



Facility Name & ID Number Shady Oaks East

# 0039263 Report Period Beginning: 07/01/14 Ending: 06/30/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,642			5,642	13
14	TOTALS	5,642			5,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 5/17/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date January 1993 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/14 Ending: 06/30/15

**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
	<b>A. General Services</b>										
1	Dietary	46,523	3,780	2,482	52,785		52,785		52,785		1
2	Food Purchase		34,219		34,219		34,219		34,219		2
3	Housekeeping		2,489		2,489		2,489		2,489		3
4	Laundry		2,050		2,050		2,050		2,050		4
5	Heat and Other Utilities			1,762	1,762		1,762	266	2,028		5
6	Maintenance	12,238	3,785	56,329	72,352		72,352	7,992	80,344		6
7	Other (specify):*							446	446		7
8	<b>TOTAL General Services</b>	58,761	46,323	60,573	165,657		165,657	8,704	174,361		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,500	2,500		2,500		2,500		9
10	Nursing and Medical Records	383,013	25,343	175,927	584,283		584,283		584,283		10
10a	Therapy			1,732	1,732		1,732		1,732		10a
11	Activities	14,119	(1,118)		13,001		13,001		13,001		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	397,132	24,225	180,159	601,516		601,516		601,516		16
	<b>C. General Administration</b>										
17	Administrative	78,944			78,944		78,944	138,593	217,537		17
18	Directors Fees										18
19	Professional Services			243,690	243,690		243,690	(223,007)	20,683		19
20	Dues, Fees, Subscriptions & Promotions			250	250		250	3,618	3,868		20
21	Clerical & General Office Expenses		408	1,422	1,830		1,830	8,139	9,969		21
22	Employee Benefits & Payroll Taxes			152,374	152,374		152,374	31,468	183,842		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,980	2,980		2,980	6,542	9,522		24
25	Other Admin. Staff Transportation			1,094	1,094		1,094	5,191	6,285		25
26	Insurance-Prop.Liab.Malpractice			12,137	12,137		12,137	3,299	15,436		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	78,944	408	413,947	493,299		493,299	(26,157)	467,142		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	534,837	70,956	654,679	1,260,472		1,260,472	(17,453)	1,243,019		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 &amp; ID Number

Shady Oaks East

#0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			26,787	26,787		26,787	13,271	40,058			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			960	960		960	3,608	4,568			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			14,672	14,672		14,672	802	15,474			34
35	Rent-Equipment & Vehicles			66	66		66	392	458			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			42,485	42,485		42,485	18,073	60,558			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,292	67,292		67,292		67,292			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			67,292	67,292		67,292		67,292			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	534,837	70,956	764,456	1,370,249		1,370,249	620	1,370,869			45

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



Shady Oaks East

ID# 0039263

Report Period Beginning: 07/01/14

Ending: 06/30/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (126)	21	1
2	Additional R&M	4,273	06	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
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	<b>Total</b>	4,147		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

## 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													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			265	1								266	5
6	Maintenance	4,273		2,776	180	763							7,992	6
7	Other (specify):*			380		66							446	7
8	<b>TOTAL General Services</b>	<b>4,273</b>		<b>3,421</b>	<b>181</b>	<b>829</b>							<b>8,704</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			44,348	14,446	79,799							138,593	17
18	Directors Fees													18
19	Professional Services			(84,123)	(22,077)	(116,807)							(223,007)	19
20	Fees, Subscriptions & Promotions			971	1,713	934							3,618	20
21	Clerical & General Office Expenses	(126)		5,371	543	2,351							8,139	21
22	Employee Benefits & Payroll Taxes			11,040	4,068	16,360							31,468	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,928	356	4,258							6,542	24
25	Other Admin. Staff Transportation			2,724	196	2,271							5,191	25
26	Insurance-Prop.Liab.Malpractice			2,465	52	782							3,299	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(126)</b>		<b>(15,276)</b>	<b>(703)</b>	<b>(10,052)</b>							<b>(26,157)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>4,147</b>		<b>(11,855)</b>	<b>(522)</b>	<b>(9,223)</b>							<b>(17,453)</b>	<b>29</b>



STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,249)	13,971	3,533	153	863							13,271	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		1,842	707	24	1,035							3,608	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(11,672)	7,364	338	4,772							802	34
35	Rent-Equipment & Vehicles			254	7	131							392	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(5,249)</b>	<b>4,141</b>	<b>11,858</b>	<b>522</b>	<b>6,801</b>							<b>18,073</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,102)</b>	<b>4,141</b>	<b>3</b>		<b>(2,422)</b>							<b>620</b>	<b>45</b>

Facility Name & ID Number

Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6-Supplemental		Shady Oaks West	Lockport	See Pg 6-Supplemental		

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	34 Rental of Space	\$ 11,672	Vesper Management	100.00%	\$	(11,672)	1
2	V	32 Interest		Vesper Management	100.00%	1,842	1,842	2
3	V	30 Depreciation		Vesper Management	100.00%	13,971	13,971	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		\$ 11,672			\$ 15,813	\$ * 4,141	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	17 Salaries & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 44,348	\$	44,348	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	11,040		11,040	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	5,723		5,723	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois	100.00%	2,533		2,533	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	7,364		7,364	19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	265		265	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%	171		171	21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	707		707	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%				23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	2,465		2,465	24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%				25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	2,724		2,724	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	161		161	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	1,928		1,928	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	292		292	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%	2		2	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	93		93	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	2,603		2,603	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%	679		679	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%	380		380	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	2,838		2,838	36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	3,533		3,533	37
38	V	19 Agency Management Allocation	89,846	Lutheran Social Services of Illinois	100.00%			(89,846)	38
39	Total		\$ 89,846			\$ 89,849	\$ *	3	39

\* 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	17 Salaries & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 14,446	\$ 14,446
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	4,068	4,068
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	6,271	6,271
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois	100.00%	427	427
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	338	338
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	1	1
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%		
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	24	24
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	52	52
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%		
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	196	196
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	7	7
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	356	356
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	40	40
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%		
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%		
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	180	180
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%	1,673	1,673
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%		
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	116	116
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	153	153
38	V	19 HR Allocation	28,348	Lutheran Social Services of Illinois	100.00%		(28,348)
39	Total		\$ 28,348			\$ 28,348	\$ *

\* 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	17 Salaries & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 79,799	\$	79,799	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	16,360		16,360	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	2,216		2,216	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois	100.00%	2,351		2,351	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	4,772		4,772	19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%				20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%				21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	1,035		1,035	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%				23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	782		782	24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%				25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	2,271		2,271	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	131		131	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	4,258		4,258	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	934		934	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%				30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%				32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	763		763	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%				34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%	66		66	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%				36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	863		863	37
38	V	19 Service Network Admin Alloc	119,023	Lutheran Social Services of Illinois	100.00%			(119,023)	38
39	Total		\$ 119,023			\$ 116,601	\$ *	(2,422)	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

\* 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: 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		
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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number

Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

VII. RELATED PARTIES (continued)

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

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

	1 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	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 Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lutheran Social Services of Illinois  
 Street Address 1001 E. Touhy Avenue, Suite 50  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number (847) 635-4600  
 Fax Number (847) 635-6764

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	17	Salaries & Wages	Non-Capital Direct Costs	28,842,438	249	\$ 3,059,096	\$ 3,059,096	418,130	\$ 44,348	1
2	22	Empl Benefits & Taxes		28,842,438	249	761,506	418,130	11,040		2
3	19	Prof Fees & Contracts		28,842,438	249	394,765	418,130	5,723		3
4	21	Supplies, Telephone,		28,842,438	249		418,130			4
5		Postage, Out. Printing		28,842,438	249	174,715	418,130	2,533		5
6	34	Rental of Space		28,842,438	249	507,950	418,130	7,364		6
7	5	Utilities		28,842,438	249	18,264	418,130	265		7
8	6	Bldg Repairs & Maintenance		28,842,438	249	11,764	418,130	171		8
9	32	Interest		28,842,438	249	48,784	418,130	707		9
10	33	Real Estate Taxes		28,842,438	249		418,130			10
11	26	Insurance		28,842,438	249	170,052	418,130	2,465		11
12	20	Advertising & Promotions		28,842,438	249		418,130			12
13	25	Transportation		28,842,438	249	187,903	418,130	2,724		13
14	35	Car Rental		28,842,438	249	11,121	418,130	161		14
15	24	Conferences & Conventions		28,842,438	249	132,973	418,130	1,928		15
16	20	Subscriptions, Dues, Awards		28,842,438	249	20,150	418,130	292		16
17	6	Furniture & Fixtures		28,842,438	249	110	418,130	2		17
18	6	Machinery & Equipment		28,842,438	249		418,130			18
19	35	Equipment Rental		28,842,438	249	6,408	418,130	93		19
20	6	Equipment Repair & Maint.		28,842,438	249	179,557	418,130	2,603		20
21	20	Employee Recruitment		28,842,438	249	46,813	418,130	679		21
22	7	Security & Waste Removal		28,842,438	249	26,190	418,130	380		22
23	21	All Other Miscellaneous		28,842,438	249	195,743	418,130	2,838		23
24	30	Depreciation		28,842,438	249	243,696	418,130	3,533		24
25	TOTALS					\$ 6,197,560	\$ 3,059,096		\$ 89,849	25



Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lutheran Social Services of Illinois  
 Street Address 1001 E. Touhy Avenue, Suite 50  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number (847) 635-4600  
 Fax Number (847) 635-6764

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	17	Salaries & Wages	49,722,670	249	\$ 1,028,026	\$ 1,028,026	698,725	\$ 14,446	1
2	22	Empl Benefits & Taxes	49,722,670	249	289,517		698,725	4,068	2
3	19	Prof Fees & Contracts	49,722,670	249	446,267		698,725	6,271	3
4	21	Supplies, Telephone,	49,722,670	249			698,725		4
5		Postage, Out. Printing	49,722,670	249	30,368		698,725	427	5
6	34	Rental of Space	49,722,670	249	24,085		698,725	338	6
7	5	Utilities	49,722,670	249	100		698,725	1	7
8	6	Bldg Repairs & Maintenance	49,722,670	249			698,725		8
9	32	Interest	49,722,670	249	1,722		698,725	24	9
10	33	Real Estate Taxes	49,722,670	249			698,725		10
11	26	Insurance	49,722,670	249	3,674		698,725	52	11
12	20	Advertising & Promotions	49,722,670	249			698,725		12
13	25	Transportation	49,722,670	249	13,929		698,725	196	13
14	35	Car Rental	49,722,670	249	466		698,725	7	14
15	24	Conferences & Conventions	49,722,670	249	25,331		698,725	356	15
16	20	Subscriptions, Dues, Awards	49,722,670	249	2,861		698,725	40	16
17	6	Furniture & Fixtures	49,722,670	249			698,725		17
18	6	Machinery & Equipment	49,722,670	249			698,725		18
19	35	Equipment Rental	49,722,670	249			698,725		19
20	6	Equipment Repair & Maint.	49,722,670	249	12,823		698,725	180	20
21	20	Employee Recruitment	49,722,670	249	119,051		698,725	1,673	21
22	7	Security & Waste Removal	49,722,670	249			698,725		22
23	21	All Other Miscellaneous	49,722,670	249	8,247		698,725	116	23
24	30	Depreciation	49,722,670	249	10,877		698,725	153	24
25	TOTALS				\$ 2,017,344	\$ 1,028,026		\$ 28,348	25

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/14Ending: 06/30/15

## VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Lutheran Social Services of Illinois

Street Address

1001 E. Touhy Avenue, Suite 50

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(847) 635-4600

Fax Number

(847) 635-6764

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	17	Salaries & Wages	Non-Capital Direct Costs	4,257,594	72	\$ 812,554	\$ 812,554	418,130	\$ 79,799	1
2	22	Empl Benefits & Taxes		4,257,594	72	166,585	418,130	16,360		2
3	19	Prof Fees & Contracts		4,257,594	72	22,564	418,130	2,216		3
4	21	Supplies, Telephone,		4,257,594	72	23,944	418,130	2,351		4
5		Postage, Out. Printing		4,257,594	72		418,130			5
6	34	Rental of Space		4,257,594	72	48,591	418,130	4,772		6
7	5	Utilities		4,257,594	72		418,130			7
8	6	Bldg Repairs & Maintenance		4,257,594	72		418,130			8
9	32	Interest		4,257,594	72	10,540	418,130	1,035		9
10	33	Real Estate Taxes		4,257,594	72		418,130			10
11	26	Insurance		4,257,594	72	7,965	418,130	782		11
12	20	Advertising & Promotions		4,257,594	72		418,130			12
13	25	Transportation		4,257,594	72	23,125	418,130	2,271		13
14	35	Car Rental		4,257,594	72	1,332	418,130	131		14
15	24	Conferences & Conventions		4,257,594	72	43,354	418,130	4,258		15
16	20	Subscriptions, Dues, Awards		4,257,594	72	9,507	418,130	934		16
17	6	Furniture & Fixtures		4,257,594	72		418,130			17
18	6	Machinery & Equipment		4,257,594	72		418,130			18
19	35	Equipment Rental		4,257,594	72		418,130			19
20	6	Equipment Repair & Maint.		4,257,594	72	7,766	418,130	763		20
21	20	Employee Recruitment		4,257,594	72		418,130			21
22	7	Security & Waste Removal		4,257,594	72	673	418,130	66		22
23	21	All Other Miscellaneous		4,257,594	72		418,130			23
24	30	Depreciation		4,257,594	72	8,783	418,130	863		24
25	TOTALS					\$ 1,187,285	\$ 812,554		\$ 116,601	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263 Report Period Beginning: 07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending: 06/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number

Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Tax Exempt Bonds		X	Construction of Facility	2/26/2006		\$ 332,000	\$ 262,280		\$ 2,802	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	LSSI Allocation (Sch VIII)		X							1,766	6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>				\$38,774.00		\$ 332,000	\$ 262,280		\$ 4,568	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 332,000	\$ 262,280		\$ 4,568	15								

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.)

\*\* 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 Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

\* 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.)



# 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks East COUNTY Will

FACILITY IDPH LICENSE NUMBER 0039263

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

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

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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



Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 6,675 B. General Construction Type: Exterior Face Brick Frame Wood 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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Shady Oaks East

**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	16		1993	\$ 558,820	\$ 13,971	40	\$ 13,971	\$	\$ 300,450	4
5		2014	1998	100,000		40	2,500	2,500	5,000	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1994	14,744		20			14,744	9
10	Various		1995	2,100		20			2,100	10
11	Various		1998	20,585		20	886	886	13,752	11
12	Various		1999	15,803		20			15,803	12
13	Various		2001	5,750		20			5,750	13
14	Various		2004	28,216		20			28,216	14
15	Various		2005	37,125		20	3,523	3,523	37,125	15
16	Various		2006	20,578		20	1,710	1,710	19,124	16
17	Various		2007	3,180		20	318	318	2,637	17
18	Various		2011	13,917		20	696	696	2,979	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

\*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

**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		9,905					9,905	67
68			4,549			(4,549)		68
69			26,787			(26,787)		69
70		\$ 830,723	\$ 45,307		\$ 23,604	\$ (21,703)	\$ 457,585	70

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



Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 830,723	\$ 45,307		\$ 23,604	\$ (21,703)	\$ 457,585	1
2	Bathroom Tile/Shower Stalls	2012	6,500		20	325	325	1,300	2
3	Painting - Whole Interior Of Building	2012	7,600		20	380	380	1,520	3
4	Hand Rails/Wall Guards-Acivity Room, Dining, Corridors, Patien	2012	7,196		20	360	360	1,439	4
5	Painting - Whole Interior Of Building	2012	7,600		20	380	380	1,520	5
6	Staining Of All Windows & Laundry Room Electric, Plumbing, In	2012	6,596		20	330	330	990	6
7	Repair & Repaint Damaged Areas & Carpentry In East Building	2012	6,680		20	334	334	1,002	7
8	Repair & Repaint Damaged Areas & Carpentry In East Building	2012	5,847		20	292	292	877	8
9	Plumbing Work	2013	15,950		20	798	798	1,596	9
10	Paving Of Driveway & Parking Areas	2014	15,651		20	783	783	1,566	10
11	Repave Driveway/Parking Areas	2014	15,651		20	783	783	783	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	34

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

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

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	
1		\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 925,994	\$ 45,307		\$ 28,369	\$ (16,939)	\$ 470,176	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Management Assets- Security System	1999	9,905		20			9,905	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,905	\$		\$	\$	\$ 9,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,905	\$		\$	\$	\$ 9,905	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 9,905	\$		\$	\$	\$ 9,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocation From LSSI			4,549			(4,549)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$ 4,549		\$	\$ (4,549)	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$ 4,549		\$	\$ (4,549)	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$ 4,549		\$	\$ (4,549)	\$

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



Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 26,686	\$	\$ 2,670	\$ 2,670	10	\$ 11,541	71
72	Current Year Purchases	3,062		306	306	10	306	72
73	Fully Depreciated Assets	73,617				10	73,617	73
74								74
75	TOTALS	\$ 103,365	\$	\$ 2,976	\$ 2,976		\$ 85,464	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		2006 FORD/BRAUN PARA TRA	2006	\$ 34,256	\$	\$	\$	5	\$ 34,256	76
77		Dodge Braun Entervan	2013	43,569		8,714	8,714	5	17,428	77
78										78
79										79
80	TOTALS			\$ 77,825	\$	\$ 8,714	\$ 8,714		\$ 51,684	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 1,107,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,307	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,058	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,249)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 607,324	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	<u>Parker Storage</u>			<u>3,000</u>			5
6	<u>LSSI Alloc. (Sch VIII)</u>			<u>12,474</u>			6
7	<b>TOTAL</b>			\$ <b>15,474</b>			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: \$ 93 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>		\$	\$ <u>66</u>	17
18	<u>LSSI Alloc. (Sch VIII)</u>			<u>299</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <b>365</b>	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. /2016 \$ \_\_\_\_\_

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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		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): <a href="#">See Supplemental</a>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name & ID Number Shady Oaks East

# 0039263

Report Period Beginning: 07/01/14

Ending: 06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)		<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$	<b>24</b> *

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

Facility Name &amp; ID Number Shady Oaks East

# 0039263

Report Period Beginning: 07/01/14

Ending:

06/30/15

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,057,834	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,057,834	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	86,296	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 86,296	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	126	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 126	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,144,256	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	165,657	31
32	Health Care	601,516	32
33	General Administration	493,299	33
<b>B. Capital Expense</b>			
34	Ownership	42,485	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	67,292	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,370,249	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(225,993)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (225,993)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 914,238	44
45	Private Pay - Net Inpatient Revenue	143,596	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,057,834	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 Shady Oaks East

# 0039263

Report Period Beginning: 07/01/14

Ending: 06/30/15

**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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	1,779	2,199	50,084	22.78	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	679	868	14,119	16.27	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	836	971	16,738	17.24	13
14	Head Cook	2,300	2,581	29,785	11.54	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	576	633	12,238	19.33	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	564	651	22,913	35.20	20
21	Assistant Administrator					21
22	Other Administrative	2,444	2,788	56,031	20.10	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,299	1,468	32,223	21.95	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,923	24,679	300,706	12.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	32,400	36,838	\$ 534,837 *	\$ 14.52	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	As Needed	\$ 2,482	01-03	35
36	Medical Director	As Needed	2,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	3,990	10-03	38
39	Pharmacist Consultant	As Needed	114	10-03	39
40	Physical Therapy Consultant	As Needed	1,732	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	As Needed	900	10-03	47
48	Developmental Training Services	As Needed	2,709	10a-03	48
49	TOTAL (lines 35 - 48)		\$ 14,427		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	As Needed	42,864	10-03	51
52	Certified Nurse Assistants/Aides	As Needed	125,350	10-03	52
53	TOTAL (lines 50 - 52)		\$ 168,214		53



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kristen Stockle	Administrator	0	\$ 22,913	Workers' Compensation Insurance	\$ 27,749	IDPH License Fee	\$	
Kevin Bercaw	Assoc. Exec. Dir.	0	5,902	Unemployment Compensation Insurance	9,808	Advertising: Employee Recruitment		
Daniel Asensio	Other Admin	0	20,896	FICA Taxes	39,257	Health Care Worker Background Check		
Amy Bandstra	Other Admin	0	23,477	Employee Health Insurance	57,611	(Indicate # of checks performed)		
Tetyana Kostyshyna	Other Admin	0	5,756	Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	150	
				Disability/Life Insurance	615	Dues	100	
				Pension Expense	17,334	LSSI Alloc. (Sch. VIII)	3,618	
				LSSI Alloc. (Sch. VIII)	31,468			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	( )	
			\$ 78,944			Non-allowable advertising	( )	
B. Administrative - Other						Yellow page advertising	( )	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 3,868	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount
Vendor/Payee	Type							
Frost, Ruttenberg & Rothblatt	Accounting		\$ 2,500				Out-of-State Travel	\$
Johnson & Colmar	Legal		3,973					
LSSI	Management Services		237,218				In-State Travel	
							Seminar Expense	2,980
							LSSI Alloc. (Sch. VIII)	6,542
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)					TOTAL	\$	(agree to Sch. V, line 24, col. 8)	
			\$ 243,690				TOTAL	\$ 9,522

\* Attach copy of IMRF notifications

\*\*See instructions.



**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? No  
If YES, give association name and amount. N/A
- (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. \$ 7,098 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. 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. \$ 67,292  
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (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? N/A
  - 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? Yes
  - 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: Baker Tilly Virchow Krause LLC
- (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.