

Facility Name & ID Number Shawnee Christian Nursing Center

0048744 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	159	Skilled (SNF)	159	58,194	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,194	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,263	7,076	9,703	48,042	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,263	7,076	9,703	48,042	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.55%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 9,426

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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
	A. General Services										
1	Dietary	261,901	20,083	16,084	298,068		298,068		298,068		1
2	Food Purchase		240,385		240,385		240,385	(2,320)	238,065		2
3	Housekeeping	267,653	25,397	276	293,326		293,326		293,326		3
4	Laundry		15,501		15,501		15,501		15,501		4
5	Heat and Other Utilities			150,723	150,723		150,723	11,505	162,228		5
6	Maintenance	108,723	21,820	16,770	147,313		147,313	3,759	151,072		6
7	Other (specify):* Trash			6,295	6,295		6,295		6,295		7
8	TOTAL General Services	638,277	323,186	190,148	1,151,611		1,151,611	12,944	1,164,555		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,311,746	446,561	13,325	2,771,632	(276,279)	2,495,353	(70)	2,495,283		10
10a	Therapy			964,809	964,809		964,809		964,809		10a
11	Activities	11,791			11,791		11,791		11,791		11
12	Social Services	187,243	2,643	5,027	194,913		194,913	2,054	196,967		12
13	CNA Training										13
14	Program Transportation			4,413	4,413		4,413	(2,081)	2,332		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,510,780	449,204	1,011,574	3,971,558	(276,279)	3,695,279	(97)	3,695,182		16
	C. General Administration										
17	Administrative	110,340	1,463	477,708	589,511		589,511	(400,257)	189,254		17
18	Directors Fees										18
19	Professional Services			5,853	5,853		5,853	48,783	54,636		19
20	Dues, Fees, Subscriptions & Promotions			31,823	31,823		31,823	(9,859)	21,964		20
21	Clerical & General Office Expenses	186,033	13,175	6,963	206,171		206,171	145,126	351,297		21
22	Employee Benefits & Payroll Taxes			517,236	517,236		517,236	18,322	535,558		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,683	18,683		18,683	18,825	37,508		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			460,381	460,381		460,381	1,324	461,705		26
27	Other (specify):*										27
28	TOTAL General Administration	296,373	14,638	1,518,647	1,829,658		1,829,658	(177,736)	1,651,922		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,445,430	787,028	2,720,369	6,952,827	(276,279)	6,676,548	(164,889)	6,511,659		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shawnee Christian Nursing Center

#0048744

Report Period Beginning: July 1, 2007 Ending: June 30, 2008

June 30, 2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			171,186	171,186		171,186	17,238	188,424		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			408,867	408,867		408,867	(37,729)	371,138		32
33	Real Estate Taxes			130	130		130		130		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			20,406	20,406		20,406		20,406		35
36	Other (specify):* Def Fin Costs, FIN 47 Accretion, Loss on Adv Ref			25,442	25,442		25,442		25,442		36
37	TOTAL Ownership			626,031	626,031		626,031	(20,491)	605,540		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			105,288	105,288	276,279	381,567		381,567		39
40	Barber and Beauty Shops	16,111	653	628	17,392		17,392		17,392		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			87,292	87,292		87,292		87,292		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	16,111	653	193,208	209,972	276,279	486,251		486,251		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,461,541	787,681	3,539,608	7,788,830		7,788,830	(185,380)	7,603,450		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

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	(2,413)	2		4
5	Telephone, TV & Radio in Resident Rooms	(658)	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	(37,729)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(168)	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	38,091	21		24
25	Fund Raising, Advertising and Promotional	(9,859)	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	(86,840)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,576)		\$	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)	(85,804)	VII - B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (85,804)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (185,380)		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	X		276,279	10-2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 276,279		47

BHF USE ONLY						
48		49		50		51
						52

Shawnee Christian Nursing Center

ID# 0048744

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending	\$ 93	2	1
2	Activity	2,054	12	2
3	Miscellaneous	(70)	10	3
4	Marketing Salaries	(85,968)	21	4
5	Marketing Supplies	(766)	21	5
6	Late Fees, Finances Charges	(102)	21	6
7	Transportation	(2,081)	14	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(86,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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	(2,320)	0	0	0	0	0	0	0	0	0	0	(2,320)	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	(658)	12,163	0	0	0	0	0	0	0	0	0	11,505	5
6	Maintenance	0	3,759	0	0	0	0	0	0	0	0	0	3,759	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,978)	15,922	0	12,944	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	(70)	0	0	0	0	0	0	0	0	0	0	(70)	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	2,054	0	0	0	0	0	0	0	0	0	0	2,054	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,081)	0	0	0	0	0	0	0	0	0	0	(2,081)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(97)	0	0	0	0	0	0	0	0	0	0	(97)	16
	C. General Administration													
17	Administrative	0	(400,257)	0	0	0	0	0	0	0	0	0	(400,257)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	48,783	0	0	0	0	0	0	0	0	0	48,783	19
20	Fees, Subscriptions & Promotions	(9,859)	0	0	0	0	0	0	0	0	0	0	(9,859)	20
21	Clerical & General Office Expenses	(48,913)	194,039	0	0	0	0	0	0	0	0	0	145,126	21
22	Employee Benefits & Payroll Taxes	0	18,322	0	0	0	0	0	0	0	0	0	18,322	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	18,825	0	0	0	0	0	0	0	0	0	18,825	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	1,324	0	0	0	0	0	0	0	0	0	1,324	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(58,772)	(118,964)	0	(177,736)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,847)	(103,042)	0	(164,889)	29								

STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending:

Summary B
June 30, 2008

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	17,238	0	0	0	0	0	0	0	0	0	17,238	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,729)	0	0	0	0	0	0	0	0	0	0	(37,729)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(37,729)	17,238	0	(20,491)	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)	(99,576)	(85,804)	0	(185,380)	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 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%	\$ 12,163	\$ 12,163
2	V	6 Maintenance				3,759	3,759
3	V	17 Administration	477,708			77,451	(400,257)
4	V	19 Professional Services				48,783	48,783
5	V	21 Clerical				194,039	194,039
6	V	22 Employee Benefits				18,322	18,322
7	V	24 Travel and Seminar				18,825	18,825
8	V	26 Insurance				1,324	1,324
9	V	30 Depreciation				17,238	17,238
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 477,708			\$ 391,904	\$ * (85,804)

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

Facility Name & ID Number

Shawnee Christian Nursing Center

#

0048744

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Shawnee Christian Nursing Center

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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 _____
 Street Address _____
 City / State / Zip Code _____
 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	This workpaper is not applicable.				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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	HUD Sect. 232 Ins. Mortgage		X	Refinance Old Debt	\$42,263.00	7/19/07	\$ 6,634,900	\$ 6,524,957	8/1/2032	0.0588	\$ 408,867	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$42,263.00		\$ 6,634,900	\$ 6,524,957			\$ 408,867	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,634,900	\$ 6,524,957			\$ 408,867	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,506 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 583	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.)		\$ 389	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (194)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 324	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.		\$ 130	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	333	9
	2005	379	10
	2006	389	11
	2007	318	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Center COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0048744

CONTACT PERSON REGARDING THIS REPORT Susan McGhee

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>318.00</u>	\$ <u>318.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>318.00</u>	\$ <u>318.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

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>6,207</u>	<u>2</u>
3	TOTALS	180,000		\$ 77,378	3

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 1,234,290	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				57,789	4,047		4,047		96,072	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		108,597	13
14	Building Improvements			1983	22,362	588	38	588		14,994	14
15	Smoke Alarm			1984	650		20			650	15
16	Building Improvements			1985	44,866	1,122	40	1,122		25,526	16
17	Windows			1985	39,252	981	40	981		22,318	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		20			1,874	20
21	Duct Work			1986	1,600		20			1,600	21
22	Building Improvements			1986	4,103		10			4,103	22
23	Wiring			1987	891		20			891	23
24	Dining & Administration Wing			1987	688,723	17,218	40	17,218		360,975	24
25	Remodeling			1987	705	8	20	8		705	25
26	Ceiling Duct			1987	510		20			510	26
27	Duct Work			1987	635	3	20	3		635	27
28	Remodeling			1988	552	11	20	11		552	28
29	Electrical Supply			1988	373	6	20	6		373	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	190	20	190		4,675	32
33	Windows			1988	705	20	35	20		402	33
34	Baseboard			1988	739	33	20	33		739	34
35	Heat Pumps			1988	27,223	1,251	20	1,251		27,223	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 & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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	\$	\$ 20,773	37
38	Towel & Soap Dispenser	1988	1,976		10			1,676	38
39	Title Policy	1988	3,740	94	40	94		1,864	39
40	Hampton Settlement	1988	74,000	1,850	40	1,850		36,692	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		37,943	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		58,701	47
48	Wander Guard	1989	11,417	571	20	571		10,564	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		2,257	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	Door & Hardware	1990	541		5			541	58
59	Wallpaper	1990	919		5			919	59
60	Relocate Sprinklers	1990	583		10			583	60
61	Brick A/C Holes	1990	1,352	34	40	34		870	61
62	Door Frames	1990	303		5			303	62
63	Paint & Wallpaper	1990	1,118		5			1,118	63
64	Heating Receivers (11)	1990	1,975		15			1,975	64
65	Kickplates	1990	763		10			763	65
66	Air Conditioner	1990	1,184		8			1,184	66
67	Door Alarm	1990	423		5			423	67
68	Doors & Lock	1990	35,817	1,791	20	1,791		32,089	68
69	Lights (13)	1990	590		10			590	69
70	TOTAL (lines 4 thru 69)		\$ 3,182,954	\$ 84,649		\$ 84,649	\$	\$ 2,206,303	70

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

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 3,182,954	\$ 84,649		\$ 84,649	\$	\$ 2,206,303	1
2	Door Kickplates (118)	1990	2,104		10			2,104	2
3	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		6,101	3
4	Remodeling	1991	2,733	137	20	137		2,398	4
5	Door Locks	1991	510	26	20	26		455	5
6	Floor Tile Install	1991	10,926		5			10,926	6
7	Cove Base	1991	1,763		10			1,763	7
8	Handrail, Drywall	1991	569		5			569	8
9	Exit Fixtures	1991	1,619		10			1,619	9
10	A/C Units (2)	1991	15,885		10			15,885	10
11	Wallcoverings	1991	483		5			483	11
12	Heat Pump	1991	5,267		15			5,267	12
13	Walk-in Freezer	1991	8,643		15			8,643	13
14	Water Heater	1991	867		10			867	14
15	Hall Lights	1992	2,091		10			2,091	15
16	Water Heaters	1992	3,164		15			3,164	16
17	Heat Pump	1992	653		15			653	17
18	Heat Pump	1992	7,265		15			7,265	18
19	4' Loop System	1992	3,723		10			3,723	19
20	Building Lighting	1992	1,142		10			1,142	20
21	Metal Door Frames	1992	840	42	20	42		668	21
22	Garbage Disposals/Folding Door Divider	1994	1,161		5			1,161	22
23	Tub Room Remodel	1993	4,015		10			4,015	23
24	Building Remodeling	1993	6,103	305	20	305		4,590	24
25	Honeywell System	1993	5,031	252	20	252		3,801	25
26	Sink & Doors	1994	3,381		10			3,381	26
27	Storage Room Remodel	1994	2,020	101	20	101		1,465	27
28	Sewage Pump System	1994	4,256		10			4,256	28
29	Fire/Garage Door	1994	526		5			526	29
30	Handrails	1995	6,079		10			6,079	30
31	Remodeling (Side 1)	1995	7,992		5			7,992	31
32	Cabinets	1995	2,343	156	15	156		2,035	32
33	Therapy/Bath	1996	181,372	7,557	24	7,557		91,943	33
34	TOTAL (lines 1 thru 33)		\$ 3,484,410	\$ 93,572		\$ 93,572	\$	\$ 2,413,333	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 3,484,410	\$ 93,572		\$ 93,572	\$	\$ 2,413,333	1
2	Fire Alarm System Relay	1996	2,596		10			2,596	2
3	Cnvt Tub Room/Quiet	1997	1,296		5			1,296	3
4	Water Fountain	1997	502		5			502	4
5	Compressor	1997	973		3			973	5
6	Compressor Unit 1516	1997	2,377		3			2,377	6
7	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		23,760	7
8	Replace/Rewire Hot Water Heater	1998	9,445	625	10	625		9,445	8
9	Kitchen Heaters	1998	793		3			793	9
10	Compressor/Library #24	1999	2,972		3			2,972	10
11	Keyless locks	1999	1,423		5			1,423	11
12	Wallpaper dining room	1999	3,071		5			3,071	12
13	120 gal water heater	1999	3,000	300	10	300		2,725	13
14	Mixing valve water heater	2000	961		5			961	14
15	Compressor	2000	1,133		3			1,133	15
16	Security control system	2000	940	94	10	94		815	16
17	Remodel admin office/wiring	2000	1,147		5			1,147	17
18	Rooftop cond unit	2000	3,373	337	10	337		2,752	18
19	4 ton A/C	2000	2,590		5			2,590	19
20	4 ton hest pumps	2000	4,780	478	10	478		3,864	20
21	4 Ton Heat Pumps	2000	2,692	269	10	269		2,107	21
22	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		1,713	22
23	Remodel Rooms 9-17	2001	2,657	266	10	266		1,951	23
24	Install Grease Trap	2001	886		5			886	24
25	4 Person Booth Island (Bolted to Floor)	2001	593	59	10	59		413	25
26	(3) 4 Ton Heat Pumps	2001	7,985	799	10	799		5,526	26
27	Door Control System	2002	12,860	1,286	10	1,286		8,359	27
28	Countertop-Nursing Station Side 1	2002	750	50	15	50		325	28
29	Install Evap and Condenser in Walk-In Freezer	2002	3,685		4			3,685	29
30	Install Dishwasher	2002	1,100	110	10	110		678	30
31	Countertop-Nursing Station Side 2	2002	760	51	15	51		323	31
32	York Olympian Heat Pump	2002	2,265	227	10	227		1,381	32
33	3 Ton Olympian Heat Pump	2002	2,265	227	10	227		1,362	33
34	TOTAL (lines 1 thru 33)		\$ 3,607,372	\$ 101,563		\$ 101,563	\$	\$ 2,507,237	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 3,607,372	\$ 101,563		\$ 101,563	\$	\$ 2,507,237	1
2	Nursing Station - Side #3	2002	1,146	76	15	76		450	2
3	7.5 Ton York Heat Pump - Dining Room	2002	8,750	875	10	875		5,250	3
4	Replacement Compressor in kitchen AC	2002	875		3			875	4
5	30 Position Nurse Call Station w/d	2002	1,100	110	10	110		633	5
6	(10) Panic Bars/(41)Door Knobs	2002	746	63	5	63		746	6
7	4 Ton York Heat Pump - Unit #1	2003	2,341	234	10	234		1,287	7
8	Remodel DON Office	2003	871	175	5	175		871	8
9	(12) Wall Signs w/Letters	2003	789	91	5	91		789	9
10	Nurse Call Light System - Side 1	2003	970	97	10	97		477	10
11	New Roof - Side 1	2003	52,263	3,484	15	3,484		16,549	11
12	Roof Replacement	2003	93,091		3			93,091	12
13	Replace Ceiling Panels/Kitchen & Side 1	2003	571	114	5	114		542	13
14	Remodel Business Office	2004	920	184	5	184		813	14
15	Elemco/Opto 22 Energy Management System	2004	18,962	1,896	10	1,896		8,216	15
16	Service Sink w/double pedal valves	2004	1,189	119	10	119		486	16
17	Heat Pump	2004	4,800	480	10	480		1,960	17
18	Roof Replacement - Resident Rooms	2004	58,356	3,890	15	3,890		15,560	18
19	Cable for Resident Phone Lines	2005	1,460	292	5	292		973	19
20	Dining Room Remodeling	2005	3,493	699	5	699		2,330	20
21	Resident Rooms Lighting	2005	1,793	359	5	359		1,197	21
22	Network Cabling Project	2004	19,993	1,999	10	1,999		7,996	22
23	Carport	2000	1,363	136	10	136		1,065	23
24	Bus barn	2003	8,752	219	40	219		1,168	24
25	Fully depreciated land improvements	1982	62,437		15			62,437	25
26	Parking lot and sewer	1988	4,658	212	20	212		4,658	26
27	Courtyard walks and projects	1989	18,906	945	20	945		17,876	27
28	Fencing	1990	1,700		15			1,700	28
29	Landscaping, patio, wall & sidewalk	1990	18,837	942	20	942		16,847	29
30	Drainage, lanscaping & Gazebo	1991	12,452	41	20	41		12,324	30
31	100' Fence	1991	1,380		15			1,380	31
32	Landscaping, seeding, lighting & gazebo roof	1992	13,660	684	20	684		11,130	32
33	Sidewalk & Fence	1996	3,247	325	10	325		3,029	33
34	TOTAL (lines 1 thru 33)		\$ 4,029,243	\$ 120,304		\$ 120,304	\$	\$ 2,801,942	34

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

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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		\$ 4,029,243	\$ 120,304		\$ 120,304	\$	\$ 2,801,942	1
2	Enlarge parking	2002	2,386	119	20	119		712	2
3	Drainage culvert	2003	1,419	79	18	79		466	3
4	Dumpster fence	2003	769	77	10	77		451	4
5	Mini Blinds and Draperies	2006	3,348	670	5	670		1,396	5
6	Toilets and Tanks (4)	2006	716	72	10	72		150	6
7	New A/C and Heat Unit	2006	6,290	629	10	629		1,310	7
8	8 Alabaster Mini Blinds	2006	672	134	5	134		313	8
9	Water Heater	2006	4,174	417	10	417		938	9
10	A/C Unit Hallway	2006	6,820	682	10	682		1,535	10
11	New Nurse Call Light System	2006	1,575	158	10	158		355	11
12	5 Toilets	2006	872	44	20	44		110	12
13	39" X 59" Cordless Mark I (6)	2006	648	130	5	130		314	13
14	39" X 59" Cordless Mark I (6)	2006	648	130	5	130		314	14
15	New Grease Trap	2006	7,750	775	10	775		1,808	15
16	New Roof	2005	25,044	1,670	15	1,670		5,010	16
17	39" X 59" Cordless Roller Mini (7)	2005	613	123	5	123		338	17
18	New Flooring - Kitchen	2006	1,995	200	10	200		467	18
19	Landscaping Materials	2006	1,030	103	10	103		215	19
20	3 Sidewalks	2005	3,344	334	10	334		975	20
21	Side 1 Shower room remodel	2006	4,756	476	10	476		952	21
22	Build new nurse call panel & rewire	2006	1,230	123	10	123		246	22
23	Remodel Side 4 shower room	2006	3,331	333	10	333		666	23
24	(6) sets of miniblinds for resident rooms	2006	648	130	5	130		206	24
25	Industrial mixing valve	2007	598	30	20	30		40	25
26	Bryant 3 phase 35,000 BTU electric heat pump	2007	7,100	1,420	5	1,420		1,657	26
27	Reroof Maintenance Shop	2007	11,392	854	10	854		854	27
28	19 Resident Room Exhaust Fans	2007	1,790	134	10	134		134	28
29	Remodel Services	2008	748	37	10	37		37	29
30	Repour Portion of Front Parking Lot	2007	3,400	453	5	453		453	30
31	Asphalt back Parking Lot	2008	35,790	298	10	298		298	31
32	Stone work and paving of back parking lot	2007	10,277	1,199	5	1,199		1,199	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,180,416	\$ 132,337		\$ 132,337	\$	\$ 2,825,861	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	\$ 270,822	\$ 36,346	\$ 36,346	\$	Various	\$ 141,966	71
72	Current Year Purchases	11,338	757	757		Various	757	72
73	Fully Depreciated Assets	520,081				Various	520,081	73
74	Home Office Allocation	169,633	11,878	11,878			26,666	74
75	TOTALS	\$ 971,874	\$ 48,981	\$ 48,981	\$		\$ 689,470	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	12,552	78
79	Home Office Allocation			18,752	1,313	1,313			7,132	79
80	TOTALS			\$ 82,675	\$ 7,106	\$ 7,106	\$		\$ 37,257	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)		\$ 5,312,343	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 188,424	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 188,424	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)		\$ 3,552,588	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$ 10,800	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 10,800	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 136,885	92
93	Home Office Allocation	6,555	93
94			94
95		\$ 143,440	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

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:	<u>N/A</u>			\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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 _____.

N/A

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: \$ 20,406 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	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>Training courses provided at local community colleges</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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	4,299	\$ 378,018	\$	4,299	\$ 378,018	1
2	Licensed Speech and Language Development Therapist		hrs		2,430	186,117		2,430	186,117	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		6,188	400,674		6,188	400,674	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,917	\$ 964,809	\$	12,917	\$ 964,809	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# 0048744Report Period Beginning: July 1, 2007

Ending:

June 30, 2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2008 (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	\$ 924,405	\$	1
2	Cash-Patient Deposits	36,119		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>80,212</u>)	1,060,112		3
4	Supply Inventory (priced at)	31,834		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,266		6
7	Other Prepaid Expenses	19,755		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,073,491	\$	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	3,926,935		14
15	Leasehold Improvements, at Historical Cost	195,692		15
16	Equipment, at Historical Cost	866,164		16
17	Accumulated Depreciation (book methods)	(3,422,718)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	362,525		21
22	Other Long-Term Assets (spe CIP)	136,885		22
23	Other(specify): <u>Deferred Financing Costs</u>	235,425		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,382,879	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,456,370	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 207,852	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,119		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	285,464		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	324		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Bonuses, FIN 47, and other liabilities</u>	295,317		36
37	<u>Due to Auxiliary</u>	2,236		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 827,312	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,524,957		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,524,957	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,352,269	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,895,899)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,456,370	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,220,108)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,220,108)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	324,209	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)	\$ 324,209	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,895,899)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shawnee Christian Nursing Center# 0048744Report Period Beginning: July 1, 2007Ending: June 30, 2008**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	\$ 6,894,297	1
2	Discounts and Allowances for all Levels	(499,244)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,395,053	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,522,381	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,522,381	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	20,023	13
14	Non-Patient Meals	2,413	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,876	19
20	Radiology and X-Ray	25,897	20
21	Other Medical Services	34,523	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 123,539	23
D. Non-Operating Revenue			
24	Contributions	44,862	24
25	Interest and Other Investment Income***	43,148	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 88,010	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous/Unrealized Gain(Loss) on Investments</u>	(15,944)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (15,944)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,113,039	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,151,611	31
32	Health Care	4,007,447	32
33	General Administration	1,829,221	33
B. Capital Expense			
34	Ownership	627,400	34
C. Ancillary Expense			
35	Special Cost Centers	85,859	35
36	Provider Participation Fee	87,292	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,788,830	40
41	Income before Income Taxes (line 30 minus line 40)**	324,209	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 324,209	43

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

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

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

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

Facility Name & ID Number Shawnee Christian Nursing Center

0048744

Report Period Beginning: July 1, 2007

Ending:

June 30, 2008

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	1,770	1,917	\$ 75,485	\$ 39.38	1
2	Assistant Director of Nursing	3,664	3,900	116,148	29.78	2
3	Registered Nurses	7,569	8,289	189,410	22.85	3
4	Licensed Practical Nurses	30,621	36,056	579,274	16.07	4
5	CNAs & Orderlies	104,991	117,744	1,140,203	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,374	3,939	45,670	11.59	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	13,480	14,928	187,171	12.54	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,160	35,564	16.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,215	26,041	226,337	8.69	15
16	Dishwashers					16
17	Maintenance Workers	6,936	7,533	108,723	14.43	17
18	Housekeepers	26,448	28,924	267,653	9.25	18
19	Laundry					19
20	Administrator	1,983	2,043	109,590	53.64	20
21	Assistant Administrator					21
22	Other Administrative	975	1,043	15,996	15.34	22
23	Office Manager	1,907	2,030	34,207	16.85	23
24	Clerical	4,358	4,934	65,781	13.33	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 Admissions	3,219	3,481	40,378	11.60	32
33	Other(specify) <u>Comm. Liaison, V</u>	9,288	9,941	223,951	22.53	33
34	TOTAL (lines 1 - 33)	245,671	274,903	\$ 3,461,541 *	\$ 12.59	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	329	\$ 16,084	ln 1, col 3	35
36	Medical Director	52	24,000	ln 9, col 3	36
37	Medical Records Consultant	24	1,207	ln 10, col 3	37
38	Nurse Consultant	9	451	ln 10, col 3	38
39	Pharmacist Consultant	192	4,103	ln 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	79	4,579	ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	685	\$ 50,424		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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 - \$7,957
- (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. \$ 31,676 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 87,292
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,413
- (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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP 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 \$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.