FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0048744

Facility Name: Shawnee Christian Nrsing Ctr

Address: 1901 North 13th St (Number) Herrin (City) 62948 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** 618-942-3369

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenna Hudson **Telephone Number:** 314-587-7924
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/14 to 6/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Dr. Timothy Phillippe
(Title) CEO

Paid Preparer
(Signed) (Date)
(Print Name and Title) Amanda Tinney, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800 St. Louis MO 63101
(Telephone) 314-925-4389 Fax # 314-925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	159	Skilled (SNF)	159	58,035	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,239	8,120	6,574	40,933	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,239	8,120	6,574	40,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.53%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 9/1/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 159 and days of care provided 5,095

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	332,210	15,941	15,104	363,255		363,255		363,255			1
2	Food Purchase		245,184		245,184		245,184	(1,574)	243,610			2
3	Housekeeping	125,153	20,343	192	145,688		145,688		145,688			3
4	Laundry	94,717	2,332		97,049		97,049		97,049			4
5	Heat and Other Utilities			138,175	138,175		138,175	1,919	140,094			5
6	Maintenance	118,429	7,209	17,136	142,774		142,774	4,250	147,024			6
7	Other (specify):*			7,903	7,903		7,903		7,903			7
8	**TOTAL General Services**	670,509	291,009	178,510	1,140,028		1,140,028	4,595	1,144,623			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,417,854	227,662	245,918	2,891,434		2,891,434	(279)	2,891,155			10
10a	Therapy		995	746,656	747,651		747,651		747,651			10a
11	Activities	70,932	2,256	2,364	75,552		75,552		75,552			11
12	Social Services	140,911	1,553	5,564	148,028		148,028		148,028			12
13	CNA Training											13
14	Program Transportation			9,012	9,012		9,012		9,012			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,629,697	232,466	1,033,514	3,895,677		3,895,677	(279)	3,895,398			16
	C. General Administration											
17	Administrative	104,007	46	560,000	664,053		664,053	(426,176)	237,877			17
18	Directors Fees											18
19	Professional Services			87,818	87,818		87,818	40,087	127,905			19
20	Dues, Fees, Subscriptions & Promotions			27,606	27,606		27,606		27,606			20
21	Clerical & General Office Expenses	136,876	9,817	556,549	703,242		703,242	(153,869)	549,373			21
22	Employee Benefits & Payroll Taxes			788,154	788,154		788,154	45,083	833,237			22
23	Inservice Training & Education											23
24	Travel and Seminar			45,326	45,326		45,326	23,873	69,199			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,168	80,168		80,168	(10,586)	69,582			26
27	Other (specify):* **Marketing**	59,593	278	17,620	77,491		77,491	(77,491)				27
28	**TOTAL General Administration**	300,476	10,141	2,163,241	2,473,858		2,473,858	(559,079)	1,914,779			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,600,682	533,616	3,375,265	7,509,563		7,509,563	(554,763)	6,954,800			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shawnee Christian Nrsing Ctr #0048744 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			278,382	278,382		278,382	37,600	315,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			354,548	354,548		354,548	(21,839)	332,709			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,903	9,903		9,903		9,903			35
36	Other (specify):* **Deferred Fin. Cost / Admin**			10,571	10,571		10,571		10,571			36
37	**TOTAL Ownership**			653,404	653,404		653,404	15,761	669,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			347,941	347,941		347,941	(8,712)	339,229			39
40	Barber and Beauty Shops		500		500		500		500			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,141	305,141		305,141		305,141			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		500	653,082	653,582		653,582	(8,712)	644,870			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,600,682	534,116	4,681,751	8,816,549		8,816,549	(547,714)	8,268,835			45

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,574)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,751)	21		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	(21,839)	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	(384,340)	21		24
25	Fund Raising, Advertising and Promotional	(77,491)	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 See PG5A	(25,317)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (512,312)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(35,402)	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,402)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (547,714)		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 Yes	2 No	3 Amount	4 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

Shawnee Christian Nrsing Ctr

ID# 0048744

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Late Fees, Finance Charges	(358)	6	2
3	Late Fees, Finance Charges	(14)	21	3
4	Late Fees, Finance Charges	(279)	10	4
5	Fines & Penalties	(22,750)	21	5
6	Miscellaneous Revenue	(1,187)	21	6
7	Charity Care	(729)	21	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**	(25,317)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nrsing Ctr **#** 0048744 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,574)	0	0	0	0	0	0	0	0	0	0	(1,574)	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	1,919	0	0	0	0	0	0	0	0	0	1,919	5
6	Maintenance	(358)	4,608	0	0	0	0	0	0	0	0	0	4,250	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,932)	6,527	0	0	0	0	0	0	0	0	0	4,595	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	(279)	0	0	0	0	0	0	0	0	0	0	(279)	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**	(279)	0	0	0	0	0	0	0	0	0	0	(279)	16
	C. General Administration													
17	Administrative	0	(426,176)	0	0	0	0	0	0	0	0	0	(426,176)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	40,087	0	0	0	0	0	0	0	0	0	40,087	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(410,771)	256,902	0	0	0	0	0	0	0	0	0	(153,869)	21
22	Employee Benefits & Payroll Taxes	0	45,083	0	0	0	0	0	0	0	0	0	45,083	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	23,873	0	0	0	0	0	0	0	0	0	23,873	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	(10,586)	0	0	0	0	0	0	0	0	0	(10,586)	26
27	Other (specify):*	(77,491)	0	0	0	0	0	0	0	0	0	0	(77,491)	27
28	**TOTAL General Administration**	(488,262)	(70,817)	0	0	0	0	0	0	0	0	0	(559,079)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(490,473)	(64,290)	0	0	0	0	0	0	0	0	0	(554,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	37,600	0	0	0	0	0	0	0	0	0	37,600	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,839)	0	0	0	0	0	0	0	0	0	0	(21,839)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,839)	37,600	0	0	0	0	0	0	0	0	0	15,761	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	(8,712)	0	0	0	0	0	0	0	0	0	(8,712)	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	(8,712)	0	0	0	0	0	0	0	0	0	(8,712)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(512,312)	(35,402)	0	0	0	0	0	0	0	0	0	(547,714)	45

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Board of Directors Listing.						

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. [X] 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.		$ 1,919	$ 1,919	1
2	V	6	Maintenance				4,608	4,608	2
3	V	17	Administrative	560,000			133,824	(426,176)	3
4	V	19	Professional Services				40,087	40,087	4
5	V	21	Clerical				256,081	256,081	5
6	V	22	Employee Benefits				45,083	45,083	6
7	V	21	Dues & Subscriptions				180	180	7
8	V	24	Travel and Seminars				23,873	23,873	8
9	V	26	Insurance				(10,586)	(10,586)	9
10	V	30	Depreciation				37,600	37,600	10
11	V	21	Other Administrative Expense				641	641	11
12	V	39	Pharmacy Services	281,023	Senior Care Pharmacy	0.00%	272,311	(8,712)	12
13	V								13
14	Total			$ 841,023			$ 805,621	$ * (35,402)	14

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 [X]

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 N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										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: 7/1/14 Ending: 6/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Sect. 232 Ins Mortgage		X	HUD Financing	$44,626.00	8/1/2007	$ 6,634,900	$ 5,458,642	8/1/2032	5.8800	$ 326,765	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,626.00		$ 6,634,900	$ 5,458,642			$ 326,765	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	$ 5,458,642			$ 326,765	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 27,783 **Line #** 32

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

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	This page is N/A.		$	$
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? _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			6,956	2
3	TOTALS	180,000		$ 78,127	3

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 44,338	$	$ 1,544,448	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				67,457	7,253		7,253		50,013	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		135,905	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		18,880	14
15	IMPRVCONCRETE WORK			10/17/1985	44,866	1,122	40	1,122		33,369	15
16	104WINDOWS			10/17/1985	39,252	981	40	981		29,194	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		484,976	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	FEEDESIGN HVAC SYSTEM			5/18/1988	4,675		20			4,675	29
30	WINDOWS			6/1/1988	705	20	35	20		545	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		2,509	33
34	HAMPTON SETTLEMENT			9/29/1988	74,000	1,850	40	1,850		49,642	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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		851	54
55	8 DOORFRAMES	5/8/1990	303		5			303	55
56	HEATING RECEIVERS11	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)		$ 3,234,749	$ 77,596		$ 77,596	$	$ 2,709,287	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,234,749	$ 77,596		$ 77,596	$	$ 2,709,287	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 (ROOFINGETC)	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		20			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	BRAILLE DOOR SIGNS	6/7/1994	2,598		10			2,598	33
34	TOTAL (lines 1 thru 33)		$ 3,325,111	$ 77,596		$ 77,596	$	$ 2,799,649	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,325,111	$ 77,596		$ 77,596	$	$ 2,799,649	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		144,846	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		15			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									23
24									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)		$ 3,614,900	$ 85,153		$ 85,153	$	$ 3,052,912	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,614,900	$ 85,153		$ 85,153	$	$ 3,052,912	1
2	NURSING STATION SIDE 3	8/9/2002	1,146	76	15	76		987	2
3	7.5 TON YORK HEAT PUMPDINING 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)DOORKNOBS131 EXTRA K	12/9/2002	746		5			746	5
6	ENLARGE PARKING AREA	9/3/2002	2,386	119	20	119		1,531	6
7	YORK 4 TON HEAT PUMPUNIT#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		40,939	9
10	ROOF REPLACEMENT	8/4/2003	93,091		3			93,091	10
11	REPL CEILING PANELSKITCHEN & 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		972	12
13	FENCE AROUND TRASH DUMPSTERS	6/24/2003	769		10			769	13
14	BUS BARN	3/1/2003	8,752	219	40	219		2,699	14
15	ELEMCOOPTO22ENERGY MGMT SYSTEM	3/2/2004	18,962		10			18,962	15
16	SERVICE SINK WDOUBLE PEDAL VALVES	6/3/2004	1,189		10			1,189	16
17	HEAT PUMP	6/16/2004	4,800		10			4,800	17
18	ROOFRESIDENT ROOMS EXCEPT 101 & 102	7/30/2004	58,356	3,890	15	3,890		42,794	18
19	NETWORK CABLING PROJECT	7/1/2004	19,993		10			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		16,696	23
24	(7)39x59cordless roller mini blindsre	10/13/2005	613		5			613	24
25	3 sidewalks	8/10/2005	3,344	334	10	334		3,316	25
26	5 toilets	1/13/2006	872	44	20	44		414	26
27	(6) 39x59 cordless Mark I alabaster mi	2/1/2006	648		5			648	27
28	(6) 39x59 cordless MarkI alabaster min	2/23/2006	648		5			648	28
29	New Grease Trap Parts & Labor	3/1/2006	7,750	775	10	775		7,233	29
30	(8) Alabaster mini blinds MarkI 39x7	3/29/2006	672		5			672	30
31	Water HeaterSide 4 Shower & Resident r	4/17/2006	4,174	417	10	417		3,860	31
32	AC Unit Side 1 Hallway & Care plan of	4/5/2006	6,820	682	10	682		6,309	32
33	MiniBlinds and Draperies for Resident	6/30/2006	3,348		5			3,348	33
34	TOTAL (lines 1 thru 33)		$ 3,952,777	$ 96,942		$ 96,942	$	$ 3,346,213	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,952,777	$ 96,942		$ 96,942	$	$ 3,346,213	1
2	(4) toilets & tanks to meet ADA requir	6/2/2006	716	72	10	72		651	2
3	New AC & Heat Unit for Resident rooms	6/30/2006	6,290	629	10	629		5,713	3
4	New Flooring Kitchen Dishroom	3/31/2006	1,995	200	10	200		1,862	4
5	Side 1 Shower Room remodel	7/1/2006	4,756	476	10	476		4,280	5
6	Remodel Side 4 Shower room	7/1/2006	3,331	333	10	333		2,998	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		935	8
9	Industrial Mixing Valve	3/1/2007	598	30	20	30		249	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		8,829	11
12	(19) resident room exhaust fans	10/1/2007	1,791	179	10	179		1,388	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		561	15
16	Wallpaper-Side 1 Renovation	9/19/2008	3,992	399	10	399		2,728	16
17	Door Alarm System	10/1/2008	15,726	1,573	10	1,573		10,615	17
18	Satellite TV System	10/31/2008	19,930	1,993	10	1,993		13,453	18
19	Asphalt back parking lot	6/11/2008	35,790	3,579	10	3,579		25,351	19
20	Horn alerts for hallways	1/1/2009	743	74	10	74		483	20
21	Sprinkler head replacement	3/11/2009	7,174	717	10	717		4,543	21
22	Condensing Fan and blower	6/4/2009	618		5			618	22
23	24 ton heat pump	6/8/2009	9,377	938	10	938		5,704	23
24	Accumulator - Side 4 dining room	6/24/2009	547		5			547	24
25	Therapy gym remodeling project	6/30/2009	369,504	18,475	20	18,475		112,391	25
26	Floor tile for Reclaim Bath	11/9/2009	559	56	10	56		317	26
27	Flooring - Dining Room	8/31/2009	33,070	3,309	10	3,309		19,566	27
28	Call Light System	7/31/2009	47,969	4,797	10	4,797		28,781	28
29	1000 gallon fuel tank - above ground	6/27/2009	10,857	543	20	543		3,302	29
30	Roof Replacement - Dining Room	6/23/2010	11,582	1,158	10	1,158		5,888	30
31	5 Ton A/C Compressor & Replacement Lab	7/7/2010	1,074	107	10	107		537	31
32	Carpet for Office and Conference Room	10/23/2010	4,638	464	10	464		2,203	32
33	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829	10	829		4,147	33
34	TOTAL (lines 1 thru 33)		$ 4,588,292	$ 139,189		$ 139,189	$	$ 3,636,278	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,588,292	$ 139,189		$ 139,189	$	$ 3,636,278	1
2	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883	10	1,883		9,415	2
3	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385	10	1,385		6,923	3
4	122 Ft Privacy Fence	6/10/2010	1,800	180	10	180		915	4
5	Sprinkler System Upgrade	1/31/2011	5,048	505	10	505		2,272	5
6	Roof Exhaust Fans	6/30/2011	1,905	190	10	190		778	6
7	Dietary - Floor Replacement	6/30/2011	19,467	1,947	10	1,947		7,949	7
8	Doors w/Smoke Gaskets	6/30/2011	8,402	840	10	840		3,431	8
9	Memory Lane - Painting	6/30/2011	3,226	323	10	323		1,317	9
10	Memory Lane/Shadybrook - Asbestos Remo	6/30/2011	22,600	2,260	10	2,260		9,228	10
11	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	7,761	10	7,761		31,690	11
12	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	358	10	358		1,463	12
13	Memory Lane/Shadybrook - Rails and gua	6/30/2011	15,044	1,504	10	1,504		6,143	13
14	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	1,460	10	1,460		5,960	14
15	Memory Lane - Light Fixtures	6/30/2011	1,039	104	10	104		424	15
16	Shadybrook - Light Fixtures	6/30/2011	1,039	104	10	104		424	16
17	Dietary Loading - Privacy Fence	6/30/2011	2,118	212	10	212		865	17
18	Restripe Parking Lots	6/30/2011	5,375	538	10	538		2,195	18
19	Lighting for Outdoor Sign	6/30/2011	889	89	10	89		363	19
20	Fire alarm system, addressable 3 yr wa	1/9/2012	83,229	8,323	10	8,323		29,130	20
21	Fire alarm system 6 door closures inst	1/23/2012	5,907	591	10	591		2,067	21
22	120 Gal 480V Haot Water Heater	7/17/2012	5,169	517	10	517		1,551	22
23	Counter Tops Activity Room	7/11/2012	640	43	15	43		128	23
24	Drywall & Supply - Activity Room Remod	7/12/2012	117	8	15	8		23	24
25	Refurbish Parking Lot Lights	12/3/2012	1,398	280	5	280		722	25
26	Walk In Cooler/Freezer (Indoor)	3/22/2013	16,400	1,093	15	1,093		2,551	26
27	Walk-In Cooler/Freezer (Installation)	5/16/2013	4,950	330	15	330		715	27
28	4 Ton Heat Pumps Trane 15 SEER (2)	5/17/2013	14,971	1,497	10	1,497		3,244	28
29	Water heater- Laundry	3/11/2014	5,717	572	10	572		762	29
30	34x82 mini blinds - dining room	4/29/2014	384	38	10	38		48	30
31	48x82 Visions mini blinds - dining room	4/29/2014	714	71	10	71		89	31
32	47x82 mini blinds - dining room	4/29/2014	936	94	10	94		117	32
33	47 1/2 x 82 mini blinds - dining room	4/29/2014	687	69	10	69		86	33
34	TOTAL (lines 1 thru 33)		$ 4,945,927	$ 174,358		$ 174,358	$	$ 3,769,266	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: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,945,927	$ 174,358		$ 174,358	$	$ 3,769,266	1
2	4ton heat pumps & rooftop 3 phase	6/25/2014	20,900	2,090	10	2,090		2,264	2
3	Labor & install of therapy bathroom	6/30/2014	1,226	123	10	123		133	3
4	Combination door locks	7/16/2014	801	80	10	80		80	4
5	Install of handrail	10/21/2014	672	50	10	50		50	5
6	Replace vinyl flooring corridors	10/30/2014	38,151	2,861	10	2,861		2,861	6
7	Flooring Shower Room	12/29/2014	3,162	184	10	184		184	7
8	Replace sewer line under floor	7/16/2014	4,112	206	20	206		206	8
9	Lighting Fixtures	5/28/2015	35,618	594	10	594		594	9
10	MDS Office Flooring	6/25/2015	1,530	13	10	13		13	10
11	Memory Lane Showers Replace	6/25/2015	5,380	45	10	45		45	11
12	Dietary Room Floor Replace	6/25/2015	4,710	39	10	39		39	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	To Tie To FS		(1)	(5)		(5)			32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,062,188	$ 180,638		$ 180,638	$	$ 3,775,735	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: 7/1/14 Ending: 6/30/15

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	$ 568,205	$ 94,866	$ 94,866	$	Various	$ 405,362	71
72	Current Year Purchases	71,344	8,461	8,461		Various	8,461	72
73	Fully Depreciated Assets	400,637	1,095	1,095		Various	400,637	73
74	Home Office Allocation	270,841	29,121	29,121			184,834	74
75	TOTALS	$ 1,311,027	$ 133,543	$ 133,543	$		$ 999,294	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	$	$	$	8	$ 46,350	76
77		2006 Ford Bus New Motor	2015	6,894	575	575		4	575	77
78										78
79	Home Office Allocation			11,401	1,226	1,226			7,884	79
80	TOTALS			$ 64,645	$ 1,801	$ 1,801	$		$ 54,809	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)	$ 6,515,987	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 315,982	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,982	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)	$ 4,829,838	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 35,701	92
93	Home Office Allocation	103	93
94			94
95		$ 35,804	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: 7/1/14 Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 9,903 Description: See Attachment
    (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.

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   SCNC only hires certified CNAs.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	6,628	$ 281,471	$	6,628	$ 281,471	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,194	207,778		3,194	207,778	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		8,272	257,407		8,272	257,407	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	18,093	$ 746,656	$	18,093	$ 746,656	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/15 (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	$ 335,902	$	1
2	Cash-Patient Deposits	77,740		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,193,896		3
4	Supply Inventory (priced at)	10,999		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,310		6
7	Other Prepaid Expenses	32,955		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/Other AR	1,634		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,670,436	$	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	4,779,245		14
15	Leasehold Improvements, at Historical Cost	215,486		15
16	Equipment, at Historical Cost	1,093,430		16
17	Accumulated Depreciation (book methods)	(4,587,107)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	551,194		21
22	Other Long-Term Assets (spe Deferred Financing C	202,460		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,336,679	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,007,115	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 78,381	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	456,059		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	251,471		30
31	Accrued Taxes Payable (excluding real estate taxes)			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				36
37	Accrued Liabilities/Fin 47/Due To	1,891,778		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,677,689	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,458,642		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)**	$ 5,458,642	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,136,331	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,129,216)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,007,115	$	48

*(See instructions.)

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,364,036)	1
2	Restatements (describe):		2
3	PY Restatement	250,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,114,036)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,015,180)	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)**	$ (1,015,180)	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)**	$ (4,129,216)	24 *

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,683,820	1
2	Discounts and Allowances for all Levels	(2,623,741)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,060,079	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,063,667	6
7	Oxygen	24,844	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,088,511	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		13
14	Non-Patient Meals	1,574	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	409,623	17
18	Sale of Supplies to Non-Patients	20,496	18
19	Laboratory	38,684	19
20	Radiology and X-Ray	33,127	20
21	Other Medical Services	82,491	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 585,995	23
	D. Non-Operating Revenue		
24	Contributions	32,711	24
25	Interest and Other Investment Income***	33,060	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 65,771	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous	1,013	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,013	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,801,369	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,140,028	31
32	Health Care	3,895,677	32
33	General Administration	2,473,858	33
	B. Capital Expense		
34	Ownership	653,404	34
	C. Ancillary Expense		
35	Special Cost Centers	348,441	35
36	Provider Participation Fee	305,141	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,816,549	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,015,180)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,015,180)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,151,359	44
45	Private Pay - Net Inpatient Revenue	1,465,681	45
46	Medicare - Net Inpatient Revenue	(497,396)	46
47	Other-(specify) HMO/HMO Ancillary/Medicare Advantage	(53,801)	47
48	Other-(specify) Nursing	(5,764)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,060,079	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 7/1/14 Ending: 6/30/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	984	1,289	$ 96,451	$ 74.83	1
2	Assistant Director of Nursing	2,008	2,072	61,300	29.58	2
3	Registered Nurses	15,570	16,616	379,499	22.84	3
4	Licensed Practical Nurses	36,011	39,061	651,325	16.67	4
5	CNAs & Orderlies	97,015	105,111	1,064,463	10.13	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	2,290	2,716	31,664	11.66	9
10	Activity Assistants	3,467	3,805	39,268	10.32	10
11	Social Service Workers	10,685	11,860	177,332	14.95	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	1,903	2,240	41,363	18.47	13
14	Head Cook	5,534	6,110	63,528	10.40	14
15	Cook Helpers/Assistants	22,282	24,560	222,724	9.07	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	5,475	6,252	118,429	18.94	17
18	Housekeepers	12,172	13,550	139,794	10.32	18
19	Laundry	6,539	7,346	80,076	10.90	19
20	Administrator	1,979	2,252	104,007	46.18	20
21	Assistant Administrator	1,150	1,150	32,792	28.51	21
22	Other Administrative	-	-	-		22
23	Office Manager	3,331	3,497	60,454	17.29	23
24	Clerical	3,523	3,807	43,562	11.44	24
25	Vocational Instruction	-	-	-		25
26	Academic Instruction	-	-	-		26
27	Medical Director	-	-	-		27
28	Qualified MR Prof. (QMRP)	-	-	-		28
29	Resident Services Coordinator	-	-	-		29
30	Habilitation Aides (DD Homes)	-	-	-		30
31	Medical Records	1,981	2,192	24,741	11.29	31
32	Other Health Care(specify)	3,950	4,289	108,318	25.25	32
33	Other(specify)	3,586	3,958	59,592	15.06	33
34	TOTAL (lines 1 - 33)	241,435	263,733	$ 3,600,682 *	$ 13.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	304	$ 15,472	V01-3	35
36	Medical Director	120	24,000	V	36
37	Medical Records Consultant	24	1,366	V10-3	37
38	Nurse Consultant	4	200	V10-3	38
39	Pharmacist Consultant	72	3,088	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	414	V11-3	44
45	Social Service Consultant	78	5,294	V12-3	45
46	Other(specify) Contracteed BOM	411	54,581	V21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,023	$ 104,415		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	507	15,648	V10-3	51
52	Certified Nurse Assistants/Aides	10,022	215,584	V10-3	52
53	TOTAL (lines 50 - 52)	10,529	$ 231,232		53

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PHILIP PARTRIDGE	ADMINISTRATOR	0	$ 104,007
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,007

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 560,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 560,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Research	PROFESSIONAL SERVICI	$ 1,556
Delaney, Delaney & Voorn	LEGAL	9,261
Adam Lawler	LEGAL	16,083
Davis & Campbell	LEGAL	7,695
Polsinelli Shughart PC	LEGAL	20,306
CliftonLarsonAllen, LLP	AUDIT	13,917
Leader Stat	RECRUITER/CONSULTANT	19,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 87,818

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 143,869
Unemployment Compensation Insurance	27,602
FICA Taxes	256,708
Employee Health Insurance	319,780
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
NEW HIRE EXPENSE	18,100
EMPLOYEE UNIFORMS	858
EMPLOYEE EXPENSE	21,237
TOTAL (agree to Schedule V, line 22, col.8)	$ 833,237

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	43
Health Care Worker Background Check	
(Indicate # of checks performed 129)	
Patient Background Checks 164	1,640
LICENSE	3,536
DUES	17,449
SUBSCRIPTIONS	4,938
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,606

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,459
In-State Travel	38,953
Seminar Expense	1,914
Home Office Allocation	23,873
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 69,199

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	This tab is N/A.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/14 Ending: 6/30/15

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. LEADING AGE - $9,494

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 65,399 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 305,141
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. $ 1,574

(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. $ N/A
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 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.