

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,140			5,140	13
14	TOTALS	5,140			5,140	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.77%

D. How many bed reserve days during this year were paid by the Department? 360 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 05/17/1994

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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	54,923	3,611	950	59,484		59,484		59,484		1
2	Food Purchase		40,663		40,663		40,663		40,663		2
3	Housekeeping		3,605		3,605		3,605		3,605		3
4	Laundry		2,717		2,717		2,717		2,717		4
5	Heat and Other Utilities			16,330	16,330		16,330	2,935	19,265		5
6	Maintenance	17,395	8,564	128,380	154,339		154,339	22,099	176,438		6
7	Other (specify):*										7
8	TOTAL General Services	72,318	59,160	145,660	277,138		277,138	25,034	302,172		8
	B. Health Care and Programs										
9	Medical Director			3,499	3,499		3,499		3,499		9
10	Nursing and Medical Records	500,285	47,241	110,127	657,653		657,653	(550)	657,103		10
10a	Therapy										10a
11	Activities	30,799	200		30,999		30,999		30,999		11
12	Social Services			15,956	15,956		15,956		15,956		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Dev. Disabilities			72,587	72,587		72,587		72,587		15
16	TOTAL Health Care and Programs	531,084	47,441	202,169	780,694		780,694	(550)	780,144		16
	C. General Administration										
17	Administrative	87,109			87,109		87,109	273,111	360,220		17
18	Directors Fees										18
19	Professional Services			509,232	509,232		509,232	(473,605)	35,627		19
20	Dues, Fees, Subscriptions & Promotions			99	99		99	8,638	8,737		20
21	Clerical & General Office Expenses		420	13,356	13,776		13,776	15,562	29,338		21
22	Employee Benefits & Payroll Taxes			167,431	167,431		167,431	85,920	253,351		22
23	Inservice Training & Education										23
24	Travel and Seminar			443	443		443	4,013	4,456		24
25	Other Admin. Staff Transportation			320	320		320	3,446	3,766		25
26	Insurance-Prop.Liab.Malpractice			46,126	46,126		46,126	8,530	54,656		26
27	Other (specify):*										27
28	TOTAL General Administration	87,109	420	737,007	824,536		824,536	(74,385)	750,151		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	690,511	107,021	1,084,836	1,882,368		1,882,368	(49,901)	1,832,467		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shady Oaks West

#0040527

Report Period Beginning:

07/01/19

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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	
	D. Ownership											
30	Depreciation			24,416	24,416		24,416	1,540	25,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							13,040	13,040			32
33	Real Estate Taxes							2,041	2,041			33
34	Rent-Facility & Grounds			16,578	16,578		16,578	(11,029)	5,549			34
35	Rent-Equipment & Vehicles			3,786	3,786		3,786	283	4,069			35
36	Other (specify):*			170	170		170		170			36
37	TOTAL Ownership			44,950	44,950		44,950	5,875	50,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			15,879	15,879		15,879		15,879			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,334	78,334		78,334		78,334			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			94,213	94,213		94,213		94,213			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	690,511	107,021	1,223,999	2,021,531		2,021,531	(44,027)	1,977,504			45

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

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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	(32,059)	30		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		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(550)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,609)		\$	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)	(11,418)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (11,418)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (44,027)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Clothing & Personal Supplies	\$ (504)	10	1
2	Other Personal Needs	(46)	10	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	Total	(550)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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			1,377	12	1,546							2,935	5
6	Maintenance			5,433	3,717	12,949							22,099	6
7	Other (specify):*													7
8	TOTAL General Services			6,810	3,729	14,495							25,034	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(550)											(550)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(550)											(550)	16
	C. General Administration													
17	Administrative			56,690	17,202	199,219							273,111	17
18	Directors Fees													18
19	Professional Services			(109,108)	(30,037)	(334,460)							(473,605)	19
20	Fees, Subscriptions & Promotions			1,656	269	6,713							8,638	20
21	Clerical & General Office Expenses			9,530	604	5,428							15,562	21
22	Employee Benefits & Payroll Taxes			14,551	5,326	66,043							85,920	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,508	679	1,826							4,013	24
25	Other Admin. Staff Transportation			998	149	2,299							3,446	25
26	Insurance-Prop.Liab.Malpractice			3,504	636	4,390							8,530	26
27	Other (specify):*													27
28	TOTAL General Administration			(20,671)	(5,172)	(48,542)							(74,385)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(550)		(13,861)	(1,443)	(34,047)							(49,901)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks West

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Report Period Beginning:

07/01/19

Ending:

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(32,059)	13,536	9,059	1,466	9,538							1,540	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			2,563	26	10,451							13,040	32
33	Real Estate Taxes			837	11	1,193							2,041	33
34	Rent-Facility & Grounds		(13,578)	1,291	5	1,253							(11,029)	34
35	Rent-Equipment & Vehicles			112		171							283	35
36	Other (specify):*													36
37	TOTAL Ownership	(32,059)	(42)	13,862	1,508	22,606							5,875	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(32,609)	(42)	1	65	(11,441)							(44,027)	45

Facility Name & ID Number Shady Oaks West

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Report Period Beginning: 07/01/19

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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 Page 6-Supplemental		Shady Oaks East	Lockport	See Page 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	\$ 13,578	Vesper Management		\$	(13,578)	1
2	V	30 Depreciation		Vesper Management		13,536	13,536	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		\$ 13,578			\$ 13,536	\$ * (42)	14

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

Facility Name & ID Number

Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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	LSSI	100.00%			VESPER MANAGEMENT		MANAGEMENT CO.	1
2					LUTHERAN SOCIAL SERVICES OF ILLINOIS		CORPORATE OFFICE	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

Shady Oaks West

0040527

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Ending:

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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

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		\$ 56,690	\$ 56,690 15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois		14,551	14,551 16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois		7,876	7,876 17
18	V	21 Supplies, Telephone, Postage		Lutheran Social Services of Illinois		3,966	3,966 18
19	V	34 Rental of Space		Lutheran Social Services of Illinois		1,291	1,291 19
20	V	5 Utilities		Lutheran Social Services of Illinois		1,377	1,377 20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		1,888	1,888 21
22	V	32 Interest		Lutheran Social Services of Illinois		2,563	2,563 22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois		837	837 23
24	V	26 Insurance		Lutheran Social Services of Illinois		3,504	3,504 24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois			
26	V	25 Transportation		Lutheran Social Services of Illinois		998	998 26
27	V	35 Car Rental		Lutheran Social Services of Illinois		20	20 27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois		1,508	1,508 28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		1,656	1,656 29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois			
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois		102	102 31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois		92	92 32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois		2,978	2,978 33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois			
35	V	6 Security & Waste Removal		Lutheran Social Services of Illinois		465	465 35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois		5,564	5,564 36
37	V	30 Depreciation		Lutheran Social Services of Illinois		9,059	9,059 37
38	V	19 Agency Management Allocation	116,984	Lutheran Social Services of Illinois			(116,984) 38
39	Total		\$ 116,984			\$ 116,985	\$ * 1 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		\$ 17,202	\$ 17,202 15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois		5,326	5,326 16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois		1,956	1,956 17
18	V	21 Supplies, Telephone, Postage		Lutheran Social Services of Illinois		527	527 18
19	V	34 Rental of Space		Lutheran Social Services of Illinois		5	5 19
20	V	5 Utilities		Lutheran Social Services of Illinois		12	12 20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		14	14 21
22	V	32 Interest		Lutheran Social Services of Illinois		26	26 22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois		11	11 23
24	V	26 Insurance		Lutheran Social Services of Illinois		636	636 24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois			
26	V	25 Transportation		Lutheran Social Services of Illinois		149	149 26
27	V	35 Car Rental		Lutheran Social Services of Illinois			
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois		679	679 28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		102	102 29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois			
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois			
32	V	35 Equipment Rental		Lutheran Social Services of Illinois			
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois		3,702	3,702 33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois		167	167 34
35	V	6 Security & Waste Removal		Lutheran Social Services of Illinois		1	1 35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois		77	77 36
37	V	30 Depreciation		Lutheran Social Services of Illinois		1,466	1,466 37
38	V	19 HR Allocation	31,993	Lutheran Social Services of Illinois			(31,993) 38
39	Total		\$ 31,993			\$ 32,058	\$ * 65 39

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

Facility Name & ID Number Shady Oaks West# 0040527Report Period Beginning: 07/01/19Ending: 06/30/20

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		\$ 199,219	\$ 199,219 15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois		66,043	66,043 16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois		21,970	21,970 17
18	V	21 Supplies, Telephone, Postage		Lutheran Social Services of Illinois		5,351	5,351 18
19	V	34 Rental of Space		Lutheran Social Services of Illinois		1,253	1,253 19
20	V	5 Utilities		Lutheran Social Services of Illinois		1,546	1,546 20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		1,573	1,573 21
22	V	32 Interest		Lutheran Social Services of Illinois		10,451	10,451 22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois		1,193	1,193 23
24	V	26 Insurance		Lutheran Social Services of Illinois		4,390	4,390 24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois		71	71 25
26	V	25 Transportation		Lutheran Social Services of Illinois		2,299	2,299 26
27	V	35 Car Rental		Lutheran Social Services of Illinois		148	148 27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois		1,826	1,826 28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		2,302	2,302 29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois		11	11 30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois			
32	V	35 Equipment Rental		Lutheran Social Services of Illinois		23	23 32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois		11,227	11,227 33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois		4,340	4,340 34
35	V	6 Security & Waste Removal		Lutheran Social Services of Illinois		138	138 35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois		77	77 36
37	V	30 Depreciation		Lutheran Social Services of Illinois		9,538	9,538 37
38	V	19 Service Network Admin Alloc	356,430	Lutheran Social Services of Illinois			(356,430) 38
39	Total		\$ 356,430			\$ 344,989	\$ * (11,441) 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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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		\$			\$	\$	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		\$			\$	\$ *	39

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	See attached Board of Directors								\$	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 West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	27,323,461	261	\$ 2,760,107	\$ 2,760,107	561,201	\$ 56,690	1
2	22	Empl Benefits & Taxes		27,323,461	261	708,439		561,201	14,551	2
3	19	Prof Fees & Contracts		27,323,461	261	383,458		561,201	7,876	3
4	21	Supplies, Telephone, Postage		27,323,461	261	193,080		561,201	3,966	4
5	34	Rental of Space		27,323,461	261	62,871		561,201	1,291	5
6	5	Utilities		27,323,461	261	67,064		561,201	1,377	6
7	6	Bldg Repairs & Maintenance		27,323,461	261	91,899		561,201	1,888	7
8	32	Interest		27,323,461	261	124,799		561,201	2,563	8
9	33	Real Estate Taxes		27,323,461	261	40,769		561,201	837	9
10	26	Insurance		27,323,461	261	170,596		561,201	3,504	10
11	20	Advertising & Promotions		27,323,461	261			561,201		11
12	25	Transportation		27,323,461	261	48,572		561,201	998	12
13	35	Car Rental		27,323,461	261	988		561,201	20	13
14	24	Conferences & Conventions		27,323,461	261	73,406		561,201	1,508	14
15	20	Subscriptions, Dues, Awards		27,323,461	261	80,607		561,201	1,656	15
16	6	Furniture & Fixtures		27,323,461	261			561,201		16
17	6	Machinery & Equipment		27,323,461	261	4,972		561,201	102	17
18	35	Equipment Rental		27,323,461	261	4,467		561,201	92	18
19	6	Equipment Repair & Maint.		27,323,461	261	144,978		561,201	2,978	19
20	20	Employee Recruitment		27,323,461	261			561,201		20
21	6	Security & Waste Removal		27,323,461	261	22,658		561,201	465	21
22	21	All Other Miscellaneous		27,323,461	261	270,916		561,201	5,564	22
23	30	Depreciation		27,323,461	261	441,071		561,201	9,059	23
24										24
25	TOTALS					\$ 5,695,717	\$ 2,760,107		\$ 116,985	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	46,883,610	261	\$ 940,027	\$ 940,027	857,938	\$ 17,202	1
2	22	Empl Benefits & Taxes	46,883,610	261	291,029		857,938	5,326	2
3	19	Prof Fees & Contracts	46,883,610	261	106,899		857,938	1,956	3
4	21	Supplies, Telephone, Postage	46,883,610	261	28,816		857,938	527	4
5	34	Rental of Space	46,883,610	261	300		857,938	5	5
6	5	Utilities	46,883,610	261	654		857,938	12	6
7	6	Bldg Repairs & Maintenance	46,883,610	261	743		857,938	14	7
8	32	Interest	46,883,610	261	1,398		857,938	26	8
9	33	Real Estate Taxes	46,883,610	261	606		857,938	11	9
10	26	Insurance	46,883,610	261	34,773		857,938	636	10
11	20	Advertising & Promotions	46,883,610	261			857,938		11
12	25	Transportation	46,883,610	261	8,135		857,938	149	12
13	35	Car Rental	46,883,610	261			857,938		13
14	24	Conferences & Conventions	46,883,610	261	37,098		857,938	679	14
15	20	Subscriptions, Dues, Awards	46,883,610	261	5,567		857,938	102	15
16	6	Furniture & Fixtures	46,883,610	261			857,938		16
17	6	Machinery & Equipment	46,883,610	261			857,938		17
18	35	Equipment Rental	46,883,610	261			857,938		18
19	6	Equipment Repair & Maint.	46,883,610	261	202,324		857,938	3,702	19
20	20	Employee Recruitment	46,883,610	261	9,143		857,938	167	20
21	6	Security & Waste Removal	46,883,610	261	50		857,938	1	21
22	21	All Other Miscellaneous	46,883,610	261	4,201		857,938	77	22
23	30	Depreciation	46,883,610	261	80,136		857,938	1,466	23
24									24
25	TOTALS				\$ 1,751,899	\$ 940,027		\$ 32,058	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	5,346,349	95	\$ 1,897,884	\$ 1,897,884	561,201	\$ 199,219	1
2	22	Empl Benefits & Taxes		5,346,349	95	629,164	561,201	66,043	2	
3	19	Prof Fees & Contracts		5,346,349	95	209,302	561,201	21,970	3	
4	21	Supplies, Telephone, Postage		5,346,349	95	50,977	561,201	5,351	4	
5	34	Rental of Space		5,346,349	95	11,936	561,201	1,253	5	
6	5	Utilities		5,346,349	95	14,729	561,201	1,546	6	
7	6	Bldg Repairs & Maintenance		5,346,349	95	14,986	561,201	1,573	7	
8	32	Interest		5,346,349	95	99,563	561,201	10,451	8	
9	33	Real Estate Taxes		5,346,349	95	11,361	561,201	1,193	9	
10	26	Insurance		5,346,349	95	41,820	561,201	4,390	10	
11	20	Advertising & Promotions		5,346,349	95	678	561,201	71	11	
12	25	Transportation		5,346,349	95	21,897	561,201	2,299	12	
13	35	Car Rental		5,346,349	95	1,411	561,201	148	13	
14	24	Conferences & Conventions		5,346,349	95	17,397	561,201	1,826	14	
15	20	Subscriptions, Dues, Awards		5,346,349	95	21,929	561,201	2,302	15	
16	6	Furniture & Fixtures		5,346,349	95	100	561,201	11	16	
17	6	Machinery & Equipment		5,346,349	95		561,201		17	
18	35	Equipment Rental		5,346,349	95	215	561,201	23	18	
19	6	Equipment Repair & Maint.		5,346,349	95	106,958	561,201	11,227	19	
20	20	Employee Recruitment		5,346,349	95	41,347	561,201	4,340	20	
21	6	Security & Waste Removal		5,346,349	95	1,319	561,201	138	21	
22	21	All Other Miscellaneous		5,346,349	95	737	561,201	77	22	
23	30	Depreciation		5,346,349	95	90,865	561,201	9,538	23	
24									24	
25	TOTALS					\$ 3,286,577	\$ 1,897,884		\$ 344,989	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending: 06/30/20

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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	Name of Lender	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			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
B. Non-Facility Related*																		
10	LSSI Allocation (Sch VIII)		X									13,040	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	13,040	14					
15	TOTALS (line 9+line14)						\$	\$			\$	13,040	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

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 2019 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2,041	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,041	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	2,041	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	_____	8
	2016	_____	9
	2017	_____	10
	2018	_____	11
	2019	_____	12

Allocated from LSSI: \$2,041

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks West COUNTY Will

FACILITY IDPH LICENSE NUMBER 0040527

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks West COUNTY Will

FACILITY IDPH LICENSE NUMBER 0040527

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,243 B. General Construction Type: Exterior Face Brick/Siding 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 West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		1994	\$ 541,423	\$ 13,536	40	\$ 13,536	\$	\$ 345,804	4
5		2014	1998	100,000		40	2,500	2,500	17,500	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1994	775		20			775	9
10	Various		1998	21,295		20	531	531	11,872	10
11	Various		1999	15,803		20			15,803	11
12	Various		2002	2,592		20			2,592	12
13	Various		2003	2,591		20			2,591	13
14	Various		2004	54,276		20			54,276	14
15	Various		2005	39,942		20			39,942	15
16	Various		2006	11,373		20			11,373	16
17	Various		2007	4,185		20			4,185	17
18	Various		2010	7,950		20	232	232	2,552	18
19	Various		2011	14,125		20	706	706	5,845	19
20	Various		2012	39,962		20	1,998	1,998	17,443	20
21	Various		2013	32,560		20	1,628	1,628	12,031	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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		9,322					9,322	67
68			20,063			(20,063)		68
69			24,417			(24,417)		69
70		\$ 898,174	\$ 58,016		\$ 21,131	\$ (36,885)	\$ 553,907	70

**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	Totals from Page 12A, Carried Forward		\$ 898,174	\$ 58,016		\$ 21,131	\$ (36,885)	\$ 553,907	1
2	Kitchen Remodel - Flooring, Plumbing, Sink	2017	23,254		20	1,163	1,163	4,650	2
3	Common Area - Flooring Replacement	2017	20,300		20	1,015	1,015	3,045	3
4	Commercial Metal Door Replacement - West Entrance	2019	7,643		20	382	382	764	4
5	Generator Upgrade - Transfer Switches, Breakers, Enclosures	2019	9,250		20	463	463	926	5
6	Replacement Of Fire Doors - West	2019	3,829		20	191	191	382	6
7	Installation Of New Flr Sink Receptor Under 4 Bathing Stations	2019	5,000		20	250	250	500	7
8	Hvac Replacement	2019	6,600		20	330	330	330	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)		\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	34

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	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		\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	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		\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	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)	\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	34

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	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)	\$ 974,049	\$ 58,016		\$ 24,925	\$ (33,091)	\$ 564,504	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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Management Assets- Security System	1999	9,322		20			9,322	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)		\$ 9,322	\$		\$	\$	\$ 9,322	34

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		\$ 9,322	\$		\$	\$	\$ 9,322	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)	\$ 9,322	\$		\$	\$	\$ 9,322	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	Allocation From LSSI			20,063			(20,063)		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)		\$	\$ 20,063		\$	\$ (20,063)	\$	34

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

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/19

Ending:

06/30/20

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		\$	\$ 20,063		\$	\$ (20,063)	\$
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		\$	\$ 20,063		\$	\$ (20,063)	\$

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

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	\$ 10,317	\$	\$ 1,032	\$ 1,032	10	\$ 7,789	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	70,015				10	70,015	73
74								74
75	TOTALS	\$ 80,332	\$	\$ 1,032	\$ 1,032		\$ 77,804	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										77
78										78
79										79
80	TOTALS			\$ 34,256	\$	\$	\$		\$ 34,256	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)	\$ 1,088,637	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,016	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,957	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,059)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 676,564	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?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	Parker Storage			3,000			5
6	LSSI Alloc. (Sch VIII)			2,549			6
7	TOTAL			\$ 5,549			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: \$ 115 Description: See Attached

(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	Facility		\$	\$ 3,786	17
18	LSSI Alloc. (Sch VIII)			168	18
19					19
20					20
21	TOTAL		\$	\$ 3,954	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. _____ /2021 \$ _____

13. _____ /2022 \$ _____

14. _____ /2023 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	39 - 03	hrs	\$		\$ 420	\$		\$ 420	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	39 - 03	visits			15,459			15,459	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			\$		\$ 15,879	\$		\$ 15,879	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/20

(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	\$	\$	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	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning: 07/01/19

Ending: 06/30/20

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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,277,217	1
2	Discounts and Allowances for all Levels	49,041	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,326,258	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		9,778	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,778	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,336,036	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	277,138	31
32	Health Care	780,694	32
33	General Administration	824,536	33
B. Capital Expense			
34	Ownership	44,950	34
C. Ancillary Expense			
35	Special Cost Centers	15,879	35
36	Provider Participation Fee	78,334	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,021,531	40
41	Income before Income Taxes (line 30 minus line 40)**	(685,495)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (685,495)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,266,640	44
45	Private Pay - Net Inpatient Revenue	59,618	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,326,258	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 West**

0040527

Report Period Beginning: **07/01/19**

Ending:

06/30/20

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	1,585	49,075	26.53	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,468	30,799	18.94	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	1,335	28,945	19.48	13
14	Head Cook	2,031	25,978	12.07	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	739	17,395	18.72	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	748	24,122	29.13	20
21	Assistant Administrator				21
22	Other Administrative	2,811	62,987	20.71	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)	1,760	42,181	20.87	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	27,984	409,029	15.91	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	40,461	\$ 690,511 *	\$ 17.42	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	\$ 950	01-03	35
36	Medical Director	As Needed	3,499	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	9,668	10-03	38
39	Pharmacist Consultant	As Needed	651	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist	As Needed	15,956	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,724		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	25,746	10-03	51
52	Certified Nurse Assistants/Aides	As Needed	74,062	10-03	52
53	TOTAL (lines 50 - 52)		\$ 99,808		53

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning: 07/01/19

Ending: 06/30/20

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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,223 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 78,334
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly Virchow Krause LLP
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.