

		FOR BHF USE					

LL1

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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.

<p>I. IDPH License ID Number: <u>0023812</u></p> <p>Facility Name: <u>Sheltering Oak, Inc.</u></p> <p>Address: <u>P.O. Box 367</u> <u>Island Lake</u> <u>60042</u> <small>Number City Zip Code</small></p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>847 526-8865</u> Fax # <u>847 487-9584</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/01/1973</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Leonard Pesz, President</u> Telephone Number: <u>(847)526-8865</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2010</u> to <u>9/30/2011</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Leonard Pesz</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>President</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) <u>Accountant's Compilation Report Attached</u> (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>John Verchota</u> <u>CPA</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>Miller Verchota, Inc., CPA's</u> <u>444 N. IL Rte 31, Crystal Lake, IL 60012</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>815-477-8000</u> Fax # <u>815-477-7170</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Leonard Pesz</u>		(Title) <u>President</u>	Paid Preparer	(Signed) <u>Accountant's Compilation Report Attached</u> (Date) _____		(Print Name and Title) <u>John Verchota</u> <u>CPA</u>		(Firm Name & Address) <u>Miller Verchota, Inc., CPA's</u> <u>444 N. IL Rte 31, Crystal Lake, IL 60012</u>		(Telephone) <u>815-477-8000</u> Fax # <u>815-477-7170</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																						
	<input type="checkbox"/> Limited Liability Co.																																						
	<input type="checkbox"/> Trust																																						
	<input type="checkbox"/> Other _____																																						
Officer or Administrator of Provider	(Signed) _____ (Date) _____																																						
	(Type or Print Name) <u>Leonard Pesz</u>																																						
	(Title) <u>President</u>																																						
Paid Preparer	(Signed) <u>Accountant's Compilation Report Attached</u> (Date) _____																																						
	(Print Name and Title) <u>John Verchota</u> <u>CPA</u>																																						
	(Firm Name & Address) <u>Miller Verchota, Inc., CPA's</u> <u>444 N. IL Rte 31, Crystal Lake, IL 60012</u>																																						
	(Telephone) <u>815-477-8000</u> Fax # <u>815-477-7170</u>																																						

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.

0023812 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,997	0		21,997	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,997			21,997	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.09%

D. How many bed-hold days during this year were paid by the Department? 61 (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)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 05/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2011 Fiscal Year: 9/30/2011

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

Facility Name & ID Number Sheltering Oak, Inc. # 0023812 Report Period Beginning: 10/1/2010 Ending: 9/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	153,412	4,621	5,868	163,901		163,901		163,901		1
2	Food Purchase		152,816		152,816		152,816	(7)	152,809		2
3	Housekeeping	42,906	6,357		49,263		49,263		49,263		3
4	Laundry	29,511	2,523		32,034		32,034		32,034		4
5	Heat and Other Utilities			58,865	58,865		58,865		58,865		5
6	Maintenance	65,314	22,788	34,525	122,627		122,627		122,627		6
7	Other (specify):* Waste Removal			2,970	2,970		2,970		2,970		7
8	TOTAL General Services	291,143	189,105	102,228	582,476		582,476	(7)	582,469		8
	B. Health Care and Programs										
9	Medical Director			15,800	15,800		15,800		15,800		9
10	Nursing and Medical Records	521,110	31,688	11,955	564,753		564,753		564,753		10
10a	Therapy										10a
11	Activities	68,247	790	4,340	73,377		73,377		73,377		11
12	Social Services	74,253		6,292	80,545		80,545		80,545		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	663,610	32,478	38,387	734,475		734,475		734,475		16
	C. General Administration										
17	Administrative	88,959			88,959		88,959		88,959		17
18	Directors Fees										18
19	Professional Services			58,638	58,638		58,638	(37,830)	20,808		19
20	Dues, Fees, Subscriptions & Promotions			2,167	2,167		2,167	(635)	1,532		20
21	Clerical & General Office Expenses	78,320	12,106	6,076	96,502		96,502		96,502		21
22	Employee Benefits & Payroll Taxes			371,622	371,622		371,622		371,622		22
23	Inservice Training & Education										23
24	Travel and Seminar			720	720		720		720		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			108,223	108,223		108,223		108,223		26
27	Other (specify):* Other Tax/Penalties			5,084	5,084		5,084	(5,084)			27
28	TOTAL General Administration	167,279	12,106	552,530	731,915		731,915	(43,549)	688,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,122,032	233,689	693,145	2,048,866		2,048,866	(43,556)	2,005,310		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Sheltering Oak, Inc.

#0023812

Report Period Beginning:

10/1/2010

Ending:

9/30/2011

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			14,229	14,229		14,229		14,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			38,142	38,142		38,142		38,142			33
34	Rent-Facility & Grounds			176,564	176,564		176,564	(168,177)	8,387			34
35	Rent-Equipment & Vehicles			2,785	2,785		2,785		2,785			35
36	Other (specify):*											36
37	TOTAL Ownership			231,720	231,720		231,720	(168,177)	63,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			110	110		110		110			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,435	38,435		38,435		38,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,122,032	233,689	963,300	2,319,021		2,319,021	(211,733)	2,107,288			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(7)	2		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	(5,084)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(37,830)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(635)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,556)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(168,177)	VII B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (168,177)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (211,733)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Sheltering Oak, Inc.

ID# 0023812

Report Period Beginning: 10/1/2010

Ending: 9/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6		(168,177)	34
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	(168,177)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheltering Oak, Inc.# 0023812

Report Period Beginning:

10/1/2010

Ending:

9/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7)	0	0	0	0	0	0	0	0	0	0	(7)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7)	0	0	0	0	0	0	0	0	0	0	(7)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37,830)	0	0	0	0	0	0	0	0	0	0	(37,830)	19
20	Fees, Subscriptions & Promotions	(635)	0	0	0	0	0	0	0	0	0	0	(635)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,084)	0	0	0	0	0	0	0	0	0	0	(5,084)	27
28	TOTAL General Administration	(43,549)	0	0	0	0	0	0	0	0	0	0	(43,549)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,556)	0	0	0	0	0	0	0	0	0	0	(43,556)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheltering Oak, Inc.# 0023812

Report Period Beginning:

10/1/2010 Ending:

9/30/2011

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	0	0	0	0	0	0	0	0	0	0	0	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	(168,177)	0	0	0	0	0	0	0	0	0	0	(168,177)	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	(168,177)	0	0	0	0	0	0	0	0	0	0	(168,177)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(211,733)	0	0	0	0	0	0	0	0	0	0	(211,733)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Leonard Pesz	50	N/A	N/A	N/A	N/A	N/A
Estate of Lynn Marlowe	50	N/A	N/A	N/A	N/A	N/A

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Rent	\$ 176,564	Above Owners	100.00%	\$	(176,564)	1
2	V	Facility Depreciation		Above Owners	100.00%	8,387	8,387	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 176,564			\$ 8,387	\$ * (168,177)	14

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

VII. RELATED PARTIES (continued)

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Sheltering Oak, Inc.

0023812

Report Period Beginning:

10/1/2010

Ending:

9/30/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leonard Pesz	President/Treasurer	General Manager	50.00	0	40	100.00	Salary	\$ 76,715	17-1	1
2	Christina Pesz	N/A	Clerical	0.00	0	40	100.00	Hourly	14,968	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 91,683		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.

0023812 Report Period Beginning: 10/1/2010 Ending: 1/30/2011

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheltering Oak, Inc.

0023812

Report Period Beginning:

10/1/2010

Ending:

9/30/2011

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		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	None					\$	\$			\$								
2																		
3																		
4																		
5																		
Working Capital																		
6	None																	
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10	None																	
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	33,493		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.)		\$	33,493		2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	38,142		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.		\$	38,142		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>27,518</u>	<u>8</u>	FOR BHF USE ONLY	
	2007	<u>31,120</u>	<u>9</u>	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	<u>32,249</u>	<u>10</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	<u>33,493</u>	<u>11</u>	15	LESS REFUND FROM LINE 6 \$ 15
	2010	<u>38,142</u>	<u>12</u>	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Taxes of \$38,142 paid in FYE 09/30/2011 were for Calendar Year 2010 (2010 taxes paid in 2011)					

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheltering Oak, Inc. COUNTY Lake
 FACILITY IDPH LICENSE NUMBER 0023812
 CONTACT PERSON REGARDING THIS REPORT Leonard Pesz, President
 TELEPHONE 847-526-8865 FAX #: 847-487-9584

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>09-28-100-016</u>	<u>Nursing Home Facility @</u>	\$ <u>38,142.37</u>	\$ <u>38,142.37</u>
2.	<u></u>	<u>27888 N. Beech Street</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u>Island Lake, IL 60042</u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>38,142.37</u></u>	\$ <u><u>38,142.37</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Sheltering Oak, Inc.

0023812

Report Period Beginning:

10/1/2010 Ending:

9/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,725 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>217,800</u>	<u>1955</u>	<u>\$ 30,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,800		\$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	44	1973	1973	\$ 233,000	\$	50	\$ 4,660	\$ 4,660	\$ 178,245	4
5	26	1976	1976	167,731		45	3,727	3,727	131,378	5
6										6
7										7
8										8
Improvement Type**										
9	Fully depreciated improvements			56,497					56,497	9
10	Fencing		1995	1,411	9	15	9		1,411	10
11	Fire doors and locks		1995	13,022	334	39	334		5,316	11
12	Timer and stones		1998	3,474	232	15	232		2,997	12
13	Exit doors		1999	1,566	40	39	40		507	13
14	Boiler		2000	6,403	320	20	320		3,627	14
15	Pond aerator		2002	1,189	79	15	79		731	15
16	Pond aerator		2003	1,106	74	15	74		617	16
17	Water heaters		2003	8,350	522	16	522		4,524	17
18	Retaining Wall		2004	2,320	155	15	155		1,072	18
19	Hot water regulator		2005	4,107	257	16	257		1,542	19
20	Kitchen fire doors		2005	876	22	39	22		145	20
21	Fire alarm system		2006	26,712	685	39	685		3,254	21
22	Custom Crete - Kitchen Floor		2010	3,400	73	39	73		73	22
23	Black Diamond - Hot Water Heaters (2)		2011	12,564	471	20	471		471	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.

0023812

Report Period Beginning:

10/1/2010 Ending:

9/30/2011

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	543,728	\$	3,273	\$	11,660	\$	8,387	\$	392,407	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheltering Oak, Inc.

0023812

Report Period Beginning:

10/1/2010

Ending:

9/30/2011

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	\$ 287,986	\$ 10,553	\$ 10,553	\$	5-20 Yrs	\$ 223,393	71
72	Current Year Purchases	5,158	344	344		10 Yrs	344	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 293,144	\$ 10,897	\$ 10,897	\$		\$ 223,737	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	Fully Depreciated			\$ 48,456	\$	\$	\$		\$ 48,456	76
77										77
78										78
79										79
80	TOTALS			\$ 48,456	\$	\$	\$		\$ 48,456	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)	\$ 915,328	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,170	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,557	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,387	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 664,600	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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.

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? YES NO

If NO, see instructions.

		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: _____ *

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: \$ 2,785 Description: Dishwasher

(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

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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.

0023812

Report Period Beginning: 10/1/2010

Ending: 9/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (15,545)	\$ (15,545)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	419,811	419,811	3
4	Supply Inventory (priced at)	4,950	4,950	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,767	1,767	6
7	Other Prepaid Expenses	6,116	6,116	7
8	Accounts Receivable (owners or related parties)	98,987	98,987	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 516,086	\$ 516,086	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost		400,731	14
15	Leasehold Improvements, at Historical Cost	142,997	142,997	15
16	Equipment, at Historical Cost	341,598	341,598	16
17	Accumulated Depreciation (book methods)	(354,977)	(664,600)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 129,618	\$ 250,726	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 645,704	\$ 766,812	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 141,408	\$ 191,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,018	93,101	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				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 284,426	\$ 284,427	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 284,426	\$ 284,427	46
47	TOTAL EQUITY(page 18, line 24)	\$ 361,278	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 645,704	\$ 284,427	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 429,876	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 429,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,598)	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	(62,000)	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)	\$ (68,598)	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)	\$ 361,278	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.# 0023812Report Period Beginning: 10/1/2010Ending: 9/30/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,296,964	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,296,964	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Stale Dated Checks</u>	11,264	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,264	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,308,228	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	583,587	31
32	Health Care	734,474	32
33	General Administration	728,001	33
B. Capital Expense			
34	Ownership	230,329	34
C. Ancillary Expense			
35	Special Cost Centers	110	35
36	Provider Participation Fee	38,325	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,314,826	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,598)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,598)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Shelting Oak, Inc.**

0023812

Report Period Beginning: **10/1/2010**

Ending:

9/30/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,944	1,944	\$ 57,976	\$ 29.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,900	6,119	129,192	21.11	3
4	Licensed Practical Nurses	2,105	2,549	52,705	20.68	4
5	CNAs & Orderlies	18,805	19,485	203,407	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,080	35,390	17.01	9
10	Activity Assistants	2,877	3,249	32,857	10.11	10
11	Social Service Workers	2,160	2,160	41,723	19.32	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	31,292	15.04	13
14	Head Cook	3,117	3,190	37,425	11.73	14
15	Cook Helpers/Assistants	7,826	8,014	84,695	10.57	15
16	Dishwashers					16
17	Maintenance Workers	4,159	4,245	65,314	15.39	17
18	Housekeepers	4,257	4,375	42,906	9.81	18
19	Laundry	2,973	3,043	29,511	9.70	19
20	Administrator	2,240	2,320	88,959	38.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,200	76,715	34.87	23
24	Clerical	160	160	1,605	10.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,162	1,162	19,273	16.59	28
29	Resident Services Coordinator	1,960	2,080	32,530	15.64	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	1,960	2,080	58,557	28.15	33
34	TOTAL (lines 1 - 33)	69,685	72,535	\$ 1,122,032 *	\$ 15.47	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	122	\$ 5,868	1-3	35
36	Medical Director	198	15,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	70	1,743	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	4,340	11-3	44
45	Social Service Consultant	103	6,292	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	565	\$ 34,043		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	340	10,212	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	340	\$ 10,212		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.

0023812

Report Period Beginning: 10/1/2010

Ending: 9/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joseph S. Agnello	Administrator	1	\$ 83,190	Workers' Compensation Insurance	\$ 38,465	IDPH License Fee	\$	
Nicholas J. Papp	Administrator		5,769	Unemployment Compensation Insurance	9,792	Advertising: Employee Recruitment	575	
				FICA Taxes	85,835	Health Care Worker Background Check		
				Employee Health Insurance	237,530	(Indicate # of checks performed <u>1</u>)		
				Employee Meals	0	Secretary of State Annual Report	100	
				Illinois Municipal Retirement Fund (IMRF)*	0	Lake County Health Department	341	
						Other Licenses	416	
						Public Relations	635	
						IL Nursing Home Adm. Assn.	100	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 88,959					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising (635)	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Meyer Magence	Attorney		\$ 4,416	N/A		\$	Out-of-State Travel	\$
Ed Ventura	Accounting		3,438					
Shaw Law, Ltd	Legal		32,582					
Mary Koopman, CSR	Legal		832				In-State Travel	
Miller Verchota, Inc.	Accounting		17,371					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Seminar Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 58,638				(agree to Sch. V, line 24, col. 8)	
							Reg Skills 320	
							Admin Seminar 400	
							Entertainment Expense ()	
							TOTAL 720	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltering Oak, Inc.# 0023812Report Period Beginning: 10/1/2010Ending: 9/30/2011**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. INHAA \$100
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,325
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. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
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? 100%
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? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT