,508	1								
2	1996-A General Rev Bonds		x	Refinance Debt	\$1,593.00	7/1/1996	225,000	183,150	7/1/2021	0.0675	12,977	2								
3	1999-A General Rev Bonds		x	Refinance Debt	\$6,745.00	1/1/1999	1,000,000	851,400	1/1/2024	0.0650	55,955	3								
4	2001-Z General Rev Bonds		x	Refinance Debt	\$21,974.00	10/1/2001	3,200,000	3,126,933	10/1/2031	0.0700	220,033	4								
5												5								
Working Capital																				
6	CHI Revolving Loan Fund		x	working capital				56,132		0.0200	1,277	6								
7	Virgil Hampton Annuity Payable		x	annuity							19,500	7								
8												8								
9	TOTAL Facility Related				\$49,700.00		\$ 7,145,000	\$ 6,112,615			\$ 445,250	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 7,145,000	\$ 6,112,615			\$ 445,250	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* 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

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2005 report.		\$	499	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.)		\$	447	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	(52)	3
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	190	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.		\$	138	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2001	_____	8		
	2002	_____	9		
	2003	_____	10		
	2004	333	11		
	2005	379	12		
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2005	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Center COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0025619

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-18-429-008</u>	<u>Williams 1st SOL</u>	\$ <u>379.00</u>	\$ <u>379.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>379.00</u>	\$ <u>379.00</u>

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 x 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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

0025619 Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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, 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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>180,000</u>	<u>1980</u>	<u>\$ 71,171</u>	<u>1</u>
2	<u>Home Office</u>			<u>7,991</u>	<u>2</u>
3	TOTALS	180,000		\$ 79,162	3

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159		1980	1971	\$ 1,666,025	\$ 44,338	35	\$ 44,338		\$ 1,145,614	4
5			1980	1980	107,504		20				5
6											6
7											7
8		Home Office Allocation			66,712	8,355		8,355		20,897	8
		Improvement Type**									
9		Storage Building		1981	6,510		20			6,510	9
10											10
11		Hearing & A/C System		1982	37,091		20			37,091	11
12		TV System		1982	9,873		15			9,873	12
13		TV System		1982	1,182		20			1,182	13
14		Building Improvements		1982	159,808	4,098	39	4,098		100,401	14
15		Building Improvements		1983	22,362	588	38	588		13,818	15
16											16
17		Smoke Alarm		1984	650		20			650	17
18		Building Improvements		1985	44,866	1,122	40	1,122		23,282	18
19											19
20		Windows		1985	39,252	981	40	981		20,356	20
21		Ceiling Tile		1985	4,232	80	20	80		4,232	21
22											22
23		Light Fixtures		1985	777		10			777	23
24		Ceiling Tile		1986	1,874	94	20	94		1,841	24
25		Duct Work		1986	1,600	80	20	80		1,580	25
26		Building Improvements		1986	4,103		10			4,103	26
27		Wiring		1987	891	45	20	45		878	27
28		Dining & Administration Wing		1987	688,723	17,218	40	17,218		326,539	28
29		Remodeling		1987	705	35	20	35		662	29
30		Ceiling Duct		1987	510	26	20	26		492	30
31		Duct Work		1987	635	32	20	32		600	31
32											32
33		Remodeling		1988	552	28	20	28		513	33
34		Electrical Supply		1988	373	19	20	19		348	34
35		Air Cleaner & Duct		1988	1,694		10			1,694	35
36		Mirror		1988	1,562		10			1,562	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

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HVAC System	1988	\$ 4,675	\$ 234	20	\$ 234	\$	\$ 4,251	37
38	Windows	1988	705	20	35	20		362	38
39	Baseboard	1988	739	37	20	37		669	39
40	Heat Pumps	1988	27,223	1,361	20	1,361		24,611	40
41	Floor Tile	1988	340		5			340	41
42	Duct Work	1988	22,066	1,103	20	1,103		19,670	42
43									43
44	Towel & Soap Dispenser	1988	1,976		10			1,976	44
45	Title Policy	1988	3,740	94	40	94		1,676	45
46	Hampton Settlement	1988	74,000	1,850	40	1,850		32,992	46
47	Wall Heat Pump	1989	1,300		10			1,300	47
48	Flourescent Light	1989	673		10			673	48
49	A/C Electrical Work	1989	6,950		8			6,950	49
50	Heat Pumps/Duct System	1989	39,940	1,997	20	1,997		33,949	50
51	Down Spouts	1989	600		15			600	51
52	Laundry Room Roof	1989	2,200		15			2,200	52
53									53
54	Heat Pumps	1989	63,466	3,173	20	3,173		52,355	54
55	Wander Guard	1989	11,417	571	20	571		9,422	55
56	Air Conditioning	1989	5,820		8			5,820	56
57	Ceiling Tile	1989	1,868		10			1,868	57
58	Trimming (1200")	1990	840		5			840	58
59	Remodel Rooms	1990	2,446	122	20	122		2,013	59
60	Baseboard (120')	1990	706		5			706	60
61	Shelving	1990	851		5			851	61
62	Floor Tile	1990	426		5			426	62
63	Water Heater	1990	386		15			386	63
64	Smoke Detectors	1990	890		5			890	64
65	Flourescent Lights (20)	1990	775		10			775	65
66	Door & Hardware	1990	541		5			541	66
67	Wallpaper	1990	919		5			919	67
68	Relocate Sprinklers	1990	583		10			583	68
69	Brick A/C Holes	1990	1,352	34	40	34		802	69
70	TOTAL (lines 4 thru 69)		\$ 3,150,479	\$ 87,735		\$ 87,735	\$	\$ 1,936,911	70

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,150,479	\$ 87,735		\$ 87,735	\$	\$ 1,936,911	1
2	Door Frames	1990	303		5			303	2
3	Paint & Wallpaper	1990	1,118		5			1,118	3
4	Heating Receivers (11)	1990	1,975		15			1,975	4
5	Kickplates	1990	763		10			763	5
6	Air Conditioner	1990	1,184		8			1,184	6
7	Door Alarm	1990	423		5			423	7
8	Doors & Lock	1990	35,817	1,791	20	1,791		28,507	8
9	Lights (13)	1990	590		10			590	9
10	Door Kickplates (118)	1990	2,104		10			2,104	10
11	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		5,407	11
12	Remodeling	1991	2,733	137	20	137		2,124	12
13	Door Locks	1991	510	26	20	26		403	13
14	Floor Tile Install	1991	10,926		5			10,926	14
15	Cove Base	1991	1,763		10			1,763	15
16	Handrail, Drywall	1991	569		5			569	16
17	Exit Fixtures	1991	1,619		10			1,619	17
18	A/C Units (2)	1991	15,885		10			15,885	18
19	Wallcoverings	1991	483		5			483	19
20	Heat Pump	1991	5,267	351	15	351		5,206	20
21	Walk-in Freezer	1991	8,643	576	15	576		8,544	21
22	Water Heater	1991	867		10			867	22
23	Hall Lights	1992	2,091		10			2,091	23
24	Water Heaters	1992	3,164	211	15	211		3,042	24
25	Heat Pump	1992	653	44	15	44		634	25
26	Heat Pump	1992	7,265	484	15	484		6,816	26
27	4' Loop System	1992	3,723		10			3,723	27
28	Building Lighting	1992	1,142		10			1,142	28
29	Metal Door Frames	1992	840	42	20	42		584	29
30	Garbage Disposals/Folding Door Divider	1994	1,161		5			1,161	30
31	Tub Room Remodel	1993	4,015		10			4,015	31
32	Building Remodeling	1993	6,103	305	20	305		3,980	32
33	Honeywell System	1993	5,031	252	20	252		3,297	33
34	TOTAL (lines 1 thru 33)		\$ 3,286,139	\$ 92,301		\$ 92,301	\$	\$ 2,058,159	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,286,139	\$ 92,301		\$ 92,301	\$	\$ 2,058,159	1
2	Sink & Doors	1994	3,381		10			3,381	2
3									3
4	Storage Room Remodel	1994	2,020	101	20	101		1,263	4
5	Sewage Pump System	1994	4,256		10			4,256	5
6	Fire/Garage Door	1994	526		5			526	6
7	Handrails	1995	6,079		10			6,079	7
8	Remodeling (Side 1)	1995	7,992		5			7,992	8
9	Cabinets	1995	2,343	156	15	156		1,723	9
10	Therapy/Bath	1996	181,372	7,557	24	7,557		76,829	10
11	Fire Alarm System Relay	1996	2,596	260	10	260		2,578	11
12	Cnvt Tub Room/Quiet	1997	1,296		5			1,296	12
13	Water Fountain	1997	502		5			502	13
14									14
15	Compressor	1997	973		3			973	15
16	Compressor Unit 1516	1997	2,377		3			2,377	16
17									17
18	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		18,576	18
19	Replace/Rewire Hot Water Heater	1998	9,445	945	10	945		7,875	19
20	Kitchen Heaters	1998	793		3			793	20
21	Compressor/Library #24	1999	2,972		3			2,972	21
22	Keyless locks	1999	1,423		5			1,423	22
23	Wallpaper dining room	1999	3,071		5			3,071	23
24	120 gal water heater	1999	3,000	300	10	300		2,125	24
25	Mixing valve water heater	2000	961		5			961	25
26	Compressor	2000	1,133		3			1,133	26
27	Security control system	2000	940	94	10	94		627	27
28	Remodel admin office/wiring	2000	1,147		5			1,147	28
29	Rooftop cond unit	2000	3,373	337	10	337		2,078	29
30	4 ton A/C	2000	2,590		5			2,590	30
31	4 ton hest pumps	2000	4,780	478	10	478		2,908	31
32	4 Ton Heat Pumps	2000	2,692	269	10	269		1,569	32
33	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		1,271	33
34	TOTAL (lines 1 thru 33)		\$ 3,581,264	\$ 105,611		\$ 105,611	\$	\$ 2,219,053	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,581,264	\$ 105,611		\$ 105,611	\$	\$ 2,219,053	1
2	Remodel Rooms 9-17	2001	2,657	266	10	266		1,419	2
3	Install Grease Trap	2001	886	134	5	134		886	3
4	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		295	4
5	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		3,928	5
6	Door Control System	1/1/2002	12,860	1,286	10	1,286		5,787	6
7	Countertop-Nursing Station Side 1	1/1/2002	750	50	15	50		225	7
8	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685	615	4	615		3,685	8
9	Install Dishwasher	5/24/2002	1,100	110	10	110		458	9
10	Countertop-Nursing Station Side 2	3/22/2002	760	51	15	51		221	10
11	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		927	11
12	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		908	12
13	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		298	13
14	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		3,500	14
15	Replacement Compressor in kitchen AC	8/31/2002	875	23	3	23		875	15
16	30 Position Nurse Call Station w/d	10/2/2002	1,100	110	10	110		413	16
17	(10) Panic Bars/(41)Door Knobs	12/9/2002	746	149	5	149		534	17
18	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		819	18
19	Remodel DON Office	2/11/2003	871	174	5	174		522	19
20	(12) Wall Signs w/Letters	2/27/2003	789	158	5	158		540	20
21	Nurse Call Light System - Side 1	8/1/2003	970	97	10	97		283	21
22	New Roof - Side 1	8/4/2003	52,263	3,484	15	3,484		9,581	22
23	Roof Replacement	8/4/2003	93,091	31,030	3	31,030		90,504	23
24	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571	114	5	114		314	24
25	Remodel Business Office	2/16/2004	920	184	5	184		445	25
26	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	1,896	10	1,896		4,424	26
27	Service Sink w/double pedal valves	6/3/2004	1,189	119	10	119		248	27
28	Heat Pump	6/16/2004	4,800	480	10	480		1,000	28
29	Roof Replacement - Resident Rooms	7/30/2004	58,356	3,890	15	3,890		7,780	29
30	Cable for Resident Phone Lines	3/18/2005	1,460	292	5	292		389	30
31	Dining Room Remodeling	3/1/2005	3,493	699	5	699		932	31
32	Resident Rooms Lighting	3/31/2005	1,793	359	5	359		479	32
33	Network Cabling Project	7/1/2004	19,993	1,999	10	1,999		3,998	33
34	TOTAL (lines 1 thru 33)		\$ 3,891,549	\$ 155,877		\$ 155,877	\$	\$ 2,365,670	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning:

July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,891,549	\$ 155,877		\$ 155,877	\$	\$ 2,365,670	1
2	Carport	9/22/2000	1,363	136	10	136		793	2
3	Bus barn	3/1/2003	8,752	219	40	219		730	3
4	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	4
5	Parking lot and sewer	2/29/1988	4,658	233	20	233		4,213	5
6	Courtyard walks and projects	9/30/1989	18,906	945	20	945		15,986	6
7	Fencing	6/8/1990	1,700		15			1,700	7
8	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	942	20	942		14,963	8
9	Drainage, lanscaping & Gazebo	8/14/1991	12,452	41	20	41		12,242	9
10	100' Fence	12/5/1991	1,380	92	15	92		1,342	10
11	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		9,762	11
12	Sidewalk & fence	8/30/1996	3,247	325	10	325		2,379	12
13	Enlarge parking	9/3/2002	2,386	119	20	119		474	13
14	Drainage culvert	3/28/2003	1,419	79	18	79		308	14
15	Dumpster fence	6/24/2003	769	77	10	77		297	15
16									16
17	Mini Blinds and Draperies	6/30/2006	3,348	56	5	56		56	17
18	Toilets and Tanks (4)	6/2/2006	716	6	10	6		6	18
19	New A/C and Heat Unit	6/30/2006	6,290	52	10	52		52	19
20	8 Alabaster Mini Blinds	3/29/2006	672	45	5	45		45	20
21	Water Heater	4/17/2006	4,174	104	10	104		104	21
22	A/C Unit Hallway	4/5/2006	6,820	171	10	171		171	22
23	New Nurse Call Light System	4/20/2006	1,575	39	10	39		39	23
24	5 Toilets	1/13/2006	872	22	20	22		22	24
25	39" X 59" Cordless Mark I (6)	2/1/2006	648	54	5	54		54	25
26	39" X 59" Cordless Mark I (6)	2/23/2006	648	54	5	54		54	26
27	New Grease Trap	3/1/2006	7,750	258	10	258		258	27
28	New Roof	7/28/2005	25,044	1,670	15	1,670		1,670	28
29	39" X 59" Cordless Roller Mini (7)	10/13/2005	613	92	5	92		92	29
30	New Flooring - Kitchen	3/31/2006	1,995	67	10	67		67	30
31	Landscaping Materials	6/29/2006	1,030	9	10	9		9	31
32	3 Sidewalks	8/10/2005	3,344	307	10	307		307	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,109,054	\$ 162,775		\$ 162,775	\$	\$ 2,496,302	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: July 1, 2005 Ending: June 30, 2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 295,216	\$ 37,899	\$ 37,899	\$	Various	\$ 157,853	71
72	Current Year Purchases	39,998	4,096	4,096		Various	4,096	72
73	Fully Depreciated Assets	427,163	3,094	3,094		Various	427,163	73
74	Home Office Allocation	135,827	17,010	17,010			102,584	74
75	TOTALS	\$ 898,204	\$ 62,099	\$ 62,099	\$		\$ 691,696	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	\$ 14,250	\$	\$	\$	8	\$ 14,250	76
77	Patient Transportation	New Motor	2000	3,323				3	3,323	77
78	Patient Transportation	2006 Ford Starcraft	2006	46,350	966	966		8	966	78
79	Home Office Allocation			16,423	2,057	2,057			2,058	79
80	TOTALS			\$ 80,346	\$ 3,023	\$ 3,023	\$		\$ 20,597	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 5,166,766	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 227,897	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 227,897	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)		\$ 3,208,595	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	CIP	\$ 10,316	92
93	Home Office Allocation	3,645	93
94			94
95		\$ 13,961	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

0025619

Report Period Beginning: July 1, 2005 Ending: June 30, 2006

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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.)

	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. No class offered and could not have even if desired.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7 8
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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# 0025619Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2006 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 77,902	\$	1
2	Cash-Patient Deposits	18,872		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>100,572</u>)	1,635,383		3
4	Supply Inventory (priced at)	8,268		4
5	Short-Term Investments	(307)		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	894		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,748,812	\$	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	3,896,118		14
15	Leasehold Improvements, at Historical Cost	146,224		15
16	Equipment, at Historical Cost	826,300		16
17	Accumulated Depreciation (book methods)	(3,083,056)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	230,119		21
22	Other Long-Term Assets (spe CIP)	10,316		22
23	Other(specify): <u>Deferred Bond Costs</u>	15,814		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,123,806	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,872,618	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 320,540	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,872		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,830		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	190		32
33	Accrued Interest Payable	11,054		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Liabilities</u>	35,292		36
37	<u>Due to Auxiliary</u>	2,671		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 587,449	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	56,132		39
40	Mortgage Payable			40
41	Bonds Payable	6,056,483		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,112,615	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,700,064	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,828,445)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,871,619	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,071,063)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,071,063)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	322,618	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)	\$ 322,618	17
	B. Transfers (Itemize):		
18	Transfer to Affiliate	(80,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (80,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,828,445)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shawnee Christian Nursing Center# 0025619Report Period Beginning: July 1, 2005Ending: June 30, 2006**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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,569,871	1
2	Discounts and Allowances for all Levels	(795,894)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,773,977	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,214,346	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,214,346	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	22,963	13
14	Non-Patient Meals	139	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,539	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,034	19
20	Radiology and X-Ray	9,232	20
21	Other Medical Services	6,173	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 61,080	23
D. Non-Operating Revenue			
24	Contributions	135,364	24
25	Interest and Other Investment Income***	14,569	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149,933	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue	(3,209)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (3,209)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,196,127	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,020,883	31
32	Health Care	3,455,489	32
33	General Administration	1,620,684	33
B. Capital Expense			
34	Ownership	647,463	34
C. Ancillary Expense			
35	Special Cost Centers	41,937	35
36	Provider Participation Fee	87,053	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,873,509	40
41	Income before Income Taxes (line 30 minus line 40)**	322,618	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 322,618	43

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

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

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

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

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning: July 1, 2005

Ending:

June 30, 2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,763	1,830	\$ 106,307	\$ 58.09	1
2	Assistant Director of Nursing	758	788	19,113	24.26	2
3	Registered Nurses	6,243	13,377	235,711	17.62	3
4	Licensed Practical Nurses	24,172	28,132	401,119	14.26	4
5	CNAs & Orderlies	104,415	116,359	1,053,695	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,087	3,819	42,820	11.21	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,296	13,724	146,402	10.67	11
12	Dietician					12
13	Food Service Supervisor	1,794	2,092	37,990	18.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,524	25,905	214,441	8.28	15
16	Dishwashers					16
17	Maintenance Workers	4,326	4,515	58,985	13.06	17
18	Housekeepers	12,545	14,656	138,223	9.43	18
19	Laundry	10,069	11,130	99,396	8.93	19
20	Administrator	2,077	2,150	111,998	52.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,875	2,414	45,129	18.69	23
24	Clerical	3,714	4,294	32,737	7.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,821	1,984	26,633	13.42	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Ward Clerk	2,703	2,871	27,430	9.55	32
33	Other(specify) <u>Comm. Liaison, etc</u>	6,318	6,860	154,214	22.48	33
34	TOTAL (lines 1 - 33)	223,500	256,900	\$ 2,952,343 *	\$ 11.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	308	\$ 13,431	1.3	35
36	Medical Director	24	6,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,486	122,639	10.3	38
39	Pharmacist Consultant	192	3,583	10.3	39
40	Physical Therapy Consultant	5,257	307,101	10A.3	40
41	Occupational Therapy Consultant	4,784	272,700	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,527	88,953	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	122	7,148	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13,700	\$ 821,555		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	202	6,396	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	202	\$ 6,396		53

Facility Name & ID Number Shawnee Christian Nursing Center

0025619

Report Period Beginning: July 1, 2005

Ending: June 30, 2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Scott Bushong	Operations Director		\$ 111,998	Workers' Compensation Insurance	\$ 118,561	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,763	Advertising: Employee Recruitment	23,562	
				FICA Taxes	206,508	Health Care Worker Background Check		
				Employee Health Insurance	224,640	(Indicate # of checks performed <u>128</u>)	1,280	
				Employee Meals		Supplies-General	2,075	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Promotion	18,531	
						License, Dues, & Subscriptions	16,021	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 111,998	Workers' Comp Medical Expense	818	Less: Public Relations Expense	()	
(List each licensed administrator separately.)				Employee Physicals	3,043	Non-allowable advertising	(20,606)	
B. Administrative - Other				Employee Uniforms	(1,881)	Yellow page advertising	()	
Description			Amount	Employee Expense	13,988	TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fee Expense			\$ 410,292	Home Office Allocation	25,747		\$ 40,863	
						TOTAL (agree to Schedule V, line 22, col.8)		
							\$ 593,187	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 410,292	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
American Recruiters	Administrator Placement		\$ 19,200				In-State Travel	7,206
V. Ostrand & E. Kelley	Legal		7,974				Seminar Expense	1,147
Davis & Campbell	Legal		2,146				Home Office Allocation	16,313
Tobin & Associates	Legal		2,998				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 24,666
TOTAL (agree to Schedule V, line 19, column 3)			\$ 32,318	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network, \$6,677.46
- (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. \$ 20,398 Line 3.10.2
- (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.
n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 87,053
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 139
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 38%
- d. Have vehicle usage logs been maintained? No
- 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: Eck, Schafer & 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? Yes If no, please explain. _____
- (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 \$2500, 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.