

Facility Name & ID Number Shawnee Christian Nursing Ctr# 0048744 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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	58,035	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	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	31,265	6,625	10,040	47,930	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,265	6,625	10,040	47,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.59%

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

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

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

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

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

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

YES NO

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

YES NO

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

Date started 9/1/1980

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

YES Date 9/1/1980 NO

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

YES NO If YES, enter number of beds certified 159 and days of care provided 9,625Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0048744 Report Period Beginning: July 1, 2008 Ending: June 30, 2009

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	273,678	18,888	15,855	308,421		308,421		308,421		1
2	Food Purchase		254,721		254,721		254,721	1,013	255,734		2
3	Housekeeping	266,957	41,383	1,546	309,886		309,886		309,886		3
4	Laundry		5,986		5,986		5,986		5,986		4
5	Heat and Other Utilities			175,941	175,941		175,941	8,380	184,321		5
6	Maintenance	151,574	30,288	14,123	195,985		195,985	2,829	198,814		6
7	Other (specify):* Trash			4,861	4,861		4,861		4,861		7
8	TOTAL General Services	692,209	351,266	212,326	1,255,801		1,255,801	12,222	1,268,023		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,371,321	537,884	12,260	2,921,465	(303,259)	2,618,206	(20)	2,618,186		10
10a	Therapy			1,018,279	1,018,279		1,018,279		1,018,279		10a
11	Activities	96,073			96,073		96,073		96,073		11
12	Social Services	137,863	1,946	5,622	145,431		145,431	1,478	146,909		12
13	CNA Training										13
14	Program Transportation			2,746	2,746		2,746		2,746		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,605,257	539,830	1,062,907	4,207,994	(303,259)	3,904,735	1,458	3,906,193		16
	C. General Administration										
17	Administrative	92,573	2,748	510,072	605,393		605,393	(435,864)	169,529		17
18	Directors Fees										18
19	Professional Services			93,878	93,878		93,878	34,258	128,136		19
20	Dues, Fees, Subscriptions & Promotions			41,646	41,646		41,646		41,646		20
21	Clerical & General Office Expenses	120,804	19,284	69,299	209,387		209,387	190,026	399,413		21
22	Employee Benefits & Payroll Taxes			565,168	565,168		565,168	31,710	596,878		22
23	Inservice Training & Education										23
24	Travel and Seminar			27,173	27,173		27,173	14,574	41,747		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			162,497	162,497		162,497	1,705	164,202		26
27	Other (specify):* Marketing	68,744	332	22,143	91,219		91,219	(120,983)	(29,764)		27
28	TOTAL General Administration	282,121	22,364	1,491,876	1,796,361		1,796,361	(284,574)	1,511,787		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,579,587	913,460	2,767,109	7,260,156	(303,259)	6,956,897	(270,894)	6,686,003		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 Ctr

#0048744

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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			175,987	175,987		175,987	19,974	195,961			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			418,881	418,881		418,881	(7,803)	411,078			32
33	Real Estate Taxes			471	471		471		471			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,574	39,574		39,574		39,574			35
36	Other (specify):* Def Fin Costs, FIN 47 Accretion			10,406	10,406		10,406		10,406			36
37	TOTAL Ownership			645,319	645,319		645,319	12,171	657,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			77,479	77,479	303,259	380,738		380,738			39
40	Barber and Beauty Shops	18,661	749		19,410		19,410		19,410			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,053	87,053		87,053		87,053			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	18,661	749	164,532	183,942	303,259	487,201		487,201			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,598,248	914,209	3,576,960	8,089,417		8,089,417	(258,723)	7,830,694			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. 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	(1,273)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,086)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,959)	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	(10,000)	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	(6,313)	21		24
25	Fund Raising, Advertising and Promotional	(120,983)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	2,931			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,683)		\$	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)	(110,040)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,040)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (258,723)		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		303,259	10-2
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 303,259	47

BHF USE ONLY

48		49		50		51		52
----	--	----	--	----	--	----	--	----

Shawnee Christian Nursing Ctr

ID# 0048744

Report Period Beginning: July 1, 2008

Ending: June 30, 2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ 2,286	2	1
2	Activity	1,478	12	2
3	Miscellaneous	(20)	10	3
4	Late Fees, Finances Charges	(62)	21	4
5	Charity Care	(751)	21	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				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	2,931		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Ctr# 0048744

Report Period Beginning:

July 1, 2008

Ending:

June 30, 2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	1,013	0	0	0	0	0	0	0	0	0	0	1,013	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	(3,086)	11,466	0	0	0	0	0	0	0	0	0	8,380	5
6	Maintenance	0	2,829	0	0	0	0	0	0	0	0	0	2,829	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,073)	14,295	0	12,222	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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	1,478	0	0	0	0	0	0	0	0	0	0	1,478	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	1,458	0	0	0	0	0	0	0	0	0	0	1,458	16
	C. General Administration													
17	Administrative	0	(435,864)	0	0	0	0	0	0	0	0	0	(435,864)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	34,258	0	0	0	0	0	0	0	0	0	34,258	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(17,126)	207,152	0	0	0	0	0	0	0	0	0	190,026	21
22	Employee Benefits & Payroll Taxes	0	31,710	0	0	0	0	0	0	0	0	0	31,710	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,574	0	0	0	0	0	0	0	0	0	14,574	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	1,705	0	0	0	0	0	0	0	0	0	1,705	26
27	Other (specify):*	(120,983)	0	0	0	0	0	0	0	0	0	0	(120,983)	27
28	TOTAL General Administration	(138,109)	(146,465)	0	(284,574)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(138,724)	(132,170)	0	(270,894)	29								

STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nursing Ctr# 0048744

Report Period Beginning:

July 1, 2008 Ending:

Summary B

June 30, 2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	19,974	0	0	0	0	0	0	0	0	0	19,974	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,959)	2,156	0	0	0	0	0	0	0	0	0	(7,803)	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	(9,959)	22,130	0	12,171	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(148,683)	(110,040)	0	0	0	0	0	0	0	0	0	(258,723)	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%	\$ 11,466	\$ 11,466	1
2	V	6 Maintenance				2,829	2,829	2
3	V	17 Administration	510,072			74,208	(435,864)	3
4	V	19 Professional Services				34,258	34,258	4
5	V	21 Clerical				207,152	207,152	5
6	V	22 Employee Benefits				31,710	31,710	6
7	V	24 Travel and Seminar				14,574	14,574	7
8	V	26 Insurance				1,705	1,705	8
9	V	30 Depreciation				19,974	19,974	9
10	V	32 Interest				2,156	2,156	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 510,072			\$ 400,032	\$ * (110,040)	14

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

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 Ctr

0048744

Report Period Beginning:

July 1, 2008

Ending: ne 30, 2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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

Facility Name & ID Number

Shawnee Christian Nursing Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending:

June 30, 2009

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										
										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	\$10,860.00	8/1/07	\$ 6,634,900	\$ 6,402,064	8/1/2032	0.0588	\$ 418,881	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$10,860.00		\$ 6,634,900	\$ 6,402,064			\$ 418,881	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	\$ 6,402,064			\$ 418,881	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 37,443 Line # 32

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

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

Facility Name & ID Number Shawnee Christian Nursing Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending:

June 30, 2009

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:

	1	2	3	4	
A. Land.	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>6,141</u>	<u>2</u>
3	TOTALS	180,000		\$ 77,312	3

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		\$ 1,278,419	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				58,328	4,271		4,271		109,861	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		111,319	13
14	Building Improvements			1983	22,362	588	38	588		13,349	14
15	Smoke Alarm			1984	650		20			650	15
16	Building Improvements			1985	44,866	1,122	40	1,122		26,639	16
17	Windows			1985	39,252	981	40	981		23,306	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		381,667	24
25	Remodeling			1987	705		20			705	25
26	Ceiling Duct			1987	510		20			510	26
27	Duct Work			1987	635		20			635	27
28	Remodeling			1988	552		20			552	28
29	Electrical Supply			1988	373		20			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		20			4,675	32
33	Windows			1988	705	20	35	20		425	33
34	Baseboard			1988	739		20			739	34
35	Heat Pumps			1988	27,223		20			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 Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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	\$ 184	20	\$ 184	\$	\$ 22,066	37
38	Towel & Soap Dispenser	1988	1,976		10			1,676	38
39	Title Policy	1988	3,740	94	40	94		1,948	39
40	Hampton Settlement	1988	74,000	1,850	40	1,850		38,542	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		61,879	47
48	Wander Guard	1989	11,417	571	20	571		11,132	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		2,385	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		648	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		33,877	68
69	Lights (13)	1990	590		10			590	69
70	TOTAL (lines 4 thru 69)		\$ 3,183,493	\$ 82,452		\$ 82,452	\$	\$ 2,296,781	70

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

Facility Name & ID Number Shawnee Christian Nursing Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		\$ 3,183,493	\$ 82,452		\$ 82,452	\$	\$ 2,296,781	1
2	Door Kickplates (118)	1990	2,104		10			2,104	2
3	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		6,439	3
4	Remodeling	1991	2,733	137	20	137		2,528	4
5	Door Locks	1991	510	26	20	26		472	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		711	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		4,908	24
25	Honeywell System	1993	5,031	252	20	252		4,046	25
26	Sink & Doors	1994	3,381		10			3,381	26
27	Storage Room Remodel	1994	2,020	101	20	101		1,566	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		2,200	32
33	Therapy/Bath	1996	181,372	7,557	24	7,557		99,503	33
34	TOTAL (lines 1 thru 33)		\$ 3,484,949	\$ 91,375		\$ 91,375	\$	\$ 2,512,728	34

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

Facility Name & ID Number Shawnee Christian Nursing Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		\$ 3,484,949	\$ 91,375		\$ 91,375	\$	\$ 2,512,728	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		26,351	7
8	Replace/Rewire Hot Water Heater	1998	9,445		10			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	275	10	275		3,000	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		909	16
17	Remodel admin office/wiring	2000	1,147		5			1,147	17
18	Rooftop cond unit	2000	3,373	337	10	337		3,064	18
19	4 ton A/C	2000	2,590		5			2,590	19
20	4 ton hest pumps	2000	4,780	478	10	478		4,342	20
21	4 Ton Heat Pumps	2000	2,692	269	10	269		2,378	21
22	Remodel Rooms 18,20,22,24,37	2000	2,214	221	10	221		1,937	22
23	Remodel Rooms 9-17	2001	2,657	266	10	266		2,258	23
24	Install Grease Trap	2001	886		5			886	24
25	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		474	25
26	(3) 4 Ton Heat Pumps	8/22/2001	7,985	799	10	799		6,321	26
27	Door Control System	1/1/2002	12,860	1,286	10	1,286		9,645	27
28	Countertop-Nursing Station Side 1	1/1/2002	750	50	15	50		375	28
29	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685		4			3,685	29
30	Install Dishwasher	5/24/2002	1,100	110	10	110		788	30
31	Countertop-Nursing Station Side 2	3/22/2002	760	51	15	51		372	31
32	York Olympian Heat Pump	6/21/2002	2,265	227	10	227		1,604	32
33	3 Ton Olympian Heat Pump	7/3/2002	2,265	227	10	227		1,586	33
34	TOTAL (lines 1 thru 33)		\$ 3,607,911	\$ 98,716		\$ 98,716	\$	\$ 2,613,982	34

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

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		\$ 3,607,911	\$ 98,716		\$ 98,716	\$	\$ 2,613,982	1
2	Nursing Station - Side #3	8/9/2002	1,146	76	15	76		528	2
3	7.5 Ton York Heat Pump - Dining Room	7/31/2002	8,750	875	10	875		6,125	3
4	Replacement Compressor in kitchen AC	8/31/2002	875		3			875	4
5	30 Position Nurse Call Station w/d	10/2/2002	1,100	110	10	110		788	5
6	(10) Panic Bars/(41)Door Knobs	12/9/2002	746		5			746	6
7	4 Ton York Heat Pump - Unit #1	1/8/2003	2,341	234	10	234		1,522	7
8	(12) Wall Signs w/Letters	2/27/2003	789		5			789	8
9	Nurse Call Light System - Side 1	8/1/2003	970	97	10	97		574	9
10	New Roof - Side 1	8/4/2003	52,263	3,484	15	3,484		20,034	10
11	Roof Replacement	8/4/2003	93,091		3			93,091	11
12	Replace Ceiling Panels/Kitchen & Side 1	10/23/2003	571	29	5	29		571	12
13	Remodel Business Office	2/16/2004	920	107	5	107		920	13
14	Elemco/Opto 22 Energy Management System	3/2/2004	18,962	1,896	10	1,896		10,113	14
15	Service Sink w/double pedal valves	6/3/2004	1,189	119	10	119		604	15
16	Heat Pump	6/16/2004	4,800	480	10	480		2,440	16
17	Roof Replacement - Resident Rooms	7/30/2004	58,356	3,890	15	3,890		19,452	17
18	Cable for Resident Phone Lines	3/18/2005	1,460	292	5	292		1,265	18
19	Dining Room Remodeling	3/1/2005	3,493	699	5	699		3,027	19
20	Resident Rooms Lighting	3/31/2005	1,793	359	5	359		1,554	20
21	Network Cabling Project	7/1/2004	19,993	1,999	10	1,999		9,997	21
22	Carport	9/22/2000	1,363	136	10	136		1,204	22
23	Bus barn	3/1/2003	8,752	219	40	219		1,386	23
24	Fully depreciated land improvements	6/30/1982	62,437		15			62,437	24
25	Parking lot and sewer	2/29/1988	4,658		20			4,658	25
26	Courtyard walks and projects	9/30/1989	18,906	945	20	945		18,821	26
27	Fencing	6/8/1990	1,700		15			1,700	27
28	Landscaping, patio, wall & sidewalk	8/30/1990	18,837	942	20	942		16,847	28
29	Drainage, lanscaping & Gazebo	8/14/1991	12,452	41	20	41		12,365	29
30	100' Fence	12/5/1991	1,380		15			1,380	30
31	Landscaping, seeding, lighting & gazebo roof	6/8/1992	13,660	684	20	684		11,814	31
32	Sidewalk & Fence	8/30/1996	3,247	218	10	218		3,247	32
33	Enlarge parking	9/3/2002	2,386	119	20	119		815	33
34	TOTAL (lines 1 thru 33)		\$ 4,031,297	\$ 116,766		\$ 116,766	\$	\$ 2,925,671	34

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

Facility Name & ID Number Shawnee Christian Nursing Ctr

0048744

Report Period Beginning:

July 1, 2008 Ending: June 30, 2009

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		\$ 4,031,297	\$ 116,766		\$ 116,766	\$	\$ 2,925,671	1
2	Drainage culvert	3/28/2003	1,419	79	18	79		499	2
3	Dumpster fence	6/24/2003	769	77	10	77		468	3
4	Mini Blinds and Draperies	6/30/2006	3,348	670	5	670		2,064	4
5	Toilets and Tanks (4)	6/2/2006	716	72	10	72		221	5
6	New A/C and Heat Unit	6/30/2006	6,290	629	10	629		1,939	6
7	8 Alabaster Mini Blinds	3/29/2006	672	134	5	134		448	7
8	Water Heater	4/17/2006	4,174	417	10	417		1,356	8
9	A/C Unit Hallway	4/5/2006	6,820	682	10	682		2,217	9
10	New Nurse Call Light System	4/20/2006	1,575	158	10	158		512	10
11	5 Toilets	1/13/2006	872	44	20	44		153	11
12	39" X 59" Cordless Mark I (6)	2/1/2006	648	130	5	130		443	12
13	39" X 59" Cordless Mark I (6)	2/23/2006	648	130	5	130		443	13
14	New Grease Trap	3/1/2006	7,750	775	10	775		2,583	14
15	New Roof	7/28/2005	25,044	1,670	15	1,670		6,678	15
16	39" X 59" Cordless Roller Mini (7)	10/13/2005	613	123	5	123		460	16
17	New Flooring - Kitchen	3/31/2006	1,995	200	10	200		665	17
18	Landscaping Materials	6/29/2006	1,030	103	10	103		318	18
19	3 Sidewalks	8/10/2005	3,344	334	10	334		1,310	19
20	Side 1 Shower room remodel	7/1/2006	4,756	476	10	476		1,427	20
21	Build new nurse call panel & rewire	7/1/2006	1,230	123	10	123		369	21
22	Remodel Side 4 shower room	7/1/2006	3,331	333	10	333		999	22
23	(6) sets of miniblinds for resident rooms	12/31/2006	648	130	5	130		335	23
24	Industrial mixing valve	3/1/2007	598	30	20	30		70	24
25	Bryant 3 phase 35,000 BTU electric heat pump	5/8/2007	7,100	1,420	5	1,420		3,077	25
26	Reroof Maintenance Shop	10/3/2007	11,392	1,139	10	1,139		1,994	26
27	19 Resident Room Exhaust Fans	10/1/2007	1,790	179	10	179		313	27
28	Remodel Services	1/17/2008	748	75	10	75		112	28
29	Repour Portion of Front Parking Lot	11/27/2007	3,400	680	5	680		1,133	29
30	Asphalt back Parking Lot	6/11/2008	35,790	3,579	10	3,579		3,877	30
31	Stone work and paving of back parking lot	12/7/2007	10,277	2,055	5	2,055		3,254	31
32	Wallpaper - Side 1 Renovation	9/19/2008	3,992	333	10	333		333	32
33	Door Alarm System	10/1/2008	15,726	1,179	10	1,179		1,179	33
34	TOTAL (lines 1 thru 33)		\$ 4,199,802	\$ 134,924		\$ 134,924	\$	\$ 2,966,920	34

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

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 12E, Carried Forward		\$ 4,199,802	\$ 134,924		\$ 134,924	\$	\$ 2,966,920	1
2	Horn alerts for hallways	1/1/2009	743	37	10	37		37	2
3	Sprinkler head replacement	3/11/2009	7,174	239	10	239		239	3
4	Condensing fan and blower	6/4/2009	618	10	5	10		10	4
5	24 ton heat pump	6/8/2009	9,377	78	10	78		78	5
6	Accumulator - Side 4 dining room	6/24/2009	547	9	5	9		9	6
7	Therapy gym remodeling project	6/30/2009	369,504	1,540	20	1,540		1,540	7
8	Satellite TV system	10/31/2008	19,930	1,495	10	1,495		1,495	8
9	100 gallon fuel tank - above ground	6/27/2009	10,857	45	20	45		45	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	TOTAL (lines 1 thru 33)		\$ 4,618,551	\$ 138,378		\$ 138,378	\$	\$ 2,970,374	34

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

XI. OWNERSHIP COSTS (continued)

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

	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	\$ 248,579	\$ 32,714	\$ 32,714	\$	Various	\$ 141,053	71
72	Current Year Purchases	110,120	3,372	3,372		Various	3,372	72
73	Fully Depreciated Assets	519,725					519,725	73
74	Home Office Allocation	192,182	14,073	14,073			28,486	74
75	TOTALS	\$ 1,070,606	\$ 50,160	\$ 50,160	\$		\$ 692,636	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	5,794	5,794		8	18,347	78
79	Home Office Allocation			22,259	1,630	1,630			9,918	79
80	TOTALS			\$ 86,182	\$ 7,424	\$ 7,424	\$		\$ 45,838	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)	\$ 5,852,652	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,961	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,961	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)	\$ 3,708,847	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	\$ 69,682	92
93	Home Office Allocation	5,684	93
94			94
95		\$ 75,366	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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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: \$ 39,574 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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)	
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	\$	6,462	\$ 431,880	\$	6,462	\$ 431,880	1
2	Licensed Speech and Language Development Therapist		hrs		2,434	191,120		2,434	191,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,967	395,279		5,967	395,279	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	14,863	\$ 1,018,279	\$	14,863	\$ 1,018,279	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 Ctr# 0048744Report Period Beginning: July 1, 2008Ending: June 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2009 (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	\$ 282,373	\$	1
2	Cash-Patient Deposits	38,994		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (29,143))	1,832,709		3
4	Supply Inventory (priced at)	16,748		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,673		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Rec</u>	110		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,187,607	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	4,353,674		14
15	Leasehold Improvements, at Historical Cost	206,549		15
16	Equipment, at Historical Cost	942,347		16
17	Accumulated Depreciation (book methods)	(3,564,463)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	553,857		21
22	Other Long-Term Assets (spe CIP)	69,682		22
23	Other(specify): <u>Deferred Financing Costs</u>	225,615		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,869,232	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,056,839	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,776	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,994		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	354,572		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	477		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>	268,871		36
37	<u>Due to Auxiliary</u>	3,388		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 735,078	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,402,064		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)	\$ 6,402,064	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,137,142	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,080,303)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,056,839	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,895,899)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,895,899)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	815,596	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)	\$ 815,596	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)	\$ (2,080,303)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Shawnee Christian Nursing Ctr**# **0048744**Report Period Beginning: **July 1, 2008**Ending: **June 30, 2009**

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	\$ 7,348,027	1
2	Discounts and Allowances for all Levels	(935,974)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,412,053	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,344,051	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,344,051	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	19,007	13
14	Non-Patient Meals	1,273	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,847	17
18	Sale of Supplies to Non-Patients	88	18
19	Laboratory	41,873	19
20	Radiology and X-Ray	26,929	20
21	Other Medical Services	16,604	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 117,621	23
D. Non-Operating Revenue			
24	Contributions	29,254	24
25	Interest and Other Investment Income***	9,959	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,213	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous/Unrealized Gain(Loss) on Investments	(7,925)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (7,925)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,905,013	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,255,801	31
32	Health Care	4,207,994	32
33	General Administration	1,796,361	33
B. Capital Expense			
34	Ownership	645,319	34
C. Ancillary Expense			
35	Special Cost Centers	96,889	35
36	Provider Participation Fee	87,053	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,089,417	40
41	Income before Income Taxes (line 30 minus line 40)**	815,596	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 815,596	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 Ctr**

0048744

Report Period Beginning: **July 1, 2008**

Ending:

June 30, 2009

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	1,125	1,140	\$ 46,927	\$ 41.16	1
2	Assistant Director of Nursing	2,575	3,066	91,078	29.71	2
3	Registered Nurses	12,835	14,567	321,645	22.08	3
4	Licensed Practical Nurses	29,991	34,834	546,507	15.69	4
5	CNAs & Orderlies	95,873	107,662	1,135,410	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,957	4,269	57,159	13.39	8
9	Activity Director	1,896	2,048	21,737	10.61	9
10	Activity Assistants	6,398	6,805	62,445	9.18	10
11	Social Service Workers	4,037	4,559	61,592	13.51	11
12	Dietician					12
13	Food Service Supervisor	2,013	2,160	37,354	17.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,482	25,444	236,324	9.29	15
16	Dishwashers					16
17	Maintenance Workers	9,415	10,052	151,574	15.08	17
18	Housekeepers	26,287	29,015	266,957	9.20	18
19	Laundry					19
20	Administrator	1,703	1,828	92,573	50.64	20
21	Assistant Administrator					21
22	Other Administrative	1,950	2,002	43,012	21.48	22
23	Office Manager	1,935	2,038	42,050	20.63	23
24	Clerical	3,179	3,660	35,742	9.77	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 C: Ward Clerk, Direc	7,596	8,325	67,803	8.14	32
33	Other(specify) <u>Comm. Liaison, V</u>	11,133	11,958	280,359	23.45	33
34	TOTAL (lines 1 - 33)	247,380	275,432	\$ 3,598,248 *	\$ 13.06	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	320	\$ 15,855	ln 1, col 3	35
36	Medical Director	120	24,000	ln 9, col 3	36
37	Medical Records Consultant	32	1,820	ln 10, col 3	37
38	Nurse Consultant	14	599	ln 10, col 3	38
39	Pharmacist Consultant	156	4,543	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	97	5,622	ln 12, col 3	45
46	Other(specify) <u>Administrator</u>	374	18,232	ln 21, col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,114	\$ 70,671		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 Ctr

0048744

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

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 - \$7,498
- (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. \$ 34,375 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. \$ 87,053
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. \$ 1,273
- (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
- (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.