

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0025619

**Facility Name:** Shawnee Christian Nursing Center

**Address:** 1901 N 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
<b>IRS Exemption Code</b> <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:** Susan McGhee **Telephone Number:** 217-732-5175

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2006 to 6/30/2007 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Tim Phillippe</u>	
	(Title) <u>Chief Executive Officer</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u>	
	(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Drive, Suite 100, St. Louis, MO 631</u>	
	(Telephone) <u>314-336-3679</u> Fax # <u>314-336-3650</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: 7/1/2006 Ending: 6/30/2007

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	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>32,933</u>	<u>7,976</u>	<u>8,435</u>	<u>49,344</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>32,933</u>	<u>7,976</u>	<u>8,435</u>	<u>49,344</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.02%

D. How many bed-hold days during this year were paid by the Department?

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)

NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 8,016Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 6/30/2007 Fiscal Year: 6/30/2007

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

Facility Name & ID Number      Shawnee Christian Nursing Center      #      0025619      Report Period Beginning:      7/1/2006      Ending:      6/30/2007

**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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	256,536	20,108	15,687	292,331		292,331		292,331			1
2	Food Purchase		215,299		215,299		215,299	3,232	218,531			2
3	Housekeeping	265,248	30,208		295,456		295,456		295,456			3
4	Laundry											4
5	Heat and Other Utilities			127,965	127,965		127,965	12,092	140,057			5
6	Maintenance	77,710	13,109	17,971	108,790		108,790	5,533	114,323			6
7	Other (specify):* <b>Trash Removal</b>			5,607	5,607		5,607		5,607			7
8	<b>TOTAL General Services</b>	599,494	278,724	167,230	1,045,448		1,045,448	20,857	1,066,305			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	2,205,533	426,496	104,934	2,736,963		2,736,963	(211,287)	2,525,676			10
10a	Therapy			864,833	864,833		864,833		864,833			10a
11	Activities	11,885			11,885		11,885		11,885			11
12	Social Services	170,560	3,697	7,853	182,110		182,110	(1,971)	180,139			12
13	CNA Training											13
14	Program Transportation			824	824		824	(824)				14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,387,978	430,193	996,944	3,815,115		3,815,115	(214,082)	3,601,033			16
	<b>C. General Administration</b>											
17	Administrative	54,389	2,316	429,304	486,009		486,009	(336,432)	149,577			17
18	Directors Fees											18
19	Professional Services			34,504	34,504		34,504	44,193	78,697			19
20	Dues, Fees, Subscriptions & Promotions			45,024	45,024		45,024	(14,363)	30,661			20
21	Clerical & General Office Expenses	177,255	14,798	310,210	502,263		502,263	(103,565)	398,698			21
22	Employee Benefits & Payroll Taxes			629,680	629,680		629,680	30,833	660,513			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,842	29,842		29,842	19,969	49,811			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,878	115,878		115,878	1,269	117,147			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	231,644	17,114	1,594,442	1,843,200		1,843,200	(358,096)	1,485,104			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,219,116	726,031	2,758,616	6,703,763		6,703,763	(551,321)	6,152,442			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

Page 4

Facility Name & ID Number Shawnee Christian Nursing Center

#0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			176,624	176,624		176,624	25,496	202,120			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			408,992	408,992		408,992	(24,934)	384,058			32
33	Real Estate Taxes			393	393		393		393			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Deferred Financing Costs</b>			1,291	1,291		1,291		1,291			36
37	<b>TOTAL Ownership</b>			587,300	587,300		587,300	562	587,862			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			60,059	60,059		60,059		60,059			39
40	Barber and Beauty Shops	16,268	1,841		18,109		18,109		18,109			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	<b>TOTAL Special Cost Centers</b>	16,268	1,841	147,112	165,221		165,221		165,221			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,235,384	727,872	3,493,028	7,456,284		7,456,284	(550,759)	6,905,525			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: 7/1/2006

Ending: 6/30/2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(269)	2		4
5	Telephone, TV & Radio in Resident Rooms	(650)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,224)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2)	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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(17,347)	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	(154,394)	21		24
25	Fund Raising, Advertising and Promotional	(14,363)	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	(306,020)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (518,269)</b>		<b>\$</b>	<b>30</b>

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (518,269)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Shawnee Christian Nursing Center

ID# 0025619

Report Period Beginning: 7/1/2006

Ending: 6/30/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ 3,501	2	1
2	Activity	(1,971)	12	2
3	Miscellaneous	(81)	10	3
4	Marketing Salaries	(88,300)	21	4
5	Marketing Supplies & Other	(6,460)	21	5
6	Late Fees/Finance Charges	(679)	21	6
7	Pharmacy-Chargeable	(211,206)	10	7
8	Transportation	(824)	14	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(306,020)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	3,232	0	0	0	0	0	0	0	0	0	0	3,232	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	(650)	12,742	0	0	0	0	0	0	0	0	0	12,092	5
6	Maintenance	0	5,533	0	0	0	0	0	0	0	0	0	5,533	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>2,582</b>	<b>18,275</b>	<b>0</b>	<b>20,857</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(211,287)	0	0	0	0	0	0	0	0	0	0	(211,287)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,971)	0	0	0	0	0	0	0	0	0	0	(1,971)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(824)	0	0	0	0	0	0	0	0	0	0	(824)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(214,082)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(214,082)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(336,432)	0	0	0	0	0	0	0	0	0	(336,432)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	44,193	0	0	0	0	0	0	0	0	0	44,193	19
20	Fees, Subscriptions & Promotions	(14,363)	0	0	0	0	0	0	0	0	0	0	(14,363)	20
21	Clerical & General Office Expenses	(267,182)	163,617	0	0	0	0	0	0	0	0	0	(103,565)	21
22	Employee Benefits & Payroll Taxes	0	30,833	0	0	0	0	0	0	0	0	0	30,833	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	19,969	0	0	0	0	0	0	0	0	0	19,969	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,269	0	0	0	0	0	0	0	0	0	1,269	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(281,545)</b>	<b>(76,551)</b>	<b>0</b>	<b>(358,096)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(493,045)</b>	<b>(58,276)</b>	<b>0</b>	<b>(551,321)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006 Ending:

6/30/2007

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	25,496	0	0	0	0	0	0	0	0	0	25,496	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,224)	290	0	0	0	0	0	0	0	0	0	(24,934)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(25,224)</b>	<b>25,786</b>	<b>0</b>	<b>562</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(518,269)</b>	<b>(32,490)</b>	<b>0</b>	<b>(550,759)</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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%	\$ 12,742	\$ 12,742
2	V	6 Maintenance				5,533	5,533
3	V	17 Administration	429,304			92,872	(336,432)
4	V	19 Professional Services				44,193	44,193
5	V	21 Clerical				163,617	163,617
6	V	22 Employee Benefits				30,833	30,833
7	V	24 Travel & Seminar				19,969	19,969
8	V	26 Insurance				1,269	1,269
9	V	30 Depreciation				25,496	25,496
10	V	32 Interest				290	290
11	V						
12	V						
13	V						
14	Total		\$ 429,304			\$ 396,814	\$ * (32,490)

\* 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: 7/1/2006 Ending: 6/30/2007

## 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: 7/1/2006

Ending: 7/30/2007

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

Name of Related Organization Christian Homes, Inc.  
 Street Address 200 N. Postville Dr.  
 City / State / Zip Code Lincoln, IL 62656  
 Phone Number ( )  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

Facility Name & ID Number Shawnee Christian Nursing Center # 0025619 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

## 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	1993 Tax Exempt		X	Refinance Debt	\$19,608.00	9/1/93	\$ 2,720,000	\$ 1,790,000	9/1/18	0.0700	\$ 128,450	1
2	1991-D General Rev Bonds		X	Refinance Debt	\$28,546.00	10/1/91	4,000,000	2,497,000	10/1/21	0.0675	14,046	2
3	1996-A General Rev Bonds		X	Refinance Debt	\$13,741.00	7/1/96	225,000	1,572,527	7/1/21	0.0675	19,945	3
4	1999-A General Rev Bonds		X	Refinance Debt	\$3,028.00	1/1/99	1,000,000	371,000	1/1/24	0.0650	51,818	4
5	2001-Z General Rev Bonds		X	Refinance Debt		10/1/01	3,200,000		10/1/31	0.0700	193,743	5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$64,923.00		\$ 11,145,000	\$ 6,230,527			\$ 408,002	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 11,145,000	\$ 6,230,527			\$ 408,002	15

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

\* 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 Susan McGhee

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

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>389.00</u>	\$ <u>389.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>389.00</u>	\$ <u>389.00</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? X 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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

7/1/2006 Ending:

6/30/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 45,600 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (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 Allocation</u>			<u>7,182</u>	<u>2</u>
3	<b>TOTALS</b>	<b>180,000</b>		<b>\$ 78,353</b>	<b>3</b>

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159		1980	1971	\$ 1,666,025	\$ 44,338	35	\$ 44,338		\$ 1,189,952	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocations				61,934	7,676		7,676		97,047	8
	Improvement Type**										
9	Storage Building			1981	6,510		20			6,510	9
10	Hearing & A/C System			1982	37,091		20			37,091	10
11	TV System			1982	9,873		15			9,873	11
12	TV System			1982	1,182		20			1,182	12
13	Building Improvements			1982	159,808	4,098	39	4,098		104,499	13
14	Building Improvements			1983	22,362	588	38	588		14,406	14
15	Smoke Alarm			1984	650		20			650	15
16	Building Improvements			1985	44,866	1,122	40	1,122		24,404	16
17	Windows			1985	39,252	981	40	981		21,337	17
18	Ceiling Tile			1985	4,232		20			4,232	18
19	Light Fixtures			1985	777		10			777	19
20	Ceiling Tile			1986	1,874	33	20	33		1,874	20
21	Duct Work			1986	1,600	20	20	20		1,600	21
22	Building Improvements			1986	4,103		10			4,103	22
23	Wiring			1987	891	13	20	13		891	23
24	Dining & Administration Wing			1987	688,723	17,218	40	17,218		343,757	24
25	Remodeling			1987	705	35	20	35		697	25
26	Ceiling Duct			1987	510	18	20	18		510	26
27	Duct Work			1987	635	32	20	32		632	27
28	Remodeling			1988	552	28	20	28		541	28
29	Electrical Supply			1988	373	19	20	19		367	29
30	Air Cleaner & Duct			1988	1,694		10			1,694	30
31	Mirror			1988	1,562		10			1,562	31
32	HVAC System			1988	4,675	234	20	234		4,485	32
33	Windows			1988	705	20	35	20		382	33
34	Baseboard			1988	739	37	20	37		706	34
35	Heat Pumps			1988	27,223	1,361	20	1,361		25,972	35
36	Floor Tile			1988	340		5			340	36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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	Duct Work	1988	\$ 22,066	\$ 1,103	20	\$ 1,103	\$	\$ 19,670	37
38	Towel & Soap Dispenser	1988	1,976		10			1,976	38
39	Title Policy	1988	3,740	94	40	94		1,770	39
40	Hampton Settlement	1988	74,000	1,850	40	1,850		34,842	40
41	Wall Heat Pump	1989	1,300		10			1,300	41
42	Flourescent Light	1989	673		10			673	42
43	A/C Electrical Work	1989	6,950		8			6,950	43
44	Heat Pumps/Duct System	1989	39,940	1,997	20	1,997		35,946	44
45	Down Spouts	1989	600		15			600	45
46	Laundry Room Roof	1989	2,200		15			2,200	46
47	Heat Pumps	1989	63,466	3,173	20	3,173		55,528	47
48	Wander Guard	1989	11,417	571	20	571		9,993	48
49	Air Conditioning	1989	5,820		8			5,820	49
50	Ceiling Tile	1989	1,868		10			1,868	50
51	Trimming (1200')	1990	840		5			840	51
52	Remodel Rooms	1990	2,446	122	20	122		2,135	52
53	Baseboard (120')	1990	706		5			706	53
54	Shelving	1990	851		5			851	54
55	Floor Tile	1990	426		5			426	55
56	Water Heater	1990	386		15			386	56
57	Smoke Detectors	1990	890		5			890	57
58	Flourescent Lights (20)	1990	775		10			775	58
59	Door & Hardware	1990	541		5			541	59
60	Wallpaper	1990	919		5			919	60
61	Relocate Sprinklers	1990	583		10			583	61
62	Brick A/C Holes	1990	1,352	34	40	34		836	62
63	Door Frames	1990	303		5			303	63
64	Paint & Wallpaper	1990	1,118		5			1,118	64
65	Heating Receivers (11)	1990	1,975		15			1,975	65
66	Kickplates	1990	763		10			763	66
67	Air Conditioner	1990	1,184		8			1,184	67
68	Door Alarm	1990	423		5			423	68
69	Doors & Lock	1990	35,817	1,791	20	1,791		30,298	69
70	TOTAL (lines 4 thru 69)		\$ 3,187,284	\$ 88,606		\$ 88,606	\$	\$ 2,127,161	70

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

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,187,284	\$ 88,606		\$ 88,606	\$	\$ 2,127,161	1
2	Lights (13)	1990	590		10			590	2
3	Door Kickplates (118)	1990	2,104		10			2,104	3
4	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		5,754	4
5	Remodeling	1991	2,733	137	20	137		2,261	5
6	Door Locks	1991	510	26	20	26		429	6
7	Floor Tile Install	1991	10,926		5			10,926	7
8	Cove Base	1991	1,763		10			1,763	8
9	Handrail, Drywall	1991	569		5			569	9
10	Exit Fixtures	1991	1,619		10			1,619	10
11	A/C Units (2)	1991	15,885		10			15,885	11
12	Wallcoverings	1991	483		5			483	12
13	Heat Pump	1991	5,267	61	15	61		5,267	13
14	Walk-in Freezer	1991	8,643	99	15	99		8,643	14
15	Water Heater	1991	867		10			867	15
16	Hall Lights	1992	2,091		10			2,091	16
17	Water Heaters	1992	3,164	122	15	122		3,164	17
18	Heat Pump	1992	653	19	15	19		653	18
19	Heat Pump	1992	7,265	449	15	449		7,265	19
20	4' Loop System	1992	3,723		10			3,723	20
21	Building Lighting	1992	1,142		10			1,142	21
22	Metal Door Frames	1992	840	42	20	42		626	22
23	Garbage Disposals/Folding Door Divider	1994	1,161		5			1,161	23
24	Tub Room Remodel	1993	4,015		10			4,015	24
25	Building Remodeling	1993	6,103	305	20	305		4,285	25
26	Honeywell System	1993	5,031	252	20	252		3,549	26
27	Sink & Doors	1994	3,381		10			3,381	27
28	Storage Room Remodel	1994	2,020	101	20	101		1,364	28
29	Sewage Pump System	1994	4,256		10			4,256	29
30	Fire/Garage Door	1994	526		5			526	30
31	Handrails	1995	6,079		10			6,079	31
32	Remodeling (Side 1)	1995	7,992		5			7,992	32
33	Cabinets	1995	2,343	156	15	156		1,879	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,307,958	\$ 90,722		\$ 90,722	\$	\$ 2,241,472	34

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

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,307,958	\$ 90,722		\$ 90,722	\$	\$ 2,241,472	1
2	Therapy/Bath	1996	181,372	7,557	24	7,557		84,386	2
3	Fire Alarm System Relay	1996	2,596	18	10	18		2,596	3
4	Cnvt Tub Room/Quiet	1997	1,296		5			1,296	4
5	Water Fountain	1997	502		5			502	5
6	Compressor	1997	973		3			973	6
7	Compressor Unit 1516	1997	2,377		3			2,377	7
8	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		21,168	8
9	Replace/Rewire Hot Water Heater	1998	9,445	945	10	945		8,820	9
10	Kitchen Heaters	1998	793		3			793	10
11	Compressor/Library #24	1999	2,972		3			2,972	11
12	Keyless locks	1999	1,423		5			1,423	12
13	Wallpaper dining room	1999	3,071		5			3,071	13
14	120 gal water heater	1999	3,000	300	10	300		2,425	14
15	Mixing valve water heater	2000	961		5			961	15
16	Compressor	2000	1,133		3			1,133	16
17	Security control system	2000	940	94	10	94		721	17
18	Remodel admin office/wiring	2000	1,147		5			1,147	18
19	Rooftop cond unit	2000	3,373	337	10	337		2,415	19
20	4 ton A/C	2000	2,590		5			2,590	20
21	4 ton hest pumps	2000	4,780	478	10	478		3,386	21
22	4 Ton Heat Pumps	2000	2,692	269	10	269		1,838	22
23	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		1,492	23
24	Remodel Rooms 9-17	2001	2,657	266	10	266		1,685	24
25	Install Grease Trap	2001	886		5			886	25
26	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		354	26
27	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		4,727	27
28	Door Control System	1/1/2002	12,860	1,286	10	1,286		7,073	28
29	Countertop-Nursing Station Side 1	1/1/2002	750	50	15	50		275	29
30	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685		4			3,685	30
31	Install Dishwasher	5/24/2002	1,100	110	10	110		568	31
32	Countertop-Nursing Station Side 2	3/22/2002	760	51	15	51		272	32
33	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		1,154	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,610,027	\$ 106,381		\$ 106,381	\$	\$ 2,410,636	34

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

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,610,027	\$ 106,381		\$ 106,381	\$	\$ 2,410,636	1
2	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		1,135	2
3	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		374	3
4	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		4,375	4
5	Replacement Compressor in kitchen AC	8/31/2002	875	23	3	23		898	5
6	30 Position Nurse Call Station w/d	10/2/2002	1,100	110	10	110		523	6
7	(10) Panic Bars/(41)Door Knobs	12/9/2002	746	149	5	149		683	7
8	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		1,053	8
9	Remodel DON Office	2/11/2003	871	174	5	174		696	9
10	(12) Wall Signs w/Letters	2/27/2003	789	158	5	158		698	10
11	Nurse Call Light System - Side 1	8/1/2003	970	97	10	97		380	11
12	New Roof - Side 1	8/4/2003	52,263	3,484	15	3,484		13,065	12
13	Roof Replacement	8/4/2003	93,091	2,587	3	2,587		93,091	13
14	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571	114	5	114		428	14
15	Remodel Business Office	2/16/2004	920	184	5	184		629	15
16	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	1,896	10	1,896		6,320	16
17	Service Sink w/double pedal valves	6/3/2004	1,189	119	10	119		367	17
18	Heat Pump	6/16/2004	4,800	480	10	480		1,480	18
19	Roof Replacement - Resident Rooms	7/30/2004	58,356	3,890	15	3,890		11,670	19
20	Cable for Resident Phone Lines	3/18/2005	1,460	292	5	292		681	20
21	Dining Room Remodeling	3/1/2005	3,493	699	5	699		1,631	21
22	Resident Rooms Lighting	3/31/2005	1,793	359	5	359		838	22
23	Network Cabling Project	7/1/2004	19,993	1,999	10	1,999		5,997	23
24	Carport	9/22/2000	1,363	136	10	136		929	24
25	Bus barn	3/1/2003	8,752	219	40	219		949	25
26	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	26
27	Parking lot and sewer	2/29/1988	4,658	233	20	233		4,446	27
28	Courtyard walks and projects	9/30/1989	18,906	945	20	945		16,931	28
29	Fencing	6/8/1990	1,700		15			1,700	29
30	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	942	20	942		15,905	30
31	Drainage, lanscaping & Gazebo	8/14/1991	12,452	41	20	41		12,283	31
32	100' Fence	12/5/1991	1,380	38	15	38		1,380	32
33	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		10,446	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,030,916	\$ 127,845		\$ 127,845	\$	\$ 2,685,054	34

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

Facility Name &amp; ID Number Shawnee Christian Nursing Center

# 0025619

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 4,030,916	\$ 127,845		\$ 127,845	\$	\$ 2,685,054	1
2	Sidewalk & fence	8/30/1996	3,247	325	10	325		2,704	2
3	Enlarge parking	9/3/2002	2,386	119	20	119		593	3
4	Drainage culvert	3/28/2003	1,419	79	18	79		387	4
5	Dumpster fence	6/24/2003	769	77	10	77		374	5
6	Mini Blinds and Draperies	6/30/2006	3,348	670	5	670		726	6
7	Toilets and Tanks (4)	6/2/2006	716	72	10	72		78	7
8	New A/C and Heat Unit	6/30/2006	6,290	629	10	629		681	8
9	8 Alabaster Mini Blinds	3/29/2006	672	134	5	134		179	9
10	Water Heater	4/17/2006	4,174	417	10	417		521	10
11	A/C Unit Hallway	4/5/2006	6,820	682	10	682		853	11
12	New Nurse Call Light System	4/20/2006	1,575	158	10	158		197	12
13	5 Toilets	1/13/2006	872	44	20	44		66	13
14	39" X 59" Cordless Mark I (6)	2/1/2006	648	130	5	130		184	14
15	39" X 59" Cordless Mark I (6)	2/23/2006	648	130	5	130		184	15
16	New Grease Trap	3/1/2006	7,750	775	10	775		1,033	16
17	New Roof	7/28/2005	25,044	1,670	15	1,670		3,340	17
18	39" X 59" Cordless Roller Mini (7)	10/13/2005	613	123	5	123		215	18
19	New Flooring - Kitchen	3/31/2006	1,995	200	10	200		267	19
20	Landscaping Materials	6/29/2006	1,030	103	10	103		112	20
21	3 Sidewalks	8/10/2005	3,344	334	10	334		641	21
22	Side 1 Shower room remodel	7/1/2006	4,756	476	10	476		476	22
23	Build new nurse call panel & rewire	7/1/2006	1,230	123	10	123		123	23
24	Remodel Side 4 shower room	7/1/2006	3,331	333	10	333		333	24
25	(6) sets of miniblinds for resident rooms	12/31/2006	648	76	5	76		76	25
26	Industrial mixing valve	3/1/2007	598	10	20	10		10	26
27	Bryant 3 phase 35,000 BTU electric heat pump	5/8/2007	7,100	237	5	237		237	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,121,939	\$ 135,971		\$ 135,971	\$	\$ 2,699,644	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: 7/1/2006 Ending: 6/30/2007

## 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	\$ 280,249	\$ 38,288	\$ 38,288	\$	Various	\$ 150,333	71
72	Current Year Purchases	37,981	4,248	4,248		Various	4,248	72
73	Fully Depreciated Assets	477,730				Various	477,730	73
74	Home Office Allocation	130,695	16,200	16,200			28,796	74
75	TOTALS	\$ 926,655	\$ 58,736	\$ 58,736	\$		\$ 661,107	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	5,793	5,793		8	6,759	78
79	Home Office Allocation			13,060	1,619	1,619			4,514	79
80	TOTALS			\$ 76,983	\$ 7,412	\$ 7,412	\$		\$ 28,846	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)		\$ 5,203,930	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 202,119	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 202,119	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)		\$ 3,389,597	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	\$ 7,707	92
93	Home Office Allocation	17,838	93
94			94
95		\$ 25,545	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.

**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	<b>TOTAL</b>				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**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	<b>TOTAL</b>		\$	\$	21

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

\* 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.</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)	
<b>TOTAL TRAINED</b>	

- (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		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	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 prescrpts													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.

## STATE OF ILLINOIS

Page 17

Facility Name & ID Number Shawnee Christian Nursing Center# 0025619Report Period Beginning: 7/1/2006

Ending:

6/30/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 229,619	\$	1
2	Cash-Patient Deposits	22,001		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (212,156) )	1,176,404		3
4	Supply Inventory (priced at <u>FIFO</u> )	23,382		4
5	Short-Term Investments	5,709		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,833		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Rec.</u>	830		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,461,778	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	3,913,779		14
15	Leasehold Improvements, at Historical Cost	146,225		15
16	Equipment, at Historical Cost	859,883		16
17	Accumulated Depreciation (book methods)	(3,256,602)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	243,258		21
22	Other Long-Term Assets (spe <u>Deferred Fin &amp; CIP</u> )	97,538		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,086,052	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,547,830	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 230,394	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,001		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	239,101		30
31	Accrued Taxes Payable (excluding real estate taxes)	583		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,442		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37	<u>Other Accrued Expenses</u>	34,890		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 537,411	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,230,527		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,230,527	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,767,938	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,220,108)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,547,830	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,828,445)	1
2	Restatements (describe):		2
3	Prior Period Adjustment - FIN 47	(10,830)	3
4	Prior Period Adjustment - Insurance Accrual	39,387	4
5	Error on PY Cost Report	1,000	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,798,888)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(12,928)	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)	\$ (12,928)	17
	<b>B. Transfers (Itemize):</b>		
18	Transfer to Affiliate	(408,290)	18
19	Rounding	(2)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (408,292)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,220,108)	24 *

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

Facility Name & ID Number Shawnee Christian Nursing Center# 0025619Report Period Beginning: 7/1/2006Ending: 6/30/2007**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,662,259	1
2	Discounts and Allowances for all Levels	(821,302)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,840,957</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,394,607	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,394,607</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	27,454	13
14	Non-Patient Meals	269	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	24,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,397	19
20	Radiology and X-Ray	35,491	20
21	Other Medical Services	14,982	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 127,205</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	45,045	24
25	Interest and Other Investment Income***	30,991	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 76,036</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Other Revenue</b>	4,551	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 4,551</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,443,356</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,045,448	31
32	Health Care	3,815,115	32
33	General Administration	1,843,200	33
<b>B. Capital Expense</b>			
34	Ownership	587,300	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	78,168	35
36	Provider Participation Fee	87,053	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,456,284</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(12,928)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (12,928)</b>	<b>43</b>

\* 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: 7/1/2006

Ending:

6/30/2007

**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	1,538	1,590	\$ 95,441	\$ 60.03	1
2	Assistant Director of Nursing	2,269	2,299	66,959	29.13	2
3	Registered Nurses	11,596	13,297	278,334	20.93	3
4	Licensed Practical Nurses	26,858	30,383	470,129	15.47	4
5	CNAs & Orderlies	106,898	119,845	1,119,547	9.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,835	4,267	47,876	11.22	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	12,950	14,447	170,771	11.82	11
12	Dietician					12
13	Food Service Supervisor	2,026	2,240	34,795	15.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,036	26,422	221,741	8.39	15
16	Dishwashers					16
17	Maintenance Workers	4,678	5,050	77,710	15.39	17
18	Housekeepers	26,569	30,339	265,249	8.74	18
19	Laundry					19
20	Administrator	1,380	1,395	54,389	38.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,858	1,883	35,079	18.63	23
24	Clerical	4,302	5,198	44,861	8.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Dir. Of Admis., W	4,817	5,138	58,363	11.36	32
33	Other(specify) <u>CNL, Vol Coord.,</u>	8,394	9,157	194,140	21.20	33
34	TOTAL (lines 1 - 33)	244,004	272,950	\$ 3,235,384 *	\$ 11.85	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	298	\$ 13,977	1.3	35
36	Medical Director	52	18,500	9.3	36
37	Medical Records Consultant	35	1,812		37
38	Nurse Consultant	4	238	10.3	38
39	Pharmacist Consultant	192	4,287	10.3	39
40	Physical Therapy Consultant	6,004	368,448	10A.3	40
41	Occupational Therapy Consultant	6,070	381,445	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,513	114,929	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	104	6,117	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	14,272	\$ 909,753		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 615	10.3	50
51	Licensed Practical Nurses	81	2,953	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	97	\$ 3,568		53





**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 \$7,666
- (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? N/A
- (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? N/A
- (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. \$ 21,650 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (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. \$ 269
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_
- 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: LarsonAllen 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. Copy will be sent when audit is finaliz
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.