FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 7/1/15 to 6/30/16 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) Susan McGhee
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: 7/1/15 Ending: 6/30/16

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,896	10,429	5,507	38,832	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,896	10,429	5,507	38,832	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.73%

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 4,303

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: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	303,903	17,484	15,401	336,788		336,788		336,788			1
2	Food Purchase		244,833		244,833		244,833	(748)	244,085			2
3	Housekeeping	114,052	14,569	768	129,389		129,389		129,389			3
4	Laundry	79,804	860		80,664		80,664		80,664			4
5	Heat and Other Utilities			144,391	144,391		144,391	1,422	145,813			5
6	Maintenance	106,948	8,606	30,975	146,529		146,529	3,191	149,720			6
7	Other (specify):* Trash			5,276	5,276		5,276		5,276			7
8	TOTAL General Services	604,707	286,352	196,811	1,087,870		1,087,870	3,865	1,091,735			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,565,994	210,345	84,880	2,861,219		2,861,219		2,861,219			10
10a	Therapy			645,288	645,288		645,288		645,288			10a
11	Activities	71,334	1,768	6,079	79,181		79,181		79,181			11
12	Social Services	118,134	288	5,799	124,221		124,221		124,221			12
13	CNA Training											13
14	Program Transportation			5,825	5,825		5,825		5,825			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,755,462	212,401	771,871	3,739,734		3,739,734		3,739,734			16
	C. General Administration											
17	Administrative	118,391		560,000	678,391		678,391	(452,107)	226,284			17
18	Directors Fees											18
19	Professional Services			65,428	65,428		65,428	87,945	153,373			19
20	Dues, Fees, Subscriptions & Promotions			35,692	35,692		35,692	(1,396)	34,296			20
21	Clerical & General Office Expenses	120,137	9,893	107,331	237,361		237,361	297,042	534,403			21
22	Employee Benefits & Payroll Taxes			835,327	835,327		835,327	44,314	879,641			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,089	29,089		29,089	36,111	65,200			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			83,216	83,216		83,216	23,765	106,981			26
27	Other (specify):* Marketing	65,082	43,286	749	109,117		109,117	(109,116)	1			27
28	TOTAL General Administration	303,610	53,179	1,716,832	2,073,621		2,073,621	(73,442)	2,000,179			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,663,779	551,932	2,685,514	6,901,225		6,901,225	(69,577)	6,831,648			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: 7/1/15 Ending: 6/30/16

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			269,533	269,533		269,533	31,329	300,862			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			255,207	255,207		255,207	(7,180)	248,027			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,506	14,506		14,506		14,506			35
36	Other (specify):* Deferred Financing Costs/Other Admin			(4,486)	(4,486)		(4,486)		(4,486)			36
37	TOTAL Ownership			534,760	534,760		534,760	24,149	558,909			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			317,139	317,139		317,139	(12,714)	304,425			39
40	Barber and Beauty Shops		179		179		179		179			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,283	296,283		296,283		296,283			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		179	613,422	613,601		613,601	(12,714)	600,887			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,663,779	552,111	3,833,696	8,049,586		8,049,586	(58,142)	7,991,444			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: 7/1/15 Ending: 6/30/16

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	(748)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,312)	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	(7,180)	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	44,390	21		24
25	Fund Raising, Advertising and Promotional	(109,116)	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	(41,465)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (115,431)		$	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	58,685	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 58,685		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,746)		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: 7/1/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees, Finance Charges	$ 1	21	1
2	Fines & Penalties	(35,000)	21	2
3	Miscellaenous Revenue	(6,466)	21	3
4	Lobbying Expense	(1,396)	20	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				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**	(42,861)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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	(748)	0	0	0	0	0	0	0	0	0	0	(748)	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	1,422	0	0	0	0	0	0	0	0	0	1,422	5
6	Maintenance	0	3,191	0	0	0	0	0	0	0	0	0	3,191	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(748)	4,613	0	0	0	0	0	0	0	0	0	3,865	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	(452,107)	0	0	0	0	0	0	0	0	0	(452,107)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	87,945	0	0	0	0	0	0	0	0	0	87,945	19
20	Fees, Subscriptions & Promotions	(1,396)	0	0	0	0	0	0	0	0	0	0	(1,396)	20
21	Clerical & General Office Expenses	1,613	295,429	0	0	0	0	0	0	0	0	0	297,042	21
22	Employee Benefits & Payroll Taxes	0	44,314	0	0	0	0	0	0	0	0	0	44,314	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	36,111	0	0	0	0	0	0	0	0	0	36,111	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	23,765	0	0	0	0	0	0	0	0	0	23,765	26
27	Other (specify):*	(109,116)	0	0	0	0	0	0	0	0	0	0	(109,116)	27
28	**TOTAL General Administration**	(108,899)	35,457	0	0	0	0	0	0	0	0	0	(73,442)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(109,647)	40,070	0	0	0	0	0	0	0	0	0	(69,577)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nrsing Ctr **#** 0048744 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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	31,329	0	0	0	0	0	0	0	0	0	31,329	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,180)	0	0	0	0	0	0	0	0	0	0	(7,180)	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**	(7,180)	31,329	0	0	0	0	0	0	0	0	0	24,149	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	(12,714)	0	0	0	0	0	0	0	0	0	(12,714)	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	(12,714)	0	0	0	0	0	0	0	0	0	(12,714)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(116,827)	58,685	0	0	0	0	0	0	0	0	0	(58,142)	45

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

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.	100.00%	$ 1,422	$ 1,422	1
2	V	6	Maintenance				3,191	3,191	2
3	V	17	Administrative	560,000			107,893	(452,107)	3
4	V	19	Professional Services				87,945	87,945	4
5	V	21	Clerical				253,821	253,821	5
6	V	22	Employee Benefits				44,314	44,314	6
7	V	21	Dues & Subscriptions				5,176	5,176	7
8	V	24	Travel and Seminars				36,111	36,111	8
9	V	26	Insurance				23,765	23,765	9
10	V	30	Depreciation				31,329	31,329	10
11	V	21	Other Administrative Expense				36,432	36,432	11
12	V	39	Pharmacy Services	337,246	Senior Care Pharmacy	0.00%	324,532	(12,714)	12
13	V								13
14	Total			$ 897,246			$ 955,931	$ * 58,685	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: 7/1/15 Ending: 6/30/16

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: 7/1/15 Ending: 6/30/16

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: 7/1/15 Ending: 6/30/16

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	$38,137.00	8/1/2007	$ 6,634,900	$ 5,235,721	8/1/2032	3.7100	$ 228,432	1
2												2
3												3
4												4
5	Mortgage Insurance Premium										26,775	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$38,137.00		$ 6,634,900	$ 5,235,721			$ 255,207	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	$ 5,235,721			$ 255,207	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,775 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:** 7/1/15 **Ending:** 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/1/15 Ending: 6/30/16

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			6,189	2
3	TOTALS	180,000		$ 77,360	3

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$	$ 1,588,787	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Allocation				61,223	2,454		2,454		46,950	8
	Improvement Type**										
9	1981 Fixed Assets			1981	6,510		Various			6,510	9
10	1982 Fixed Assets			1982	239,522	4,098	Various	4,098		219,717	10
11	1983 Fixed Assets			1983	22,362	588	Various	588		19,469	11
12	1985 Fixed Assets			1985	89,127	2,103	Various	2,103		69,675	12
13	1986 Fixed Assets			1986	3,474		Various			3,474	13
14	1987 Fixed Assets			1987	693,842	17,218	Various	17,218		507,313	14
15	1988 Fixed Assets			1988	111,792	1,964	Various	1,964		88,007	15
16	1989 Fixed Assets			1989	81,343		Various			81,343	16
17	1990 Fixed Assets			1990	144,712	34	Various	34		144,244	17
18	1991 Fixed Assets			1991	39,417		Various			39,417	18
19	1992 Fixed Assets			1992	34,918		Various			34,918	19
20	1993 Fixed Assets			1993	6,923		Various			6,923	20
21	1994 Fixed Assets			1994	11,344		Various			11,344	21
22	1995 Fixed Assets			1995	8,422		Various			8,422	22
23	1996 Fixed Assets			1996	181,906	7,557	Various	7,557		152,937	23
24	1997 Fixed Assets			1997	3,852		Various			3,852	24
25	1998 Fixed Assets			1998	5,188		Various			5,188	25
26	1999 Fixed Assets			1999	49,735		Various			49,735	26
27	2000 Fixed Assets			2000	7,886		Various			7,886	27
28	2001 Fixed Assets			2001	9,464		Various			9,464	28
29	2002 Fixed Assets			2002	36,078	196	Various	196		35,260	29
30	2003 Fixed Assets			2003	159,995	3,782	Various	3,782		145,953	30
31	2004 Fixed Assets			2004	103,300	3,890	Various	3,890		91,629	31
32	2005 Fixed Assets			2005	35,747	1,697	Various	1,697		29,069	32
33	2006 Fixed Assets			2006	43,697	2,761	Various	2,761		42,981	33
34	2007 Fixed Assets			2007	34,557	1,348	Various	1,348		32,591	34
35	2008 Fixed Assets			2008	76,186	7,619	Various	7,619		60,327	35
36	2009 Fixed Assets			2009	480,419	28,904	Various	28,904		205,157	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: 7/1/15 Ending: 6/30/16

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	Roof Replacement - Dining Room	6/23/2010	$ 11,582	$ 1,158	10	$ 1,158	$	$ 7,046	37
38	5 Ton A/C Compressor & Replacement Lab	7/7/2010	1,074	107	10	107		644	38
39	Carpet for Office and Conference Room	10/23/2010	4,638	464	10	464		2,667	39
40	Sleepy Hollow - Wall Coverings	7/31/2010	8,293	829	10	829		4,976	40
41	Sleepy Hollow - Flooring	7/31/2010	18,830	1,883	10	1,883		11,298	41
42	Sleepy Hollow - Rub rail & door guards	7/31/2010	13,846	1,385	10	1,385		8,308	42
43	122 Ft Privacy Fence	6/10/2010	1,800	180	10	180		1,095	43
44	Sprinkler System Upgrade	1/31/2011	5,048	505	10	505		2,776	44
45	Roof Exhaust Fans	6/30/2011	1,905	190	10	190		968	45
46	Dietary - Floor Replacement	6/30/2011	19,467	1,947	10	1,947		9,896	46
47	Doors w/Smoke Gaskets	6/30/2011	8,402	840	10	840		4,271	47
48	Memory Lane - Painting	6/30/2011	3,226	323	10	323		1,640	48
49	Memory Lane/Shadybrook - Asbestos Remo	6/30/2011	22,600	2,260	10	2,260		11,488	49
50	Memory Lane/Shadybrook - Flooring	6/30/2011	77,607	7,761	10	7,761		39,450	50
51	Memory Lane/Shadybrook - Lighting	6/30/2011	3,584	358	10	358		1,822	51
52	Memory Lane/Shadybrook - Rails and gua	6/30/2011	15,044	1,504	10	1,504		7,647	52
53	4 Ton Trane Heat Pumps w/Installation	6/30/2011	14,597	1,460	10	1,460		7,420	53
54	Memory Lane - Light Fixtures	6/30/2011	1,039	104	10	104		528	54
55	Shadybrook - Light Fixtures	6/30/2011	1,039	104	10	104		528	55
56	Dietary Loading - Privacy Fence	6/30/2011	2,118	212	10	212		1,077	56
57	Restripe Parking Lots	6/30/2011	5,375	538	10	538		2,732	57
58	Lighting for Outdoor Sign	6/30/2011	889	89	10	89		452	58
59	Fire alarm system, addressable 3 yr wa	1/9/2012	83,229	8,323	10	8,323		37,453	59
60	Fire alarm system 6 door closures inst	1/23/2012	5,907	591	10	591		2,658	60
61	120 Gal 480V Haot Water Heater	7/17/2012	5,169	517	10	517		2,068	61
62	Counter Tops Activity Room	7/11/2012	640	43	15	43		171	62
63	Drywall & Supply - Activity Room Remod	7/12/2012	117	8	15	8		31	63
64	Refurbish Parking Lot Lights	12/3/2012	1,398	280	5	280		1,002	64
65	Walk In Cooler/Freezer (Indoor)	3/22/2013	16,400	1,093	15	1,093		3,644	65
66	Walk-In Cooler/Freezer (Installation)	5/16/2013	4,950	330	15	330		1,045	66
67	4 Ton Heat Pumps Trane 15 SEER (2)	5/17/2013	14,971	1,497	10	1,497		4,741	67
68	Water heater- Laundry	3/11/2014	5,717	572	10	572		1,334	68
69	34x82 mini blinds - dining room	4/29/2014	384	38	10	38		86	69
70	TOTAL (lines 4 thru 69)		$ 4,937,355	$ 168,044		$ 168,044	$	$ 3,931,504	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: 7/1/15 Ending: 6/30/16

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		$ 4,937,355	$ 168,044		$ 168,044	$	$ 3,931,504	1
2	48x82 Visions mini blinds - dining room	4/29/2014	714	71	10	71		161	2
3	47x82 mini blinds - dining room	4/29/2014	936	94	10	94		211	3
4	47 1/2 x 82 mini blinds - dining room	4/29/2014	687	69	10	69		155	4
5	4ton heat pumps & rooftop 3 phase	6/25/2014	20,900	2,090	10	2,090		4,354	5
6	Labor & install of therapy bathroom	6/30/2014	1,226	123	10	123		256	6
7	Combination door locks	7/16/2014	801	80	10	80		160	7
8	Install of handrail	10/21/2014	672	67	10	67		118	8
9	Replace vinyl flooring corridors	10/30/2014	38,151	3,815	10	3,815		6,676	9
10	Flooring Shower Room	12/29/2014	3,162	316	10	316		501	10
11	Replace sewer line under floor	7/16/2014	4,112	206	20	206		411	11
12	Lighting Fixtures	5/28/2015	35,618	3,562	10	3,562		4,155	12
13	MDS Office Flooring	6/25/2015	1,530	153	10	153		166	13
14	Memory Lane Showers Replace	6/25/2015	5,380	538	10	538		583	14
15	Dietary Room Floor Replace	6/25/2015	4,710	471	10	471		510	15
16	4 4-Ton Heat Pump Replacements	7/1/2015	23,244	2,324	10	2,324		2,324	16
17	Replace Steel Decking and Refoamed Roof	7/1/2015	3,640	364	10	364		364	17
18	Rewire and Install Lights	7/28/2015	52,992	5,299	10	5,299		5,299	18
19	Cabinets For Main Dining Room	11/4/2015	1,405	94	10	94		94	19
20	Tuck pointing of SCNC roof	4/3/2016	7,500	188	10	188		188	20
21	New canopy & entry doors@ courtyard	6/29/2016	72,068	601	10	601		601	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)		$ 5,216,803	$ 188,569		$ 188,569	$	$ 3,958,791	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: 7/1/15 Ending: 6/30/16

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	$ 433,730	$ 73,128	$ 73,128	$	Various	$ 282,736	71
72	Current Year Purchases	67,611	6,959	6,959		Various	6,959	72
73	Fully Depreciated Assets	594,722	1,607	1,607		Various	594,722	73
74	Home Office Allocation	225,285	26,937	26,937			166,305	74
75	TOTALS	$ 1,321,348	$ 108,631	$ 108,631	$		$ 1,050,722	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	Patient Transportation	2006 For Bus New Motor	2015	6,894	1,724	1,724		4	2,298	77
78										78
79	Home Office Allocation			8,890	1,937	1,937			6,556	79
80	TOTALS			$ 62,134	$ 3,661	$ 3,661	$		$ 55,204	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)	$ 6,677,645	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 300,861	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 300,861	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)	$ 5,064,717	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	$ 3,939	92
93			93
94			94
95		$ 3,939	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: 7/1/15 Ending: 6/30/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 14,506 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: 7/1/15 Ending: 6/30/16

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: 7/1/15 Ending: 6/30/16

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	$	5,448	$ 223,408	$	5,448	$ 223,408	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		3,065	186,520		3,065	186,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,034	235,360		6,034	235,360	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			$	14,547	$ 645,288	$	14,547	$ 645,288	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:** 7/1/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(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	$ (332,188)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (275,808))	1,558,115		3
4	Supply Inventory (priced at)	6,026		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,118		6
7	Other Prepaid Expenses	16,082		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest/Other AR	(126,993)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,138,160	$	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	4,940,094		14
15	Leasehold Improvements, at Historical Cost	215,486		15
16	Equipment, at Historical Cost	1,149,307		16
17	Accumulated Depreciation (book methods)	(4,844,906)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	553,440		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Financing Costs	156,950		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,252,342	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,390,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,086	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,097		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	Accrued Liabilities/Due to Auxiliary	2,282,875		36
37	Due to Resident - Funds in Trust	18,198		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,022,256	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,235,721		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)**	$ 5,235,721	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,257,977	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,867,475)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,390,502	$	48

***(See instructions.)**

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,129,216)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,129,216)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(738,751)	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)**	$ (738,751)	17
	B. Transfers (Itemize):		
18	**Restricted Contributions**	1,813	18
19	**Net Assets Released From Restriction**	(1,321)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 492	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,867,475)	24 *

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

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 6,413,454	1
2	Discounts and Allowances for all Levels	(3,743,118)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,670,336	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,011,738	6
7	Oxygen	16,328	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,028,066	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	229	13
14	Non-Patient Meals	748	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	430,092	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,597	19
20	Radiology and X-Ray	16,528	20
21	Other Medical Services	89,413	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 566,607	23
	D. Non-Operating Revenue		
24	Contributions	25,610	24
25	Interest and Other Investment Income***	7,180	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,790	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	13,036	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,036	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,310,835	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,087,870	31
32	Health Care	3,739,734	32
33	General Administration	2,073,621	33
	B. Capital Expense		
34	Ownership	534,760	34
	C. Ancillary Expense		
35	Special Cost Centers	317,318	35
36	Provider Participation Fee	296,283	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,049,586	40
41	**Income before Income Taxes (line 30 minus line 40)****	(738,751)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (738,751)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,023,842	44
45	Private Pay - Net Inpatient Revenue	639,174	45
46	Medicare - Net Inpatient Revenue	(1,551,841)	46
47	Other-(specify) HMO/HMO Ancillary/Medicare Advantage	(244,334)	47
48	Other-(specify) Nursing	(196,505)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,670,336	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: 7/1/15 Ending: 6/30/16

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	2,164	2,419	$ 107,168	$ 44.30	1
2	Assistant Director of Nursing	916	1,151	31,445	27.32	2
3	Registered Nurses	23,834	25,921	605,880	23.37	3
4	Licensed Practical Nurses	31,546	34,069	593,925	17.43	4
5	CNAs & Orderlies	99,316	107,236	1,202,913	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,719	2,895	31,324	10.82	9
10	Activity Assistants	2,888	3,144	40,011	12.73	10
11	Social Service Workers	6,921	8,268	118,134	14.29	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,160	40,742	18.86	13
14	Head Cook	5,173	5,860	63,069	10.76	14
15	Cook Helpers/Assistants	19,481	21,526	200,092	9.30	15
16	Dishwashers					16
17	Maintenance Workers	4,298	4,878	106,948	21.92	17
18	Housekeepers	10,987	12,141	114,052	9.39	18
19	Laundry	6,212	6,848	79,804	11.65	19
20	Administrator	2,036	2,206	92,027	41.72	20
21	Assistant Administrator	1,050	1,217	26,364	21.66	21
22	Other Administrative					22
23	Office Manager	1,568	1,812	39,215	21.64	23
24	Clerical	5,086	5,319	80,922	15.21	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	2,087	2,250	24,662	10.96	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,207	3,392	65,082	19.19	33
34	TOTAL (lines 1 - 33)	233,437	254,712	$ 3,663,779 *	$ 14.38	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	263	$ 14,191	V01-3	35
36	Medical Director	120	24,000	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	156	2,933	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	25	2,139	V11-3	44
45	Social Service Consultant	84	5,799	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	648	$ 49,062		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	883	27,925	V10-3	51
52	Certified Nurse Assistants/Aides	2,346	50,009	V10-3	52
53	TOTAL (lines 50 - 52)	3,229	$ 77,934		53

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Philip Partridge	Administrator	0	$ 56,500
Harry Poole	Administrator	0	35,527
Merle Taylor	Asst Administrator	0	22,231
Robert Vincent	Asst Administrator	0	4,133
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,391

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Surveys	$ 1,354
CliftonLarsonAllen, LLP	Audit	16,309
Adam Lawler	Legal	31,472
Delaney, Delaney, & Voorn	Legal	7,637
Davis & Campbell	Legal	5,528
Pulsinelli Shugart PC	Legal	1,728
Daniel Maher Law Office	Legal	1,400
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 65,428

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 143,185
Unemployment Compensation Insurance	13,629
FICA Taxes	266,872
Employee Health Insurance	377,010
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
New Hire Expense	15,804
Employee Uniforms	(4,043)
Employee Expense	18,620
457 Plan Expense	4,250
Home Office Allocation	44,314
TOTAL (agree to Schedule V, line 22, col.8)	$ 879,641

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	
Health Care Worker Background Check	
(Indicate # of checks performed 208)	
Patient Background Checks	2,080
License	4,090
Dues	11,662
Subscriptions	16,464
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,296

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,493
In-State Travel	23,017
Seminar Expense	1,579
Home Office Allocation	36,111
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 65,200

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nrsing Ctr # 0048744 Report Period Beginning: 7/1/15 Ending: 6/30/16

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 - $10,091.38**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **56,466** 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 fo
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 Departmen
during this cost report period. $ **296,283**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **748**

(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 fo
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: **Plante Moran PLLC**

(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