

Facility Name & ID Number Shawnee Christian Nrsing Ctr

0048744 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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	29,062	6,496	8,421	43,979	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,062	6,496	8,421	43,979	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.78%

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 6,759

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: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number

Shawnee Christian Nrsing Ctr

0048744

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

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	323,976	13,258	20,361	357,595		357,595		357,595		1
2	Food Purchase		239,425		239,425		239,425	(1,482)	237,943		2
3	Housekeeping	123,764	19,620		143,384		143,384		143,384		3
4	Laundry	95,350	3,826		99,176		99,176		99,176		4
5	Heat and Other Utilities			149,977	149,977		149,977	1,990	151,967		5
6	Maintenance	115,305	7,998	30,058	153,361		153,361	4,705	158,066		6
7	Other (specify):*										7
8	TOTAL General Services	658,395	284,127	200,396	1,142,918		1,142,918	5,213	1,148,131		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,448,555	170,160	99,518	2,718,233		2,718,233		2,718,233		10
10a	Therapy			875,837	875,837		875,837		875,837		10a
11	Activities	69,850	2,815		72,665		72,665		72,665		11
12	Social Services	146,897	232	5,720	152,849		152,849		152,849		12
13	CNA Training										13
14	Program Transportation			9,790	9,790		9,790		9,790		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,665,302	173,207	1,014,865	3,853,374		3,853,374		3,853,374		16
	C. General Administration										
17	Administrative	114,329	346	547,501	662,176		662,176	(425,070)	237,106		17
18	Directors Fees										18
19	Professional Services			81,391	81,391		81,391	41,056	122,447		19
20	Dues, Fees, Subscriptions & Promotions			21,991	21,991		21,991		21,991		20
21	Clerical & General Office Expenses	107,681	9,343	204,073	321,097		321,097	106,590	427,687		21
22	Employee Benefits & Payroll Taxes			884,519	884,519		884,519	46,540	931,059		22
23	Inservice Training & Education										23
24	Travel and Seminar			33,952	33,952		33,952	18,696	52,648		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,006	93,006		93,006	1,890	94,896		26
27	Other (specify):* Marketing	68,433	469	15,277	84,179		84,179	(84,179)			27
28	TOTAL General Administration	290,443	10,158	1,881,710	2,182,311		2,182,311	(294,477)	1,887,834		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,614,140	467,492	3,096,971	7,178,603		7,178,603	(289,264)	6,889,339		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	
	D. Ownership											
30	Depreciation			288,088	288,088	288,088	40,899	328,987				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			366,189	366,189	366,189	(59,430)	306,759				32
33	Real Estate Taxes			370	370	370	(370)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,040	15,040	15,040		15,040				35
36	Other (specify):* Deferred Fin. Cost / Admin			10,571	10,571	10,571		10,571				36
37	TOTAL Ownership			680,258	680,258	680,258	(18,901)	661,357				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			543,975	543,975	543,975	(22,779)	521,196				39
40	Barber and Beauty Shops	(32)	24		(8)	(8)		(8)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,859	310,859	310,859		310,859				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	(32)	24	854,834	854,826	854,826	(22,779)	832,047				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,614,108	467,516	4,632,063	8,713,687	8,713,687	(330,944)	8,382,743				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	(1,316)	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	(48,098)	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	(131,644)	21		24
25	Fund Raising, Advertising and Promotional	(84,179)	27		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,112)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (267,349)		\$	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)	(63,595)	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,595)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (330,944)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Shawnee Christian Nrsing Ctr

ID# 0048744

Report Period Beginning: 1-Jul-13

Ending: 30-Jun-14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Revenue	\$ (166)	2	1
2	Late Fees, Finance Charges	(554)	6	2
3	Late Fees, Finance Charges	(31)	21	3
4	Real Estate Tax	(370)	33	4
5	Discounts	(991)	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		(2,112)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nrsing Ctr# 0048744

Report Period Beginning:

July 1, 2013

Ending:

June 30, 2014

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	(1,482)	0	0	0	0	0	0	0	0	0	0	(1,482)	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	1,990	0	0	0	0	0	0	0	0	0	1,990	5
6	Maintenance	(554)	5,259	0	0	0	0	0	0	0	0	0	4,705	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,036)	7,249	0	5,213	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	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(425,070)	0	0	0	0	0	0	0	0	0	(425,070)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	41,056	0	0	0	0	0	0	0	0	0	41,056	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(132,666)	239,256	0	0	0	0	0	0	0	0	0	106,590	21
22	Employee Benefits & Payroll Taxes	0	46,540	0	0	0	0	0	0	0	0	0	46,540	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	18,696	0	0	0	0	0	0	0	0	0	18,696	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	1,890	0	0	0	0	0	0	0	0	0	1,890	26
27	Other (specify):*	(84,179)	0	0	0	0	0	0	0	0	0	0	(84,179)	27
28	TOTAL General Administration	(216,845)	(77,632)	0	(294,477)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(218,881)	(70,383)	0	(289,264)	29								

STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nrsing Ctr# 0048744

Report Period Beginning:

July 1, 2013 Ending:

Summary B

June 30, 2014

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	40,899	0	0	0	0	0	0	0	0	0	40,899	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,098)	(11,332)	0	0	0	0	0	0	0	0	0	(59,430)	32
33	Real Estate Taxes	(370)	0	0	0	0	0	0	0	0	0	0	(370)	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	(48,468)	29,567	0	(18,901)	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	(22,779)	0	0	0	0	0	0	0	0	0	(22,779)	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	(22,779)	0	(22,779)	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(267,349)	(63,595)	0	(330,944)	45								

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%	\$ 1,990	\$ 1,990	1
2	V	6 Maintenance				5,259	5,259	2
3	V	17 Administration	547,501			122,431	(425,070)	3
4	V	19 Professional Services				41,056	41,056	4
5	V	21 Clerical				238,623	238,623	5
6	V	22 Employee Benefits				46,540	46,540	6
7	V	24 Travel and Seminar				18,696	18,696	7
8	V	26 Insurance				1,890	1,890	8
9	V	30 Depreciation				40,899	40,899	9
10	V	32 Interest				(11,332)	(11,332)	10
11	V	21 Other Administrative Expenses				633	633	11
12	V	39 Pharmacy Services	462,998	Senior Care Pharmacy	0.00%	440,219	(22,779)	12
13	V							13
14	Total		\$ 1,010,499			\$ 946,904	\$ * (63,595)	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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	This workpapers 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 Nrsing Ctr

0048744

Report Period Beginning: July 1, 2013

Ending: ne 30, 2014

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	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 Nrsing Ctr

0048744

Report Period Beginning:

July 1, 2013 Ending:

June 30, 2014

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					
		Related**					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	HUD Financing	\$49,420.00	8/1/2007	\$ 6,634,900	\$ 5,639,037	8/1/2032	5.8800	\$ 366,189	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$49,420.00		\$ 6,634,900	\$ 5,639,037			\$ 366,189	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	\$ 5,639,037			\$ 366,189	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,657 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 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 2014 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY			
	2010 _____	9				
	2011 _____	10				
	2012 _____	11				
	2013 _____	12				
			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nrsing Ctr COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0048744

CONTACT PERSON REGARDING THIS REPORT This page is N/A

TELEPHONE _____ FAX #: _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>This page is N/A</u>	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

	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>7,815</u>	<u>2</u>
3	TOTALS	180,000		\$ 78,986	3

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		\$ 1,500,110	4
5			1980	1980	107,504		20				5
6											6
7											7
8		Home Office Allocation			75,833	8,779		8,779		53,045	8
		Improvement Type**									
9		STORAGE SHED		3/31/1981	6,510		20			6,510	9
10		HEATING AC CONTROL SYSTEM		5/31/1982	37,091		20			37,091	10
11		BUILDING IMPROVEMENTS		5/30/1982	159,808	4,098	39	4,098		131,807	11
12		PARKING LOT		6/30/1982	42,223		15			42,223	12
13		PARKING LOT IMPROVEMENT		9/30/1982	400		14			400	13
14		BUILDING IMPROVEMENTS		6/30/1983	22,362	588	38	588		18,292	14
15		IMPRVCONCRETE WORK		10/17/1985	44,866	1,122	40	1,122		32,247	15
16		104WINDOWS		10/17/1985	39,252	981	40	981		28,212	16
17		CEILING TILE		12/10/1985	4,232		20			4,232	17
18		LIGHT FIXTURES		12/19/1985	777		10			777	18
19		CEILING TILE		12/30/1986	1,874		20			1,874	19
20		HEATINGAC DUCK WORK		10/30/1986	1,600		20			1,600	20
21		ELEC WIRE FOR HEATINGAC		1/14/1987	891		20			891	21
22		DINING & ADM. WING		5/31/1987	688,723	17,218	40	17,218		467,758	22
23		CEILING DUCT WORK		8/31/1987	510		20			510	23
24		DUCTWORK		10/5/1987	635		20			635	24
25		LANDSCAPING		7/9/1987	3,083		10			3,083	25
26		ELECTRICAL SUPPLIES		3/31/1988	373		20			373	26
27		AIR CLEANER & DUCT		4/26/1988	1,694		10			1,694	27
28		MIRROR FRAME WSOAP DISH		4/26/1988	1,562		10			1,562	28
29		FEEDSIGN HVAC SYSTEM		5/18/1988	4,675		20			4,675	29
30		WINDOWS		6/1/1988	705	20	35	20		525	30
31		TOWEL & SOAP DISPENSER		8/30/1988	1,976		10			1,976	31
32		DUCT WORK		9/21/1988	22,066		20			22,066	32
33		TITLE POLICY		9/29/1988	3,740	94	40	94		2,415	33
34		HAMPTON SETTLEMENT		9/29/1988	74,000	1,850	40	1,850		47,792	34
35		SANITARY SEWER REV		2/29/1988	1,001		20			1,001	35
36		FLOURESCENT LIGHT20		6/21/1989	673		10			673	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 Nrsing Ctr

0048744

Report Period Beginning:

July 1, 2013 Ending: June 30, 2014

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	ELEC WORK FOR 7 AC	7/1/1989	\$ 6,950	\$	8	\$	\$	\$ 6,950	37
38	HEAT PUMPS DUCT SYS	7/1/1989	39,940		20			39,940	38
39	DOWN SPOUTS (GUTTER)	9/25/1989	600		15			600	39
40	LAUNDRY ROOM ROOF	9/25/1989	2,200		15			2,200	40
41	INSTALL D.D. GATE	3/23/1989	450		5			450	41
42	SEWER SYSTEM IMPROVEMENT	7/7/1989	10,000		20			10,000	42
43	GRINDER PUMP SYSTEM	8/3/1989	11,624		10			11,624	43
44	COURTYARD PROJECT	9/30/1989	8,326		20			8,326	44
45	COURTYARD SIDEWALKS	11/9/1989	580		20			580	45
46	HEAT PUMPS	1/9/1990	63,466		20			63,466	46
47	CEILING TILE	1/9/1990	1,868		10			1,868	47
48	AIR CONDITIONING	1/29/1990	5,820		8			5,820	48
49	SHELVING	2/6/1990	851		5			851	49
50	WATER HEATER	3/7/1990	386		15			386	50
51	WALLPAPER	4/10/1990	919		5			919	51
52	DOOR & HARDWARE	3/22/1990	541		5			541	52
53	RELOCATE SPRINKLERS	5/8/1990	583		10			583	53
54	BRICK AC HOLES	5/8/1990	1,352	34	40	34		817	54
55	8 DOORFRAMES	5/8/1990	303		5			303	55
56	HEATING RECEIVERSII	6/8/1990	1,975		15			1,975	56
57	KICKPLATES (150)	7/13/1990	763		10			763	57
58	INSTALLATION OF AC	8/16/1990	1,184		8			1,184	58
59	DOOR ALARM	8/16/1990	423		5			423	59
60	DOORS & LOCKS	8/16/1990	35,817		20			35,817	60
61	LIGHTS (13)	9/14/1990	590		10			590	61
62	DOOR KICKPLATES118	11/9/1990	2,104		10			2,104	62
63	ELEC CON TO EMRG GEN	12/6/1990	6,930		20			6,930	63
64	LANDSCAPING	1/9/1990	517		20			517	64
65	LANDSCAPINGCOURTYARD	8/30/1990	7,472		20			7,472	65
66	DRAINAGE WORK	9/14/1990	2,848		20			2,848	66
67	PATIO WALL SIDEWALK	9/14/1990	8,000		20			8,000	67
68	DOOR LOCKS & KEYS	1/23/1991	510		20			510	68
69	HANDRAIL DRYWALL	3/26/1991	569		5			569	69
70	TOTAL (lines 4 thru 69)		\$ 3,243,125	\$ 79,122		\$ 79,122	\$	\$ 2,641,976	70

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr

0048744

Report Period Beginning:

July 1, 2013 Ending: June 30, 2014

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	Totals from Page 12A, Carried Forward		\$ 3,243,125	\$ 79,122		\$ 79,122	\$	\$ 2,641,976	1
2	EXIT FIXTURES (28)	3/26/1991	1,619		10			1,619	2
3	AC UNITS (2 HGH EFF)	5/22/1991	15,885		10			15,885	3
4	WALLCOVERINGS	6/10/1991	483		5			483	4
5	HEAT PUMP	9/5/1991	5,267		15			5,267	5
6	WATER HEATER	12/5/1991	867		10			867	6
7	SIDEWALK (840 BY 4)	4/29/1991	2,100		20			2,100	7
8	PARKING CURBS (30)	5/22/1991	385		10			385	8
9	SAND DIRT CULVERTS	6/28/1991	828		20			828	9
10	LANDSCAPING	8/14/1991	709		20			709	10
11	DRAINAGELANDSCAPING	9/26/1991	2,615		20			2,615	11
12	BRICKWORK ON GAZEBO	11/11/1991	6,200		20			6,200	12
13	100 OF FENCING	12/5/1991	1,380		15			1,380	13
14	DOORHALLS LIGHT RLY	2/6/1992	2,091		10			2,091	14
15	HOT WATER HEATERS (2)	2/6/1992	3,164		15			3,164	15
16	HEAT PUMP (2)	2/6/1992	653		15			653	16
17	HEAT PUMP	6/8/1992	7,265		15			7,265	17
18	4 LOOP SYSTEM	6/26/1992	3,723		10			3,723	18
19	METAL DOOR FRAMES	8/20/1992	840		20			840	19
20	LANDSCAPING	8/31/1992	3,500		10			3,500	20
21	GAZEBO (ROOFING ETC)	1/8/1992	8,216		20			8,216	21
22	PARKING LOT LIGHTING	2/6/1992	772		10			772	22
23	LANDSCAPING	5/27/1992	2,794		20			2,794	23
24	REMOVEREPLACE DRIVE	6/8/1992	900		20			900	24
25	HAULINGSPREADING DIRT	9/11/1992	1,000		20			1,000	25
26	ADDITIONAL LIGHTING	3/8/1993	1,142		10			1,142	26
27	INSTALL HONEYWELL SYSTEM	6/30/1993	5,031		20			5,031	27
28	GRADE AND SEED LOT	6/30/1993	750		20			750	28
29	STORAGE ROOM REMODEL	1/6/1994	2,020	51	20	51		2,020	29
30	SEWAGE SYSTEM PUMP	4/28/1994	4,256		10			4,256	30
31	1 FIRE1 GARAGE DOOR	6/6/1994	526		5			526	31
32	S.S. SINKFAUCET	6/24/1994	783		10			783	32
33	BRILLE DOOR SIGNS	6/7/1994	2,598		10			2,598	33
34	TOTAL (lines 1 thru 33)		\$ 3,333,487	\$ 79,172		\$ 79,172	\$	\$ 2,732,338	34

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr

0048744

Report Period Beginning:

July 1, 2013 Ending: June 30, 2014

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	Totals from Page 12B, Carried Forward		\$ 3,333,487	\$ 79,172		\$ 79,172	\$	\$ 2,732,338	1
2	FOLDING DOOR DIVIDER	10/24/1994	551		5			551	2
3	GARBAGE DISPOSAL	12/12/1994	610		5			610	3
4	HANDRAILSSIDE1 RMDL	5/23/1995	6,079		10			6,079	4
5	CABINETSSIDE 1 NURSING	6/30/1995	2,343		15			2,343	5
6	THERAPYBATH ADDITION	5/14/1996	181,372	7,557	24	7,557		137,289	6
7	NEW ADDITIONSIDEWALK	8/30/1996	534		10			534	7
8	WATER FOUNTAIN	4/4/1997	502		5			502	8
9	COMPRESSOR	7/24/1997	973		3			973	9
10	COMPRESSORSUNT 15 & 16	7/31/1997	2,377		3			2,377	10
11	HEATERSKITCHEN (2)	5/11/1998	793		5			793	11
12	COMPRESSORSLIBRY#24	7/16/1998	2,972		3			2,972	12
13	KEYLESS LOCKS (2)	9/11/1998	1,423		5			1,423	13
14	REMODELINGSIDES 2 & 3	5/1/1999	38,878	2,160	15	2,160		38,878	14
15	WALLPAPER DINING ROOM	4/15/1999	3,071		5			3,071	15
16	120 GALLON WATER HEATER	6/30/1999	3,000		10			3,000	16
17	COMPRESSOR	10/18/1999	1,133		3			1,133	17
18	SECURITY CONTROL SYSTEM	11/11/1999	940		10			940	18
19	PVC FENCE	9/13/1999	2,713		10			2,713	19
20	WIRING KEYPADS SONALERTS	5/11/2000	560		5			560	20
21	ROOFTOP CONDENSING UNIT	6/8/2000	3,373		10			3,373	21
22	4 TON AC	6/30/2000	2,590		5			2,590	22
23	4 TON HEAT PUMPS	6/30/2000	4,780		10			4,780	23
24	4 TON HEAT PUMPS	9/14/2000	2,692		10			2,692	24
25	CARPORT	9/22/2000	1,363		10			1,363	25
26	INSTALL GREASE TRAP	4/11/2001	886		5			886	26
27	4 PERSON BOOTH ISLAND (BOLTED TO FLOOR	7/1/2001	593		10			593	27
28	(3) 4 TON HEAT PUMPS	8/22/2001	7,985		10			7,985	28
29	DOOR CONTROL SYSTEM	1/1/2002	12,860		10			12,860	29
30	INSTALL EVAP & CONDENSER IN WALKIN FRE	3/6/2002	3,685		4			3,685	30
31	INSTALL DISHWASHER	5/24/2002	1,100		10			1,100	31
32	YORK OLYMPIAN HEAT PUMP	6/21/2002	2,265		10			2,265	32
33	3 TON OLYMPIAN HEAT PUMP	7/3/2002	2,265		10			2,265	33
34	TOTAL (lines 1 thru 33)		\$ 3,630,748	\$ 88,889		\$ 88,889	\$	\$ 2,985,516	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	Totals from Page 12C, Carried Forward		\$ 3,630,748	\$ 88,889		\$ 88,889	\$	\$ 2,985,516	1
2	NURSING STATION SIDE 3	8/9/2002	1,146	76	15	76		910	2
3	7.5 TON YORK HEAT PUMP DINING ROOM	7/31/2002	8,750		10			8,750	3
4	REPL COMPRESSOR IN KITCHEN AC	8/31/2002	875		3			875	4
5	(10) PANIC BARS(41) DOOR KNOBS 131 EXTRA K	12/9/2002	746		5			746	5
6	ENLARGE PARKING AREA	9/3/2002	2,386	119	20	119		1,412	6
7	YORK 4 TON HEAT PUMP UNIT #1	1/8/2003	2,341		10			2,341	7
8	(12) WALL SIGNS W LETTERS	2/27/2003	789		5			789	8
9	NEW ROOF SIDE 1	10/31/2003	52,263	3,484	15	3,484		37,455	9
10	ROOF REPLACEMENT	8/4/2003	93,091		3			93,091	10
11	REPL CEILING PANELS KITCHEN & SIDE 1 RE	10/23/2003	571		5			571	11
12	CULVERT TO CARRY WATER AWAY FROM BACK	3/28/2003	1,419	79	18	79		893	12
13	FENCE AROUND TRASH DUMPSTERS	6/24/2003	769		10			769	13
14	BUS BARN	3/1/2003	8,752	219	40	219		2,480	14
15	ELEM COOP TO 22 ENERGY MGMT SYSTEM	3/2/2004	18,962	1,264	10	1,264		18,962	15
16	SERVICE SINK W DOUBLE PEDAL VALVES	6/3/2004	1,189	109	10	109		1,189	16
17	HEAT PUMP	6/16/2004	4,800	440	10	440		4,800	17
18	ROOF RESIDENT ROOMS EXCEPT 101 & 102	7/30/2004	58,356	3,890	15	3,890		38,904	18
19	NETWORK CABLING PROJECT	7/1/2004	19,993	1,999	10	1,999		19,993	19
20	RESIDENT PHONE LINES CABLING WORK	3/18/2005	1,460		5			1,460	20
21	REMODELING DINING ROOM	3/1/2005	3,493		5			3,493	21
22	LIGHTING IN RESIDENTS ROOMS	3/31/2005	1,793		5			1,793	22
23	New Roof	7/28/2005	25,044	1,670	15	1,670		15,026	23
24	(7) 39x59 cordless roller mini blinds re	10/13/2005	613		5			613	24
25	3 sidewalks	8/10/2005	3,344	334	10	334		2,982	25
26	5 toilets	1/13/2006	872	44	20	44		371	26
27	(6) 39x59 cordless Mark I alabaster mi	2/1/2006	648		5			648	27
28	(6) 39x59 cordless Mark I alabaster min	2/23/2006	648		5			648	28
29	New Grease Trap Parts & Labor	3/1/2006	7,750	775	10	775		6,458	29
30	(8) Alabaster mini blinds Mark I 39x7	3/29/2006	672		5			672	30
31	Water Heater Side 4 Shower & Resident r	4/17/2006	4,174	417	10	417		3,443	31
32	AC Unit Side 1 Hallway & Care plan of	4/5/2006	6,820	682	10	682		5,627	32
33	Mini Blinds and Draperies for Resident	6/30/2006	3,348		5			3,348	33
34	TOTAL (lines 1 thru 33)		\$ 3,968,624	\$ 104,491		\$ 104,491	\$	\$ 3,267,027	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	Totals from Page 12D, Carried Forward		\$ 3,968,624	\$ 104,491		\$ 104,491	\$	\$ 3,267,027	1
2	(4) toilets & tanks to meet ADA requir	6/2/2006	716	72	10	72		579	2
3	New AC & Heat Unit for Resident rooms	6/30/2006	6,290	629	10	629		5,084	3
4	New Flooring Kitchen Dishroom	3/31/2006	1,995	200	10	200		1,663	4
5	Side 1 Shower Room remodel	7/1/2006	4,756	476	10	476		3,805	5
6	Remodel Side 4 Shower room	7/1/2006	3,331	333	10	333		2,664	6
7	(6) sets of miniblinds for resident ro	12/31/2006	648		5			648	7
8	Landscaping materials for gazebo area	6/29/2006	1,030	103	10	103		833	8
9	Industrial Mixing Valve	3/1/2007	598	30	20	30		219	9
10	Bryant 3 phase 35000 BTU electric heat	5/8/2007	7,100		5			7,100	10
11	Reroof mansards & maint shop	10/3/2007	11,392	1,139	10	1,139		7,690	11
12	(19) resident room exhaust fans	10/1/2007	1,791	179	10	179		1,209	12
13	Repour portion of front parking lot	11/27/2007	3,400		5			3,400	13
14	Stone work and paving of back parking	12/7/2007	10,277		5			10,277	14
15	December services - remodel	1/17/2008	748	75	10	75		486	15
16	Wallpaper-Side 1 Renovation	9/19/2008	3,992	399	10	399		2,328	16
17	Door Alarm System	10/1/2008	15,726	1,573	10	1,573		9,042	17
18	Satellite TV System	10/31/2008	19,930	1,993	10	1,993		11,460	18
19	Asphalt back parking lot	6/11/2008	35,790	3,579	10	3,579		21,772	19
20	Horn alerts for hallways	1/1/2009	743	74	10	74		409	20
21	Sprinkler head replacement	3/11/2009	7,174	717	10	717		3,826	21
22	Condensing Fan and blower	6/4/2009	618	113	5	113		618	22
23	24 ton heat pump	6/8/2009	9,377	938	10	938		4,767	23
24	Accumulator - Side 4 dining room	6/24/2009	547	100	5	100		547	24
25	Therapy gym remodeling project	6/30/2009	369,504	18,475	20	18,475		93,916	25
26	Floor tile for Reclaim Bath	11/9/2009	559	56	10	56		261	26
27	Flooring - Dining Room	8/31/2009	33,070	3,307	10	3,307		16,259	27
28	Call Light System	7/31/2009	47,969	4,797	10	4,797		23,984	28
29	1000 gallon fuel tank - above ground	6/27/2009	10,857	543	20	543		2,759	29
30	Roof Replacement - Dining Room	6/23/2010	11,582	1,158	10	1,158		4,729	30
31	5 Ton A/C Compressor & Replacement Lab	7/7/2010	1,074	107	10	107		430	31
32	Carpet for Office and Conference Room	10/23/2010	4,638	464	10	464		1,739	32
33	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829	10	829		3,317	33
34	TOTAL (lines 1 thru 33)		\$ 4,604,138	\$ 146,949		\$ 146,949	\$	\$ 3,514,849	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	Totals from Page 12E, Carried Forward		\$ 4,604,138	\$ 146,949		\$ 146,949	\$	\$ 3,514,849	1
2	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883	10	1,883		7,532	2
3	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385	10	1,385		5,538	3
4	122 Ft Privacy Fence	6/10/2010	1,800	180	10	180		735	4
5	Sprinkler System Upgrade	1/31/2011	5,048	505	10	505		1,767	5
6	Roof Exhaust Fans	6/30/2011	1,905	190	10	190		587	6
7	Dietary - Floor Replacement	6/30/2011	19,467	1,947	10	1,947		6,002	7
8	Doors w/Smoke Gaskets	6/30/2011	8,402	840	10	840		2,591	8
9	Memory Lane - Painting	6/30/2011	3,226	323	10	323		995	9
10	Memory Lane/Shadybrook - Asbestos Remc	6/30/2011	22,600	2,260	10	2,260		6,968	10
11	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	7,761	10	7,761		23,929	11
12	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	358	10	358		1,105	12
13	Memory Lane/Shadybrook - Rails and gua	6/30/2011	15,044	1,504	10	1,504		4,639	13
14	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	1,460	10	1,460		4,501	14
15	Memory Lane - Light Fixtures	6/30/2011	1,039	104	10	104		320	15
16	Shadybrook - Light Fixtures	6/30/2011	1,039	104	10	104		320	16
17	Dietary Loading - Privacy Fence	6/30/2011	2,118	212	10	212		653	17
18	Restripe Parking Lots	6/30/2011	5,375	538	10	538		1,657	18
19	Lighting for Outdoor Sign	6/30/2011	889	89	10	89		274	19
20	Fire alarm system, addressable 3 yr wa	1/9/2012	83,229	8,323	10	8,323		20,807	20
21	Fire alarm system 6 door closures inst	1/23/2012	5,907	591	10	591		1,477	21
22	120 Gal 480V Haot Water Heater	7/17/2012	5,169	517	10	517		1,034	22
23	Counter Tops Activity Room	7/11/2012	640	43	15	43		85	23
24	Drywall & Supply - Activity Room Remod	7/12/2012	117	8	15	8		16	24
25	Refurbish Parking Lot Lights	12/3/2012	1,398	280	5	280		443	25
26	Walk In Cooler/Freezer (Indoor)	3/22/2013	16,400	1,093	15	1,093		1,458	26
27	Walk-In Cooler/Freezer (Installation)	5/16/2013	4,950	330	15	330		385	27
28	4 Ton Heat Pumps Trane 15 SEER (2)	5/17/2013	14,971	1,497	10	1,497		1,747	28
29	Water heater- Laundry	3/11/2014	5,717	191	10	191		191	29
30	34x82 mini blinds - dining room	4/29/2014	384	10	10	10		10	30
31	48x82 Visions mini blinds - dining room	4/29/2014	714	18	10	18		18	31
32	47x82 mini blinds - dining room	4/29/2014	936	23	10	23		23	32
33	47 1/2 x 82 mini blinds - dining room	4/29/2014	687	17	10	17		17	33
34	TOTAL (lines 1 thru 33)		\$ 4,961,775	\$ 181,531		\$ 181,531	\$	\$ 3,612,672	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	Totals from Page 12F, Carried Forward		\$ 4,961,775	\$ 181,531		\$ 181,531	\$	\$ 3,612,672	1
2	4ton heat pumps & rooftop 3 phase	6/25/2014	20,900	174	10	174		174	2
3	Labor & install of therapy bathroom	6/30/2014	1,226	10	10	10		10	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,983,901	\$ 181,715		\$ 181,715	\$	\$ 3,612,857	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	\$ 442,753	\$ 74,093	\$ 74,093	\$	various	\$ 322,734	71
72	Current Year Purchases	152,443	13,658	13,658		various	13,658	72
73	Fully Depreciated Assets	401,397	21,155	21,155		various	401,397	73
74	Home Office Allocation	298,942	28,963	28,963			178,210	74
75	TOTALS	\$ 1,295,535	\$ 137,869	\$ 137,869	\$		\$ 915,999	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	2006 Ford Starcraft	2006	\$ 46,350	\$ 4,828	\$ 4,828	\$	8	\$ 46,350	76
77										77
78										78
79	Home Office Allocation			27,269	3,157	3,157			15,531	79
80	TOTALS			\$ 73,619	\$ 7,985	\$ 7,985	\$		\$ 61,881	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)		\$ 6,432,041	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 327,569	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 327,569	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)		\$ 4,590,737	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	\$ 116	92
93			93
94			94
95		\$ 116	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 Nrsing Ctr

0048744

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 15,040 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

* 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?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$	7,326	\$	321,237	\$	7,326	\$	321,237	1
2	Licensed Speech and Language Development Therapist		hrs		3,543		223,922		3,543		223,922	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs		9,765		330,678		9,765		330,678	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			\$	20,634	\$	875,837	\$	20,634	\$	875,837	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 Nrsing Ctr

0048744

Report Period Beginning: July 1, 2013

Ending: June 30, 2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 30-Jun-14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,359	\$	1
2	Cash-Patient Deposits	70,335		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 260,212)	2,217,993		3
4	Supply Inventory (priced at)	6,012		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,503		6
7	Other Prepaid Expenses	13,257		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int. / Other A/R</u>	634		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,365,093	\$	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	4,696,694		14
15	Leasehold Improvements, at Historical Cost	211,374		15
16	Equipment, at Historical Cost	1,042,944		16
17	Accumulated Depreciation (book methods)	(4,343,949)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	639,362		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Financing Costs</u>	176,568		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,504,964	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,870,057	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 847,603	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	70,335		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,717		30
31	Accrued Taxes Payable (excluding real estate taxes)	554		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Liabilities</u>	1,423,111		36
37	<u>FIN 47 Liability / Due to</u>	16,736		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,595,056	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,639,037		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)	\$ 5,639,037	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,234,093	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,364,036)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,870,057	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,265,271)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,265,271)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(98,765)	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)	\$ (98,765)	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)	\$ (3,364,036)	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,828,733	1
2	Discounts and Allowances for all Levels	(2,928,760)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,899,973	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,682,803	6
7	Oxygen	17,926	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,700,729	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	825	13
14	Non-Patient Meals	1,316	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	545,404	17
18	Sale of Supplies to Non-Patients	9,783	18
19	Laboratory	33,955	19
20	Radiology and X-Ray	50,341	20
21	Other Medical Services	268,050	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 909,674	23
D. Non-Operating Revenue			
24	Contributions	43,103	24
25	Interest and Other Investment Income***	49,144	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92,247	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	12,299	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,299	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,614,922	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,142,918	31
32	Health Care	3,853,374	32
33	General Administration	2,182,311	33
B. Capital Expense			
34	Ownership	680,258	34
C. Ancillary Expense			
35	Special Cost Centers	543,967	35
36	Provider Participation Fee	310,859	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,713,687	40
41	Income before Income Taxes (line 30 minus line 40)**	(98,765)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (98,765)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,405,598	44
45	Private Pay - Net Inpatient Revenue	1,057,089	45
46	Medicare - Net Inpatient Revenue	(606,353)	46
47	Other-(specify) <u>HMO / Medicare Advantage</u>	43,639	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,899,973	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 Nrsing Ctr**

0048744

Report Period Beginning: **July 1, 2013**

Ending:

June 30, 2014

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	1,104	1,168	\$ 53,365	\$ 45.69	1
2	Assistant Director of Nursing	1,498	1,570	41,677	26.55	2
3	Registered Nurses	13,514	14,238	345,022	24.23	3
4	Licensed Practical Nurses	46,924	49,470	773,842	15.64	4
5	CNAs & Orderlies	100,160	106,502	1,070,509	10.05	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	1,619	1,655	20,973	12.67	9
10	Activity Assistants	4,527	4,707	48,877	10.38	10
11	Social Service Workers	9,338	10,486	146,897	14.01	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	29,096	31,272	323,976	10.36	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	5,486	5,842	115,305	19.74	17
18	Housekeepers	10,992	12,236	123,764	10.11	18
19	Laundry	7,834	8,994	95,350	10.60	19
20	Administrator	2,086	2,138	120,734	56.48	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	757	1,084	17,502	16.15	22
23	Office Manager	1,610	1,704	46,625	27.36	23
24	Clerical	3,048	3,237	37,149	11.48	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	3,542	3,720	44,661	12.01	31
32	Other Health C: MDS Coordinator	4,644	4,909	119,480	24.34	32
33	Other(specify) <u>Community Nurse</u>	4,205	4,342	68,401	15.76	33
34	TOTAL (lines 1 - 33)	251,980	269,272	\$ 3,614,108 *	\$ 13.42	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	456	\$ 20,361	ln 1, col 3	35
36	Medical Director	120	24,000	ln 9, col 3	36
37	Medical Records Consultant	8	456	ln 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	4,288	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	106	5,101	ln 12, col 3	45
46	Other(specify)				46
47	<u>Interim ADON</u>	977	88,110	ln 10, col 3	47
48					48
49	TOTAL (lines 35 - 48)	1,739	\$ 142,316		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Scharlemann	Administrator	0	\$ 65,800	Workers' Compensation Insurance	\$ 206,536	IDPH License Fee	\$	
Edgar Marthiens	Administrator	0	48,529	Unemployment Compensation Insurance	70,933	Advertising: Employee Recruitment	6,090	
				FICA Taxes	264,209	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	324,900	Patient Background Checks		
				Employee Meals		License/Dues/Subscriptions	15,901	
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Physicals	8,697			
				Employee Uniforms and Expense	9,244			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,329					
B. Administrative - Other								
Description			Amount					
Management Fee			\$ 547,501	Home Office Allocation	46,540	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 547,501	TOTAL (agree to Schedule V, line 22, col.8)	\$ 931,059	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,991	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
CliftonLarsonAllen	Accounting		\$ 16,419				Out-of-State Travel	\$ 1,223
My Innerview	Consulting		359					
National Research	Consulting		1,454				In-State Travel	31,625
Adam Lawler	Legal		22,648					
Cincinnati Insurance Co	Legal		25,978				Seminar Expense	1,104
Davis & Campbell	Legal		4,686					
Heyl, Royster, Voelker	Legal		2,897				Home Office Allocation	18,696
Polsinelli Shughart PC	Legal		16,947				Entertainment Expense	()
Title Professionals	Legal		(10,275)					
Receivable Management Services	Legal		278					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 81,391	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 52,648

* Attach copy of IMRF notifications

**See instructions.

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	This workpaper is not applicable.	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Shawnee Christian Nrsing Ctr

0048744

Report Period Beginning: July 1, 2013 Ending: June 30, 2013

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 / \$8,896
- (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. \$ 47,154 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. \$ 310,859
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. \$ 1,316
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.