



Facility Name & ID Number Shawnee Christian Nursing Ctr

# 0048744 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

**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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,453	6,714	8,904	42,071	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,453	6,714	8,904	42,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.49%

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 7,798

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name &amp; ID Number

Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning:

July 1, 2012

Ending:

June 30, 2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	325,019	12,990	13,596	351,605		351,605		351,605		1
2	Food Purchase		218,965		218,965		218,965	(2,462)	216,503		2
3	Housekeeping	126,932	22,809		149,741		149,741		149,741		3
4	Laundry	101,023	6,219		107,242		107,242		107,242		4
5	Heat and Other Utilities			140,667	140,667		140,667	1,401	142,068		5
6	Maintenance	117,875	13,042	26,204	157,121		157,121	3,108	160,229		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	670,849	274,025	180,467	1,125,341		1,125,341	2,047	1,127,388		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,525,477	264,617	67,392	2,857,486		2,857,486		2,857,486		10
10a	Therapy			971,375	971,375		971,375		971,375		10a
11	Activities	81,353	2,523	(446)	83,430		83,430		83,430		11
12	Social Services	144,617	1,714	5,794	152,125		152,125		152,125		12
13	CNA Training										13
14	Program Transportation			5,151	5,151		5,151		5,151		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,751,447	268,854	1,073,266	4,093,567		4,093,567		4,093,567		16
	<b>C. General Administration</b>										
17	Administrative	20,170	94	634,492	654,756		654,756	(542,173)	112,583		17
18	Directors Fees										18
19	Professional Services			109,114	109,114		109,114	34,146	143,260		19
20	Dues, Fees, Subscriptions & Promotions			35,462	35,462		35,462		35,462		20
21	Clerical & General Office Expenses	116,045	16,153	516,442	648,640		648,640	(71,163)	577,477		21
22	Employee Benefits & Payroll Taxes			813,888	813,888		813,888	41,749	855,637		22
23	Inservice Training & Education										23
24	Travel and Seminar			29,490	29,490		29,490	16,779	46,269		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,927	78,927		78,927	8,852	87,779		26
27	Other (specify):* <b>Marketing</b>	64,608	394	18,328	83,330		83,330	(83,330)			27
28	<b>TOTAL General Administration</b>	200,823	16,641	2,236,143	2,453,607		2,453,607	(595,140)	1,858,467		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,623,119	559,520	3,489,876	7,672,515		7,672,515	(593,093)	7,079,422		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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			280,115	280,115	280,115	32,557	312,672				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			377,691	377,691	377,691	(1,500)	376,191				32
33	Real Estate Taxes			379	379	379	(379)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,374	11,374	11,374		11,374				35
36	Other (specify):* <b>Def Fin Cost/Admin</b>			10,535	10,535	10,535		10,535				36
37	<b>TOTAL Ownership</b>			680,094	680,094	680,094	30,678	710,772				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			457,209	457,209	457,209	(32,401)	424,808				39
40	Barber and Beauty Shops	15,395	965		16,360	16,360		16,360				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			292,450	292,450	292,450		292,450				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	15,395	965	749,659	766,019	766,019	(32,401)	733,618				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,638,514	560,485	4,919,629	9,118,628	9,118,628	(594,816)	8,523,812				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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(796)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(14,575)	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				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	(56,428)	21		24
25	Fund Raising, Advertising and Promotional	(83,330)	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	(250,122)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (405,251)</b>		<b>\$</b>	<b>30</b>

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	1,018,386	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 1,018,386</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 613,135</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

<b>BHF USE ONLY</b>					
48		49		50	51
					52

## Shawnee Christian Nursing Ctr

ID# 0048744

Report Period Beginning: July 1, 2012

Ending: June 30, 2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending	\$ (1,666)	2	1
2	Late Fees, Finance Charges	(1,062)	6	2
3	Fines and Penalties	(246,982)	21	3
4	Late Fees, Finance Charges	(33)	21	4
5	Real Estate Tax	(379)	33	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	<b>Total</b>	(250,122)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Ctr# 0048744

Report Period Beginning:

July 1, 2012

Ending:

June 30, 2013

## 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	(2,462)	0	0	0	0	0	0	0	0	0	0	(2,462)	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	0	1,401	0	0	0	0	0	0	0	0	0	1,401	5
6	Maintenance	(1,062)	4,170	0	0	0	0	0	0	0	0	0	3,108	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,524)</b>	<b>5,571</b>	<b>0</b>	<b>2,047</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(542,173)	0	0	0	0	0	0	0	0	0	(542,173)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	34,146	0	0	0	0	0	0	0	0	0	34,146	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(303,443)	232,280	0	0	0	0	0	0	0	0	0	(71,163)	21
22	Employee Benefits & Payroll Taxes	0	41,749	0	0	0	0	0	0	0	0	0	41,749	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	16,779	0	0	0	0	0	0	0	0	0	16,779	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	8,852	0	0	0	0	0	0	0	0	0	8,852	26
27	Other (specify):*	(83,330)	0	0	0	0	0	0	0	0	0	0	(83,330)	27
28	<b>TOTAL General Administration</b>	<b>(386,773)</b>	<b>(208,367)</b>	<b>0</b>	<b>(595,140)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(390,297)</b>	<b>(202,796)</b>	<b>0</b>	<b>(593,093)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nursing Ctr# 0048744

Report Period Beginning:

July 1, 2012 Ending:

Summary B

June 30, 2013

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	32,557	0	0	0	0	0	0	0	0	0	32,557	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,575)	13,075	0	0	0	0	0	0	0	0	0	(1,500)	32
33	Real Estate Taxes	(379)	0	0	0	0	0	0	0	0	0	0	(379)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(14,954)</b>	<b>45,632</b>	<b>0</b>	<b>30,678</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(32,401)	0	0	0	0	0	0	0	0	0	(32,401)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(32,401)</b>	<b>0</b>	<b>(32,401)</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(405,251)</b>	<b>(189,565)</b>	<b>0</b>	<b>(594,816)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Midwest Christian Villages, Inc. dba: Christian Homes, Inc.	100.00%	\$ 1,401	\$ 1,401	1
2	V	6 Maintenance				4,170	4,170	2
3	V	17 Administration	634,492			92,319	(542,173)	3
4	V	19 Professional Services				34,146	34,146	4
5	V	21 Clerical				193,451	193,451	5
6	V	22 Employee Benefits				41,749	41,749	6
7	V	24 Travel and Seminar				16,779	16,779	7
8	V	26 Insurance				8,852	8,852	8
9	V	30 Depreciation				32,557	32,557	9
10	V	32 Interest				13,075	13,075	10
11	V	21 Other Administrative Expenses				38,829	38,829	11
12	V	39 Pharmacy Services	383,894	Senior Care Pharmacy		351,493	(32,401)	12
13	V							13
14	Total		\$ 1,018,386			\$ 828,821	\$ * (189,565)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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, 2012

Ending: ne 30, 2013

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<b>This workpaper is not applicable</b>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning:

July 1, 2012 Ending:

June 30, 2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	HUD Sect. 232 Ins Mortgage		X	HUD Financing	\$49,420.00	8/1/2007	\$ 6,634,900	\$ 5,809,156	8/1/2032	5.8800	\$ 346,734	1						
2												2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$49,420.00		\$ 6,634,900	\$ 5,809,156			\$ 346,734	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 6,634,900	\$ 5,809,156			\$ 346,734	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,481 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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 report.		\$			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.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008 _____	8	<b>FOR BHF USE ONLY</b>			
	2009 _____	9				
	2010 _____	10			13 FROM R. E. TAX STATEMENT FOR 2012 \$	13
	2011 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	12			15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16		

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Ctr 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 2012 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 2012.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>02-18-429-008</u>	<u>Williams 1st SOL</u>	\$ <u>369.54</u>	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u><u>369.54</u></u>	\$ <u><u>          </u></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 and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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>6,751</u>	<u>2</u>
3	<b>TOTALS</b>	<b>180,000</b>		<b>\$ 77,922</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$	\$ 1,455,772	4
5		1980	1980	107,504		20				5
6										6
7										7
8	Home Office Allocation			66,150	7,512		7,512		43,662	8
	<b>Improvement Type**</b>									
9	PARKING LOT		6/30/1982	42,223		Various			42,223	9
10	LANDSCAPING		8/31/1992	3,500		Various			3,500	10
11	PARKING LOT IMPROVEMENT		9/30/1982	400		Various			400	11
12	STORAGE SHED		3/31/1981	6,510		Various			6,510	12
13										13
14	HEATING AC CONTROL SYSTEM		5/31/1982	37,091		Various			37,091	14
15	BUILDING IMPROVEMENTS		5/30/1982	159,808	4,098	Various	4,098		127,710	15
16	BUILDING IMPROVEMENTS		6/30/1983	22,362	588	Various	588		17,703	16
17	IMPRV CONCRETE WORK		10/17/1985	44,866	1,122	Various	1,122		31,126	17
18	104 WINDOWS		10/17/1985	39,252	981	Various	981		27,231	18
19	CEILING TILE		12/10/1985	4,232		Various			4,232	19
20	LIGHT FIXTURES		12/19/1985	777		Various			777	20
21	CEILING TILE		12/30/1986	1,874		Various			1,874	21
22	HEATING AC DUCT WORK		10/30/1986	1,600		Various			1,600	22
23	BUILDING IMPROVEMENTS		12/30/1986	4,103		Various			4,103	23
24	ELEC WIRE FOR HEATING AC		1/14/1987	891		Various			891	24
25	DINING & ADM. WING		5/31/1987	688,723	17,218	Various	17,218		450,540	25
26	LANDSCAPING		7/9/1987	3,083		Various			3,083	26
27	CEILING DUCT WORK		8/31/1987	510		Various			510	27
28	DUCTWORK		10/5/1987	635		Various			635	28
29	SANITARY SEWER REV		2/29/1988	1,001		Various			1,001	29
30	ELECTRICAL SUPPLIES		3/31/1988	373		Various			373	30
31	AIR CLEANER & DUCT		4/26/1988	1,694		Various			1,694	31
32	MIRROR FRAME W SOAP DISH		4/26/1988	1,562		Various			1,562	32
33	FEED SIGN HVAC SYSTEM		5/18/1988	4,675		Various			4,675	33
34	WINDOWS		6/1/1988	705	20	Various	20		505	34
35	TOWEL & SOAP DISPENSER		8/30/1988	1,976		Various			1,976	35
36	DUCT WORK		9/21/1988	22,066		10			22,066	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning:

July 1, 2012 Ending: June 30, 2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	INSTALL D.D. GATE	3/23/1989	\$ 450	\$	5	\$	\$	\$ 450	37
38	SEWER SYSTEM IMPROVEMENT	7/7/1989	10,000		10			10,000	38
39	FLOURESCENT LIGHT20	6/21/1989	673		5			673	39
40	ELEC WORK FOR 7 AC	7/1/1989	6,950		20			6,950	40
41	HEAT PUMPS DUCT SYS	7/1/1989	39,940		20			39,940	41
42	TITLE POLICY	9/29/1988	3,740	94	10	94		2,322	42
43	HAMPTON SETTLEMENT	9/29/1988	74,000	1,850	10	1,850		45,942	43
44	GRINDER PUMP SYSTEM	8/3/1989	11,624		10			11,624	44
45	COURTYARD PROJECT	9/30/1989	8,326		10			8,326	45
46	DOWN SPOUTS (GUTTER)	9/25/1989	600		10			600	46
47	LAUNDRY ROOM ROOF	9/25/1989	2,200		10			2,200	47
48	COURTYARD SIDEWALKS	11/9/1989	580		10			580	48
49	LANDSCAPING	1/9/1990	517		10			517	49
50	HEAT PUMPS	1/9/1990	63,466		10			63,466	50
51	CEILING TILE	1/9/1990	1,868		10			1,868	51
52	AIR CONDITIONING	1/29/1990	5,820		10			5,820	52
53	SHELVING	2/6/1990	851		10			851	53
54	WATER HEATER	3/7/1990	386		10			386	54
55	WALLPAPER	4/10/1990	919		10			919	55
56	DOOR & HARDWARE	3/22/1990	541		10			541	56
57	RELOCATE SPRINKLERS	5/8/1990	583		10			583	57
58	BRICK AC HOLES	5/8/1990	1,352	34	10	34		783	58
59	8 DOORFRAMES	5/8/1990	303		10			303	59
60	HEATING RECEIVERSII	6/8/1990	1,975		10			1,975	60
61	KICKPLATES (150)	7/13/1990	763		10			763	61
62	INSTALLATION OF AC	8/16/1990	1,184		10			1,184	62
63	DOOR ALARM	8/16/1990	423		10			423	63
64	DOORS & LOCKS	8/16/1990	35,817		10			35,817	64
65	LANDSCAPINGCOURTYARD	8/30/1990	7,472		10			7,472	65
66	DRAINAGE WORK	9/14/1990	2,848		10			2,848	66
67	PATIO WALL SIDEWALK	9/14/1990	8,000		10			8,000	67
68	LIGHTS (13)	9/14/1990	590		10			590	68
69	DOOR KICKPLATESI18	11/9/1990	2,104		10			2,104	69
70	TOTAL (lines 4 thru 69)		\$ 3,233,036	\$ 77,855		\$ 77,855	\$	\$ 2,561,844	70

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

Facility Name &amp; ID Number Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning:

July 1, 2012 Ending: June 30, 2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,233,036	\$ 77,855		\$ 77,855	\$	\$ 2,561,844	1
2	ELEC CON TO EMRG GEN	12/6/1990	6,930					6,930	2
3	DOOR LOCKS & KEYS	1/23/1991	510					510	3
4	HANDRAIL DRYWALL	3/26/1991	569					569	4
5	EXIT FIXTURES (28)	3/26/1991	1,619					1,619	5
6	SIDEWALK (840 BY 4)	4/29/1991	2,100					2,100	6
7	PARKING CURBS (30)	5/22/1991	385					385	7
8	AC UNITS (2 HGH EFF)	5/22/1991	15,885					15,885	8
9	WALLCOVERINGS	6/10/1991	483					483	9
10	SAND DIRT CULVERTS	6/28/1991	828					828	10
11	LANDSCAPING	8/14/1991	709					709	11
12	WALKINFREEZER	9/12/1991	8,643					8,643	12
13	HEAT PUMP	9/5/1991	5,267					5,267	13
14	DRAINAGELANDSCAPING	9/26/1991	2,615					2,615	14
15	WATER HEATER	12/5/1991	867					867	15
16	BRICKWORK ON GAZEBO	11/11/1991	6,200					6,200	16
17	100 OF FENCING	12/5/1991	1,380					1,380	17
18	GAZEBO (ROOFINGETC)	1/8/1992	8,216					8,216	18
19	PARKING LOT LIGHTING	2/6/1992	772					772	19
20	DOORHALLS LIGHT RLY	2/6/1992	2,091					2,091	20
21	HOT WATER HEATERS (2)	2/6/1992	3,164					3,164	21
22	HEAT PUMP (2)	2/6/1992	653					653	22
23	LANDSCAPING	5/27/1992	2,794					2,794	23
24	HEAT PUMP	6/8/1992	7,265					7,265	24
25	REMOVEREPLACE DRIVE	6/8/1992	900					900	25
26	4 LOOP SYSTEM	6/26/1992	3,723					3,723	26
27	METAL DOOR FRAMES	8/20/1992	840	4		4		840	27
28	HAULINGSPREADING DIRT	9/11/1992	1,000	8		8		1,000	28
29	ADDITIONAL LIGHTING	3/8/1993	1,142					1,142	29
30	GRADE AND SEED LOT	6/30/1993	750	34		34		750	30
31	INSTALL HONEYWELL SYSTEM	6/30/1993	5,031	231		231		5,031	31
32	STORAGE ROOM REMODEL	1/6/1994	2,020	101		101		1,970	32
33	SEWAGE SYSTEM PUMP	4/28/1994	4,256					4,256	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,332,643	\$ 78,232		\$ 78,232	\$	\$ 2,661,401	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,332,643	\$ 78,232		\$ 78,232	\$	\$ 2,661,401	1
2	1 FIRE1 GARAGE DOOR	6/6/1994	526					526	2
3	S.S. SINKFAUCET	6/24/1994	783					783	3
4	BRAILLE DOOR SIGNS	6/7/1994	2,598					2,598	4
5	FOLDING DOOR DIVIDER	10/24/1994	551					551	5
6	GARBAGE DISPOSAL	12/12/1994	610					610	6
7	THERAPYBATH ADDITION	5/14/1996	181,372	7,557		7,557		129,731	7
8	HANDRAILSSIDE1 RMDL	5/23/1995	6,079					6,079	8
9	CABINETSSIDE 1 NURSING	6/30/1995	2,343					2,343	9
10	NEW ADDITIONSIDEWALK	8/30/1996	534					534	10
11	WATER FOUNTAIN	4/4/1997	502					502	11
12	REMODELINGSIDES 2 & 3	5/1/1999	38,878	2,592		2,592		36,718	12
13	HEATERSKITCHEN (2)	5/11/1998	793					793	13
14	COMPRESSOR	7/24/1997	973					973	14
15	COMPRESSORSUNT 15 & 16	7/31/1997	2,377					2,377	15
16	COMPRESSORSLIBRY#24	7/16/1998	2,972					2,972	16
17	KEYLESS LOCKS (2)	9/11/1998	1,423					1,423	17
18	WALLPAPER DINING ROOM	4/15/1999	3,071					3,071	18
19	120 GALLON WATER HEATER	6/30/1999	3,000					3,000	19
20	PVC FENCE	9/13/1999	2,713					2,713	20
21	COMPRESSOR	10/18/1999	1,133					1,133	21
22	SECURITY CONTROL SYSTEM	11/11/1999	940					940	22
23	WIRING KEYPADS SONALERTS	5/11/2000	560					560	23
24	ROOFTOP CONDENSING UNIT	6/8/2000	3,373					3,373	24
25	4 TON AC	6/30/2000	2,590					2,590	25
26	4 TON HEAT PUMPS	6/30/2000	4,780					4,780	26
27	4 TON HEAT PUMPS	9/14/2000	2,692					2,692	27
28	CARPORT	9/22/2000	1,363					1,363	28
29	INSTALL GREASE TRAP	4/11/2001	886					886	29
30	4 PERSON BOOTH ISLAND (BOLTED TO FLOOR)	7/1/2001	593					593	30
31	(3) 4 TON HEAT PUMPS	8/22/2001	7,985					7,985	31
32	DOOR CONTROL SYSTEM	1/1/2002	12,860					12,860	32
33	INSTALL EVAP & CONDENSER IN WALKIN FREE	3/6/2002	3,685					3,685	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,628,181	\$ 88,381		\$ 88,381	\$	\$ 2,903,138	34

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

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,628,181	\$ 88,381		\$ 88,381	\$	\$ 2,903,138	1
2	INSTALL DISHWASHER	5/24/2002	1,100					1,100	2
3	YORK OLYMPIAN HEAT PUMP	6/21/2002	2,265					2,265	3
4	3 TON OLYMPIAN HEAT PUMP	7/3/2002	2,265					2,265	4
5	NURSING STATION SIDE 3	8/9/2002	1,146	76		76		834	5
6	7.5 TON YORK HEAT PUMP DINING ROOM	7/31/2002	8,750					8,750	6
7	ENLARGE PARKING AREA	9/3/2002	2,386	119		119		1,292	7
8	REPL COMPRESSOR IN KITCHEN AC	8/31/2002	875					875	8
9	BUS BARN	3/1/2003	8,752	219		219		2,261	9
10	(10) PANIC BARS(41) DOOR KNOBS 131 EXTRA K	12/9/2002	746					746	10
11	YORK 4 TON HEAT PUMP UNIT #1	1/8/2003	2,341	117		117		2,341	11
12	(12) WALL SIGNS W LETTERS	2/27/2003	789					789	12
13	CULVERT TO CARRY WATER AWAY FROM BACK OF	3/28/2003	1,419	79		79		815	13
14	FENCE AROUND TRASH DUMPSTERS	6/24/2003	769	70		70		769	14
15	NEW ROOF SIDE 1	10/31/2003	52,263	3,484		3,484		33,971	15
16	ROOF REPLACEMENT	8/4/2003	93,091					93,091	16
17	REPL CEILING PANELS KITCHEN & SIDE 1 RES	10/23/2003	571					571	17
18	ELEM COOPTO 22 ENERGY MGMT SYSTEM	3/2/2004	18,962	1,896		1,896		17,698	18
19	SERVICE SINK W DOUBLE PEDAL VALVES	6/3/2004	1,189	119		119		1,080	19
20	HEAT PUMP	6/16/2004	4,800	480		480		4,360	20
21	ROOF RESIDENT ROOMS EXCEPT 101 & 102	7/30/2004	58,356	3,890		3,890		35,014	21
22	RESIDENT PHONE LINES CABLING WORK	3/18/2005	1,460					1,460	22
23	REMODELING DINING ROOM	3/1/2005	3,493					3,493	23
24	LIGHTING IN RESIDENTS ROOMS	3/31/2005	1,793					1,793	24
25	NETWORK CABLING PROJECT	7/1/2004	19,993	1,999		1,999		17,994	25
26	3 sidewalks	8/10/2005	3,344	334		334		2,647	26
27	New Roof	7/28/2005	25,044	1,670		1,670		13,357	27
28	(7) 39x59 cordless roller mini blinds re	10/13/2005	613					613	28
29	5 toilets	1/13/2006	872	44		44		327	29
30	(6) 39x59 cordless Mark I alabaster mi	2/1/2006	648					648	30
31	(6) 39x59 cordless Mark I alabaster min	2/23/2006	648					648	31
32	New Grease Trap Parts & Labor	3/1/2006	7,750	775		775		5,683	32
33	(8) Alabaster mini blinds Mark I 39x7	3/29/2006	672					672	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,957,346	\$ 103,754		\$ 103,754	\$	\$ 3,163,360	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,957,346	\$ 103,754		\$ 103,754	\$	\$ 3,163,360	1
2	Water HeaterSide 4 Shower & Resident ro	4/17/2006	4,174	417		417		3,026	2
3	AC Unit Side 1 Hallway & Care plan of	4/5/2006	6,820	682		682		4,945	3
4	MiniBlinds and Draperies for Resident R	6/30/2006	3,348					3,348	4
5	(4) toilets & tanks to meet ADA requirem	6/2/2006	716	72		72		508	5
6	New AC & Heat Unit for Resident rooms	6/30/2006	6,290	629		629		4,455	6
7	Landscaping materials for gazebo area	6/29/2006	1,030	103		103		730	7
8	New Flooring Kitchen Dishroom	3/31/2006	1,995	200		200		1,463	8
9	Side 1 Shower Room remodel	7/1/2006	4,756	476		476		3,329	9
10	Remodel Side 4 Shower room	7/1/2006	3,331	333		333		2,331	10
11	(6) sets of miniblinds for resident room	12/31/2006	648					648	11
12	Industrial Mixing Valve	3/1/2007	598	30		30		189	12
13	Bryant 3 phase 35000 BTU electric heat	5/8/2007	7,100					7,100	13
14	Reroof mansards & maint shop	10/3/2007	11,392	1,139		1,139		6,550	14
15	(19) resident room exhaust fans	10/1/2007	1,791	179		179		1,030	15
16	Repour portion of front parking lot	11/27/2007	3,400	227		227		3,400	16
17	Stone work and paving of back parking lo	12/7/2007	10,277	856		856		10,277	17
18	December services - remodel	1/17/2008	748	75		75		412	18
19	Asphalt back parking lot	6/11/2008	35,790	3,579		3,579		18,193	19
20	Wallpaper-Side 1 Renovation	9/19/2008	3,992	399		399		1,929	20
21	Door Alarm System	10/1/2008	15,726	1,573		1,573		7,470	21
22	Horn alerts for hallways	1/1/2009	743	74		74		334	22
23	Sprinkler head replacement	3/11/2009	7,174	717		717		3,109	23
24	Condensing Fan and blower	6/4/2009	618	124		124		504	24
25	24 ton heat pump	6/8/2009	9,377	938		938		3,829	25
26	Accumulator - Side 4 dining room	6/24/2009	547	109		109		447	26
27	1000 gallon fuel tank - above ground	6/27/2009	10,857	543		543		2,217	27
28	Therapy gym remodeling project	6/30/2009	369,504	18,475		18,475		75,440	28
29	Satellite TV System	10/31/2008	19,930	1,993		1,993		9,467	29
30	Floor tile for Reclaim Bath	11/9/2009	559	56		56		205	30
31	Flooring - Dining Room	8/31/2009	33,070	3,307		3,307		12,952	31
32	Call Light System	7/31/2009	47,969	4,797		4,797		19,188	32
33	122 Ft Privacy Fence	6/10/2010	1,800	180		180		555	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,583,414	\$ 146,035		\$ 146,035	\$	\$ 3,372,940	34

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 4,583,414	\$ 146,035		\$ 146,035	\$	\$ 3,372,940	1
2	Roof Replacement - Dining Room	6/23/2010	11,582	1,158		1,158		3,571	2
3	5 Ton A/C Compressor & Replacement Labor	7/7/2010	1,074	107		107		322	3
4	Carpet for Office and Conference Room	10/23/2010	4,638	464		464		1,275	4
5	Sprinkler System Upgrade	1/31/2011	5,048	505		505		1,262	5
6	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829		829		2,488	6
7	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883		1,883		5,649	7
8	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385		1,385		4,154	8
9	Roof Exhaust Fans	6/30/2011	1,905	190		190		397	9
10	Dietary - Floor Replacement	6/30/2011	19,467	1,947		1,947		4,056	10
11	Doors w/Smoke Gaskets	6/30/2011	8,402	840		840		1,751	11
12	Dietary Loading - Privacy Fence	6/30/2011	2,118	212		212		441	12
13	Restripe Parking Lots	6/30/2011	5,375	538		538		1,120	13
14	Lighting for Outdoor Sign	6/30/2011	889	89		89		185	14
15	Memory Lane - Painting	6/30/2011	3,226	323		323		672	15
16	Memory Lane/Shadybrook - Asbestos Remova	6/30/2011	22,600	2,260		2,260		4,708	16
17	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	7,761		7,761		16,168	17
18	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	358		358		747	18
19	Memory Lane/Shadybrook - Rails and guard	6/30/2011	15,044	1,504		1,504		3,134	19
20	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	1,460		1,460		3,041	20
21	Memory Lane - Light Fixtures	6/30/2011	1,039	104		104		217	21
22	Shadybrook - Light Fixtures	6/30/2011	1,039	104		104		217	22
23	Fire alarm system, addressable 3 yr warr	1/9/2012	83,229	8,323		8,323		12,484	23
24	Fire alarm system 6 door closures instal	1/23/2012	5,907	591		591		886	24
25	120 Gal 480V Haot Water Heater	7/17/2012	5,169	517		517		517	25
26	Counter Tops Acti vi ty Room	7/11/2012	640	43		43		43	26
27	Red Oak Gol den Oak Cabi nets Acti vi ty RM	7/1/2012	3,147	210		210		210	27
28	Drywal l & Suppl y - Acti vi ty Room Remodel	7/12/2012	117	8		8		8	28
29	Refurbi sh Parki ng Lot Li ghts	12/3/2012	1,398	163		163		163	29
30	Wal k In Cool er/Freezer (Indoor)	3/22/2013	16,400	364		364		364	30
31	Wal k-In Cool er/Freezer (Instal l ati on)	5/16/2013	4,950	55		55		55	31
32	4 Ton Heat Pumps Trane 15 SEER (2)	5/17/2013	14,971	250		250		250	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,959,545	\$ 180,578		\$ 180,578	\$	\$ 3,443,493	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 576,050	\$ 99,904	\$ 99,904	\$	Various	\$ 399,672	71
72	Current Year Purchases	8,670	1,351	1,351		Various	1,351	72
73	Fully Depreciated Assets	331,476				Various	331,476	73
74	Home Office Allocation	270,836	22,280	22,280			147,205	74
75	TOTALS	\$ 1,187,032	\$ 123,535	\$ 123,535	\$		\$ 879,704	75

D. Vehicle Costs. (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	2006 Ford Starcraft	2006	46,350	5,794	5,794		8	41,522	77
78										78
79	Home Office Allocation			24,346	2,765	2,765			9,795	79
80	TOTALS			\$ 84,946	\$ 8,559	\$ 8,559	\$		\$ 65,567	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)		\$ 6,309,445	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 312,672	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 312,672	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)		\$ 4,388,764	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	Home Office Allocation	\$ 158,272	92
93			93
94			94
95		\$ 158,272	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 Ctr

# 0048744

Report Period Beginning: July 1, 2012

Ending: June 30, 2013

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 11,374 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	<b>TOTAL</b>		\$ _____	\$ _____	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.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0048744 Report Period Beginning: July 1, 2012 Ending: June 30, 2013  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><u>Shawnee Christian Nursing Center only hires certified CNAs</u></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	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	10a-3	hrs	\$	8,333	\$ 392,999	\$	8,333	\$ 392,999	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		3,600	213,084		3,600	213,084	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		11,589	365,292		11,589	365,292	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	<b>TOTAL</b>			\$	23,522	\$ 971,375	\$	23,522	\$ 971,375	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 &amp; ID Number Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning: July 1, 2012

Ending:

June 30, 2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2013 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 10,829	\$	1
2	Cash-Patient Deposits	53,089		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 159,117 )	1,664,272		3
4	Supply Inventory (priced at )	15,262		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,144		6
7	Other Prepaid Expenses	9,922		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>	669		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,769,187	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	4,682,021		14
15	Leasehold Improvements, at Historical Cost	211,374		15
16	Equipment, at Historical Cost	976,795		16
17	Accumulated Depreciation (book methods)	(4,154,121)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	646,509		21
22	Other Long-Term Assets (specify):	186,378		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,630,927	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,400,114	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 313,618	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,089		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,266		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	185		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Other Accrued Expenses</u>	1,229,194		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,855,352	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	875		39
40	Mortgage Payable	5,809,158		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,810,033	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,665,385	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (3,265,271)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,400,114	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (2,563,122)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (2,563,122)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(702,149)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (702,149)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (3,265,271)	24 *

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

**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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 6,359,140	1	
2	Discounts and Allowances for all Levels	(2,772,057)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,587,083</b>	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	3,847,652	6	
7	Oxygen	40,739	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,888,391</b>	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care	11,345	13	
14	Non-Patient Meals	796	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	650,570	17	
18	Sale of Supplies to Non-Patients	3,649	18	
19	Laboratory	44,104	19	
20	Radiology and X-Ray	40,897	20	
21	Other Medical Services	138,636	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 889,997</b>	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions	28,532	24	
25	Interest and Other Investment Income***	15,738	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 44,270</b>	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>Miscellaneous</u>	6,738	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 6,738</b>	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,416,479</b>	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,125,341	31	
32	Health Care	4,093,567	32	
33	General Administration	2,453,607	33	
<b>B. Capital Expense</b>				
34	Ownership	680,094	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	473,569	35	
36	Provider Participation Fee	292,450	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 9,118,628</b>	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(702,149)</b>	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (702,149)</b>	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,099,243	44
45	Private Pay - Net Inpatient Revenue	1,022,288	45
46	Medicare - Net Inpatient Revenue	(517,723)	46
47	Other-(specify) <u>HMO/Medicare Advantage</u>	(15,455)	47
48	Other-(specify) <u>Special Contracts</u>	(1,270)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 3,587,083</b>	49

\* 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, 2012**

Ending:

**June 30, 2013**

**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	1,272	1,360	\$ 59,134	\$ 43.48	1
2	Assistant Director of Nursing	3,008	3,220	92,034	28.58	2
3	Registered Nurses	15,396	17,338	395,339	22.80	3
4	Licensed Practical Nurses	37,487	40,886	704,274	17.23	4
5	CNAs & Orderlies	107,024	116,244	1,107,957	9.53	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,935	2,150	25,329	11.78	9
10	Activity Assistants	5,149	5,745	56,024	9.75	10
11	Social Service Workers	6,975	8,044	144,617	17.98	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	28,698	31,691	325,019	10.26	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	5,471	6,183	117,875	19.06	17
18	Housekeepers	10,911	12,235	126,932	10.37	18
19	Laundry	8,037	9,298	101,023	10.86	19
20	Administrator	252	252	20,817	82.77	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	2,018	2,148	33,829	15.75	22
23	Office Manager	1,741	2,080	44,554	21.42	23
24	Clerical	3,303	3,555	37,015	10.41	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,416	3,899	46,362	11.89	31
32	Other Health Care(specify)	4,657	5,042	120,377	23.88	32
33	Other(specify)	4,621	5,152	80,003	15.53	33
34	TOTAL (lines 1 - 33)	251,368	276,521	\$ 3,638,514 *	\$ 13.16	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	304	\$ 13,596	In 1, col 3	35
36	Medical Director	120	24,000	In 9, col 3	36
37	Medical Records Consultant	8	456	In 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	81	5,267	In 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	96	5,709	In 12, col 3	45
46	Other(specify) <u>Administrator</u>	2,480	144,988	In 21, col 3	46
47	<u>MDS Consultant</u>	626	56,719	In 10, col 3	47
48					48
49	TOTAL (lines 35 - 48)	3,715	\$ 250,735		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



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	<a href="#">This workpaper is not applicable</a>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Shawnee Christian Nursing Ctr

# 0048744

Report Period Beginning: July 1, 2012 Ending: June 30, 201

## 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. LSN & Leading Age - \$6,590.92
- (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. \$ 55,914 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. \$ 292,450  
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. \$ 796
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
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? None  
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: CliftonLarsonAllen 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.