FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Nursing Center

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 7/1/17 to 6/30/18 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) Chuck Schmitz
(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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	20,289	10,394	8,973	39,656	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,289	10,394	8,973	39,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.33%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 7,564

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: 6/30/18 Fiscal Year: 6/30/18

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	291,030	10,498	16,196	317,724		317,724		317,724			1
2	Food Purchase		233,800		233,800		233,800		233,800			2
3	Housekeeping	113,605		19,873	133,478		133,478		133,478			3
4	Laundry	93,118		11	93,129		93,129		93,129			4
5	Heat and Other Utilities			150,087	150,087		150,087	(586,775)	(436,688)			5
6	Maintenance	128,357	41,478		169,835		169,835	2,857	172,692			6
7	Other (specify):* TRASH			4,655	4,655		4,655		4,655			7
8	TOTAL General Services	626,110	285,776	190,822	1,102,708		1,102,708	(583,918)	518,790			8
	B. Health Care and Programs											
9	Medical Director			21,112	21,112		21,112		21,112			9
10	Nursing and Medical Records	2,388,083	129,106	21,383	2,538,572		2,538,572		2,538,572			10
10a	Therapy			804,415	804,415		804,415		804,415			10a
11	Activities	81,525	7,990		89,515		89,515		89,515			11
12	Social Services	128,614		6,908	135,522		135,522		135,522			12
13	CNA Training											13
14	Program Transportation			10,616	10,616		10,616		10,616			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,598,222	137,096	864,434	3,599,752		3,599,752		3,599,752			16
	C. General Administration											
17	Administrative	104,925		588,156	693,081		693,081	82,347	775,428			17
18	Directors Fees											18
19	Professional Services			50,799	50,799		50,799	50,433	101,232			19
20	Dues, Fees, Subscriptions & Promotions			40,876	40,876		40,876	(1,219)	39,657			20
21	Clerical & General Office Expenses	110,961	29,494	465,822	606,277		606,277	(32,814)	573,463			21
22	Employee Benefits & Payroll Taxes			793,236	793,236		793,236	69,932	863,168			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,155	17,155		17,155	27,049	44,204			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,499	90,499		90,499	810	91,309			26
27	Other (specify):* MARKETING	79,984		30,513	110,497		110,497	(110,497)				27
28	TOTAL General Administration	295,870	29,494	2,077,056	2,402,420		2,402,420	86,041	2,488,461			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,520,202	452,366	3,132,312	7,104,880		7,104,880	(497,877)	6,607,003			29

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

Facility Name & ID Number Shawnee Christian Nursing Center #0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			298,101	298,101		298,101	29,561	327,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			191,327	191,327		191,327		191,327			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,630	9,630		9,630		9,630			35
36	Other (specify):* DEF FINANCING COST/ SALES TAX			18,695	18,695		18,695		18,695			36
37	**TOTAL Ownership**			517,753	517,753		517,753	29,561	547,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,111	683,878	711,989		711,989	(37,213)	674,776			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			281,700	281,700		281,700		281,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		28,111	965,578	993,689		993,689	(37,213)	956,476			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,520,202	480,477	4,615,643	8,616,322		8,616,322	(505,529)	8,110,793			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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(97)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(393,311)	21		24
25	Fund Raising, Advertising and Promotional	(110,497)	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	(7,249)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (511,154)		$	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)	5,625	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,625		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (505,529)		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 Nursing Center

ID# 0048744

Report Period Beginning: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	LOBBYING EXPENSE	(1,219)	20	3
4	MARKETING TRAVEL & ENTERTAINMENT	(6,030)	24	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(7,249)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	0	0	0	0	0	0	0	0	0	0	0	0	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	1,381	0	0	0	0	0	0	0	0	0	1,381	5
6	Maintenance	0	2,857	0	0	0	0	0	0	0	0	0	2,857	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	4,238	0	0	0	0	0	0	0	0	0	4,238	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	(505,809)	0	0	0	0	0	0	0	0	0	(505,809)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50,433	0	0	0	0	0	0	0	0	0	50,433	19
20	Fees, Subscriptions & Promotions	(1,219)	0	0	0	0	0	0	0	0	0	0	(1,219)	20
21	Clerical & General Office Expenses	(393,408)	360,594	0	0	0	0	0	0	0	0	0	(32,814)	21
22	Employee Benefits & Payroll Taxes	0	69,932	0	0	0	0	0	0	0	0	0	69,932	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,030)	33,079	0	0	0	0	0	0	0	0	0	27,049	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	810	0	0	0	0	0	0	0	0	0	810	26
27	Other (specify):*	(110,497)	0	0	0	0	0	0	0	0	0	0	(110,497)	27
28	**TOTAL General Administration**	(511,154)	9,039	0	0	0	0	0	0	0	0	0	(502,115)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(511,154)	13,277	0	0	0	0	0	0	0	0	0	(497,877)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	29,561	0	0	0	0	0	0	0	0	0	29,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	29,561	0	0	0	0	0	0	0	0	0	29,561	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	(37,213)	0	0	0	0	0	0	0	0	0	(37,213)	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	(37,213)	0	0	0	0	0	0	0	0	0	(37,213)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(511,154)	5,625	0	0	0	0	0	0	0	0	0	(505,529)	45

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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. ☐ 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 Horizons	100.00%	$ 1,381	$ 1,381	1
2	V	6	Maintenance				2,857	2,857	2
3	V	17	Administrative	588,156			82,347	(505,809)	3
4	V	19	Professional Services				50,433	50,433	4
5	V	21	Clerical				324,331	324,331	5
6	V	22	Employee Benefits				69,932	69,932	6
7	V	21	Dues & Subscriptions				8,223	8,223	7
8	V	24	Travel and Seminars				33,079	33,079	8
9	V	26	Insurance				810	810	9
10	V	30	Depreciation				29,561	29,561	10
11	V	21	Other Administrative Expense				28,040	28,040	11
12	V	39	Pharmacy Services	638,930	Midwest Senior Ministries, Inc. dba: Senior Care Pharmacy	0.00%	601,717	(37,213)	12
13	V								13
14	Total			$ 1,227,086			$ 1,232,711	$ * 5,625	14

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is 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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Sect. 232 Ins Mortgage		X	HUD FINANCING	$41,089.00	8/1/07	$ 6,634,900	$ 4,741,361	8/1/2032	3.7100	$ 180,992	1
2	Mortgage Insurance Premium										24,493	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$41,089.00		$ 6,634,900	$ 4,741,361			$ 205,485	9
	B. Non-Facility Related*											
10	INTEREST OFFSET										(14,158)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,158)	14
15	TOTALS (line 9+line14)						$ 6,634,900	$ 4,741,361			$ 191,327	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,493 Line # 32

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

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Center 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			6,256	2
3	TOTALS	180,000		$ 77,427	3

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$	$ 1,677,463	4
5			1980	1980	107,504		20				5
6											6
7											7
8	Home Office Adjustment				60,898	2,131		2,131		50,038	8
	Improvement Type**										
9	1981 Fixed Assets			1981	6,510		VARIOUS			6,510	9
10	1982 Fixed Assets			1982	202,431	4,098	VARIOUS	4,098		190,821	10
11	1983 Fixed Assets			1983	22,362	588	VARIOUS	588		20,645	11
12	1985 Fixed Assets			1985	84,118	2,103	VARIOUS	2,103		68,872	12
13	1987 Fixed Assets			1987	691,806	17,218	VARIOUS	17,218		539,713	13
14	1988 Fixed Assets			1988	84,121	1,964	VARIOUS	1,964		64,263	14
15	1989 Fixed Assets			1989	33,780		VARIOUS			33,780	15
16	1990 Fixed Assets			1990	144,712	34	VARIOUS	34		144,312	16
17	1991 Fixed Assets			1991	38,550		VARIOUS			38,550	17
18	1992 Fixed Assets			1992	23,836		VARIOUS			23,836	18
19	1993 Fixed Assets			1993	6,923		VARIOUS			6,923	19
20	1994 Fixed Assets			1994	10,734		VARIOUS			10,734	20
21	1995 Fixed Assets			1995	8,422		VARIOUS			8,422	21
22	1996 Fixed Assets			1996	181,906	7,557	VARIOUS	7,557		168,051	22
23	1997 Fixed Assets			1997	973		VARIOUS			973	23
24	1998 Fixed Assets			1998	1,423		VARIOUS			1,423	24
25	1999 Fixed Assets			1999	42,531		VARIOUS			42,531	25
26	2000 Fixed Assets			2000	7,886		VARIOUS			7,886	26
27	2001 Fixed Assets			2001	8,578		VARIOUS			8,578	27
28	2002 Fixed Assets			2002	32,393	119	VARIOUS	119		31,890	28
29	2003 Fixed Assets			2003	159,424	3,782	VARIOUS	3,782		152,946	29
30	2004 Fixed Assets			2004	98,500	3,890	VARIOUS	3,890		94,610	30
31	2005 Fixed Assets			2005	35,747	1,670	VARIOUS	1,670		32,408	31
32	2006 Fixed Assets			2006	38,371	44	VARIOUS	44		37,742	32
33	2007 Fixed Assets			2007	34,557	251	VARIOUS	251		34,190	33
34	2008 Fixed Assets			2008	76,186	6,983	VARIOUS	6,983		74,929	34
35	2009 Fixed Assets			2009	480,417	28,907	VARIOUS	28,907		262,975	35
36	2010 Fixed Assets			2010	60,063	6,006	VARIOUS	6,006		48,046	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	2011 FIXED ASSETS	2011	$ 181,941	$ 18,194	VARIOUS	$ 18,194	$	$ 129,085	37
38	Fire alarm system, addressable 3 yr warr	2012	83,229	8,323	10	8,323		54,097	38
39	Fire alarm system 6 door closures instal	2012	5,907	591	10	591		3,839	39
40	120 Gal 480V Haot Water Heater	2012	5,169	517	10	517		3,101	40
41	Counter Tops Activity Room	2012	640	43	15	43		256	41
42	Drywall & Supply - Activity Room Remodel	2012	117	8	15	8		47	42
43	Refurbish Parking Lot Lights	2012	1,398	94	5	94		1,375	43
44	Walk In Cooler/Freezer (Indoor)	2013	16,400	1,093	15	1,093		5,831	44
45	Walk-In Cooler/Freezer (Installation)	2013	4,950	330	15	330		1,705	45
46	4 Ton Heat Pumps Trane 15 SEER (2)	2013	14,971	1,497	10	1,497		7,735	46
47	Water heater- Laundry	2014	5,717	572	10	572		2,477	47
48	Labor & install of therapy bathroom	2014	1,226	123	10	123		501	48
49	4ton heat pumps & rooftop 3 phase	2014	20,900	2,090	10	2,090		8,534	49
50	34x82 mini blinds	2014	384	38	10	38		163	50
51	48x82 Visions mini blinds	2014	714	71	10	71		303	51
52	47x82 mini blinds	2014	936	94	10	94		398	52
53	47 1/2 x 82 mini blinds	2014	687	69	10	69		292	53
54	Replace sewer line under floor	2014	4,112	206	20	206		822	54
55	Combination door locks	2014	801	80	10	80		320	55
56	Replace vinyl flooring corridors	2014	38,151	3,815	10	3,815		14,307	56
57	Install of handrail	2014	672	67	10	67		252	57
58	Flooring Shower Room	2014	3,162	316	10	316		1,133	58
59	Lighting Fixtures	2015	35,618	3,562	10	3,562		11,279	59
60	Dietary room floor replace	2015	4,710	471	10	471		1,452	60
61	Memory lane showers replace	2015	5,380	538	10	538		1,659	61
62	MDS office flooring	2015	1,530	153	10	153		472	62
63	4 4-Ton Heat Pump Replacements	2015	23,244	2,324	10	2,324		6,973	63
64	Replace Steel Decking and Refoamed Roof	2015	3,640	364	10	364		1,092	64
65	Rewire and Install Lights	2015	52,992	5,299	10	5,299		15,897	65
66	Cabinets For Main Dining Room	2015	1,405	141	10	141		375	66
67	Tuck pointing of SCNC roof	2016	7,500	750	10	750		1,688	67
68	New canopy & entry doors@ courtyard	2016	72,068	7,207	10	7,207		15,014	68
69	Dietary Ceiling tile replace	2016	950	95	10	95		153	69
70	TOTAL (lines 4 thru 69)		$ 5,052,908	$ 190,818		$ 190,818	$	$ 4,176,687	70

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 5,052,908	$ 190,818		$ 190,818	$	$ 4,176,687	1
2	State Commercial Water Heater	2016	5,020	502	10	502		837	2
3	4 Ton Comfortmaker Heat Pump System	2016	23,789	2,379	10	2,379		3,767	3
4	Shady Brook Flooring replace	2017	43,350	4,335	10	4,335		6,141	4
5	Removal of Asbestos - Canteen Room, Hallway, Resident Rooms, a	2017	17,230	1,723	10	1,723		2,584	5
6	PlankTile Corridor near dining room	2017	9,100	910	10	910		1,289	6
7	Praking Lot Striping & Seal Coating	2017	4,700	671	7	671		839	7
8	New Dietary Generator for Steam oven	2017	13,498	1,350	10	1,350		1,462	8
9	Parking Lot lighting system LED upgrade	2017	5,335	267	20	267		289	9
10	3 New Double-face Signage SHCV	2017	22,825	951	20	951		951	10
11	Sewer Lift Station Control Box Pump 1&2	2017	4,514	169	20	169		169	11
12	Main Dining Room Range Exhaust	2017	1,800	105	10	105		105	12
13	New Fencing around SHCV grounds	2018	4,650	116	20	116		116	13
14	120gl Comm Elec Water Heaters AO Smith	2018	10,276	514	10	514		514	14
15	Trane 4 ton Heat Pumps	2018	6,128	204	10	204		204	15
16	Trane 4 ton Heat Pumps	2018	6,128	204	10	204		204	16
17	Trane 4 ton Heat Pumps	2018	6,128	204	10	204		204	17
18	Trane 4 ton Heat Pumps	2018	6,128	204	10	204		204	18
19	GP Dining Room paint & patchwork	2018	3,800	253	5	253		253	19
20	Activity Room paint & patchwork	2018	4,660	310	5	310		310	20
21	Therapy Room retrofit light system	2018	2,000	67	10	67		67	21
22	Therapy Room paint & patchwork	2018	2,540	169	5	169		169	22
23	Remodel Shower Rooms	2018	42,295	1,410	10	1,410		1,410	23
24	Main Dining Room retrofit light system	2018	5,920	197	10	197		197	24
25	Main Dining Room laminate countertop	2018	647	22	10	22		22	25
26									26
27									27
28	Rounding		(2)	1		1		3	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,305,367	$ 208,055		$ 208,055	$	$ 4,198,997	34

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 412,342	$ 79,003	$ 79,003	$	VARIOUS	$ 275,875	71
72	Current Year Purchases	92,126	11,450	11,450		VARIOUS	11,450	72
73	Fully Depreciated Assets	624,688				VARIOUS	624,688	73
74	HOME OFFICE ALLOCATION	159,718	25,942	25,942			118,918	74
75	TOTALS	$ 1,288,874	$ 116,395	$ 116,395	$		$ 1,030,931	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 TRANSPORTATI	2006 Ford Starcraft Allstar 15 Pa	2006	$ 46,350	$	$	$	8	$ 46,350	76
77	PATIENT TRANSPORTATI	2006 Ford Bus new motor	2015	6,894	1,724	1,724		4	5,745	77
78										78
79	HOME OFFICE ALLOCATION			8,987	4,997	4,997			8,150	79
80	TOTALS			$ 62,231	$ 6,721	$ 6,721	$		$ 60,245	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)	$ 6,733,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 331,171	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 331,171	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)	$ 5,290,173	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	$ 68,744	92
93	HOME OFFICE ALLOCATION	32,728	93
94			94
95		$ 101,472	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 20,049 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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	$	5,883	$ 312,664	$	5,883	$ 312,664	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		3,626	194,773		3,626	194,773	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		8,414	296,978		8,414	296,978	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				(208,978)		(208,978)	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					50,521		50,521	12
13	Other (specify): BILLABLE SUPPLIES	V39					231,516		231,516	13
14	TOTAL			$	17,923	$ 804,415	$ 73,059	17,923	$ 877,474	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 Nursing Center **#** 0048744 **Report Period Beginning:** 7/1/17 **Ending:** 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/18 **(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	$ 10,934	$	1
2	Cash-Patient Deposits	28,422		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 590,384)	1,520,029		3
4	Supply Inventory (priced at)	4,171		4
5	Short-Term Investments	221,433		5
6	Prepaid Insurance	5,600		6
7	Other Prepaid Expenses	14,788		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	22,595		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,827,972	$	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	5,244,469		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,182,400		16
17	Accumulated Depreciation (book methods)	(5,113,068)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	206,636		21
22	Other Long-Term Assets (spe CIP	68,744		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,671,152	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,499,124	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 415,857	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,422		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	266,108		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	ACC LIAB/ DEF FINANCING COST/ DU	3,282,768		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,993,155	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,741,361		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)**	$ 4,741,361	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,734,516	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,235,392)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,499,124	$	48

***(See instructions.)**

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,369,469)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,369,469)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,984	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) **Change in Temp Restricted Net Assets**	2,089	15
16	Other (describe) **Rounding**	4	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 134,077	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)**	$ (5,235,392)	24 *

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

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 8,974,631	1
2	Discounts and Allowances for all Levels	(6,689,978)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,284,653	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,155,194	6
7	Oxygen	7,949	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,163,143	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	1,111	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	748,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58,784	19
20	Radiology and X-Ray	36,227	20
21	Other Medical Services	424,369	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,268,758	23
	D. Non-Operating Revenue		
24	Contributions	28,887	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,887	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL		28
28a	Misc Revenue	2,865	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,865	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,748,306	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,102,708	31
32	Health Care	3,599,752	32
33	General Administration	2,402,420	33
	B. Capital Expense		
34	Ownership	517,753	34
	C. Ancillary Expense		
35	Special Cost Centers	711,989	35
36	Provider Participation Fee	281,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,616,322	40
41	**Income before Income Taxes (line 30 minus line 40)****	131,984	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 131,984	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,690,022	44
45	Private Pay - Net Inpatient Revenue	805,918	45
46	Medicare - Net Inpatient Revenue	(1,247,242)	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	(239,811)	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(724,233)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,284,653	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 Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	1,880	2,032	$ 82,957	$ 40.83	1
2	Assistant Director of Nursing	1,756	1,848	54,241	29.35	2
3	Registered Nurses	27,892	29,007	613,466	21.15	3
4	Licensed Practical Nurses	28,610	30,508	593,254	19.45	4
5	CNAs & Orderlies	78,118	83,161	1,018,929	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,327	2,389	32,394	13.56	9
10	Activity Assistants	3,764	4,007	49,130	12.26	10
11	Social Service Workers	8,464	8,939	128,614	14.39	11
12	Dietician					12
13	Food Service Supervisor	1,874	2,055	41,878	20.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,599	23,975	249,153	10.39	15
16	Dishwashers					16
17	Maintenance Workers	5,535	5,871	128,357	21.86	17
18	Housekeepers	10,430	11,007	113,605	10.32	18
19	Laundry	7,456	8,456	93,118	11.01	19
20	Administrator	1,880	2,016	104,925	52.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,124	7,472	110,961	14.85	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	1,931	2,061	25,236	12.24	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	3,729	4,152	79,984	19.26	33
34	TOTAL (lines 1 - 33)	215,369	228,956	$ 3,520,202 *	$ 15.38	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	247	$ 15,131	V01-3	35
36	Medical Director	120	20,112	V09-3	36
37	Medical Records Consultant	16	1,370	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	3,745	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				44
45	Social Service Consultant	84	5,505	V12-3	45
46	Other(specify)				46
47	TELEHEALTH	13	1,000	V10-3	47
48					48
49	TOTAL (lines 35 - 48)	648	$ 46,863		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	12	360	V10-3	51
52	Certified Nurse Assistants/Aides	531	13,676	V10-3	52
53	TOTAL (lines 50 - 52)	543	$ 14,036		53

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CAROL CURRY	ADMINISTRATOR	0	$ 104,925
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,925

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 588,156
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 588,156

C. Professional Services

Vendor/Payee	Type	Amount
National Research	Surveys	$ 2,264
CT Corporation	Registered Agent	247
Plante Moran	Accounting	10,750
Daniel Maher Law Office	Legal	380
Lawler Brown	Legal	3,618
Receivable Mgmt Service	Legal	1,085
Davis & Campbell	Legal	25,988
Tetzlaff, Cervantez & Associates	Legal	1,817
D3G	PCNA	4,650
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 50,799

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,532
Unemployment Compensation Insurance	18,874
FICA Taxes	255,558
Employee Health Insurance	343,728
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
NEW HIRE EXPENSE	25,129
EMPLOYEE UNIFORMS	(3,576)
EMPLOYEE EXPENSE	27,491
457 PLAN EXPENSE	6,500
HOME OFFICE ALLOCATION	69,932
TOTAL (agree to Schedule V, line 22, col.8)	$ 863,168

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 399)	
Patient Background Checks	3,990
License	5,273
Dues	14,204
Subscriptions	16,190
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,657

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,306
In-State Travel	10,693
Seminar Expense	1,156
HOME OFFICE ALLOCATION	33,079
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50,234

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Center # 0048744 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 - $8,706**

(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. $ **35,724** 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. $ **281,700**
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. $ **1,860**

(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: **PLANTE MORAN PLLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees