

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0039263 Facility Name: Shady Oaks East Address: 16240 Parker Road Lockport 60441 County: Will Telephone Number: (708)301-6870 Fax # (708)301-6878 HFS ID Number: Date of Initial License for Current Owners: 1994 Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code 501 C(3) PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/15 to 06/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

Facility Name & ID Number Shady Oaks East

0039263 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1	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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	<u>5,022</u>			<u>5,022</u>	13
14	TOTALS	<u>5,022</u>			<u>5,022</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.76%

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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	44,165	2,187	1,535	47,887		47,887		47,887			1
2	Food Purchase		34,698		34,698		34,698		34,698			2
3	Housekeeping		1,558		1,558		1,558		1,558			3
4	Laundry		1,310		1,310		1,310		1,310			4
5	Heat and Other Utilities			1,004	1,004		1,004	223	1,227			5
6	Maintenance	13,577	4,922	53,024	71,523		71,523	2,984	74,507			6
7	Other (specify):*							464	464			7
8	TOTAL General Services	57,742	44,675	55,563	157,980		157,980	3,671	161,651			8
	B. Health Care and Programs											
9	Medical Director			4,704	4,704		4,704		4,704			9
10	Nursing and Medical Records	322,136	16,297	89,441	427,874		427,874		427,874			10
10a	Therapy			210	210		210		210			10a
11	Activities	19,232	138		19,370		19,370		19,370			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	341,368	16,435	94,355	452,158		452,158		452,158			16
	C. General Administration											
17	Administrative	83,467			83,467		83,467	121,504	204,971			17
18	Directors Fees											18
19	Professional Services			237,582	237,582		237,582	(210,958)	26,624			19
20	Dues, Fees, Subscriptions & Promotions			250	250		250	3,192	3,442			20
21	Clerical & General Office Expenses		494	7,313	7,807		7,807	6,573	14,380			21
22	Employee Benefits & Payroll Taxes			210,885	210,885		210,885	32,059	242,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			298	298		298	13,257	13,555			24
25	Other Admin. Staff Transportation			1,458	1,458		1,458	2,385	3,843			25
26	Insurance-Prop.Liab.Malpractice			10,513	10,513		10,513	2,948	13,461			26
27	Other (specify):*											27
28	TOTAL General Administration	83,467	494	468,299	552,260		552,260	(29,040)	523,220			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	482,577	61,604	618,217	1,162,398		1,162,398	(25,369)	1,137,029			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,892	23,892		23,892	12,527	36,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3,356	3,356			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			17,044	17,044		17,044	(2,237)	14,807			34
35	Rent-Equipment & Vehicles			8	8		8	363	371			35
36	Other (specify):*											36
37	TOTAL Ownership			40,944	40,944		40,944	14,009	54,953			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,504	1,504		1,504		1,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,432	63,432		63,432		63,432			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			64,936	64,936		64,936		64,936			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	482,577	61,604	724,097	1,268,278		1,268,278	(11,360)	1,256,918			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(6,480)	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	(3,290)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,770)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,590)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,590)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (11,360)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized R&M	\$ (2,800)	06	1
2	Non-Allowable Legal Fees	(490)	19	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	(3,290)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/15 Ending: 06/30/16

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			223									223	5
6	Maintenance	(2,800)		2,411	222	3,151							2,984	6
7	Other (specify):*			346		118							464	7
8	TOTAL General Services	(2,800)		2,980	222	3,269							3,671	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			30,677	13,277	77,550							121,504	17
18	Directors Fees													18
19	Professional Services	(490)		(60,008)	(21,849)	(128,611)							(210,958)	19
20	Fees, Subscriptions & Promotions			322	2,179	691							3,192	20
21	Clerical & General Office Expenses			3,801	713	2,059							6,573	21
22	Employee Benefits & Payroll Taxes			8,793	4,240	19,026							32,059	22
23	Inservice Training & Education													23
24	Travel and Seminar			257	491	12,509							13,257	24
25	Other Admin. Staff Transportation			580	94	1,711							2,385	25
26	Insurance-Prop.Liab.Malpractice			2,002	143	803							2,948	26
27	Other (specify):*													27
28	TOTAL General Administration	(490)		(13,576)	(712)	(14,262)							(29,040)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(3,290)		(10,596)	(490)	(10,993)							(25,369)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,480)	13,971	3,506	126	1,404							12,527	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			393	4	2,959							3,356	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(13,971)	6,594	358	4,782							(2,237)	34
35	Rent-Equipment & Vehicles			105	4	254							363	35
36	Other (specify):*													36
37	TOTAL Ownership	(6,480)		10,598	492	9,399							14,009	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)	(9,770)		2	2	(1,594)							(11,360)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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:	
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)	
1	V	34	Rental of Space	\$ 13,971	Vesper Management	100.00%	\$	(13,971)	1
2	V	30	Depreciation		Vesper Management	100.00%	13,971	13,971	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			\$ 13,971			\$ 13,971	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 <u>Salaries & Wages</u>	\$	<u>Lutheran Social Services of Illinois</u>	100.00%	\$ 30,677	\$ 30,677	15
16	V	22 <u>Empl Benefits & Taxes</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	8,793	8,793	16
17	V	19 <u>Prof Fees & Contracts</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	7,560	7,560	17
18	V	21 <u>Supplies, Telephone,</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	1,671	1,671	18
19	V	34 <u>Rental of Space</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	6,594	6,594	19
20	V	5 <u>Utilities</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	223	223	20
21	V	6 <u>Bldg Repairs & Maintenance</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	41	41	21
22	V	32 <u>Interest</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	393	393	22
23	V	33 <u>Real Estate Taxes</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			23
24	V	26 <u>Insurance</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	2,002	2,002	24
25	V	20 <u>Advertising & Promotions</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			25
26	V	25 <u>Transportation</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	580	580	26
27	V	35 <u>Car Rental</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	17	17	27
28	V	24 <u>Conferences & Conventions</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	257	257	28
29	V	20 <u>Subscriptions, Dues, Awards</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	322	322	29
30	V	6 <u>Furniture & Fixtures</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			30
31	V	6 <u>Machinery & Equipment</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	5	5	31
32	V	35 <u>Equipment Rental</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	88	88	32
33	V	6 <u>Equipment Repair & Maint.</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	2,365	2,365	33
34	V	20 <u>Employee Recruitment</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			34
35	V	7 <u>Security & Waste Removal</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	346	346	35
36	V	21 <u>All Other Miscellaneous</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	2,130	2,130	36
37	V	30 <u>Depreciation</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	3,506	3,506	37
38	V	19 <u>Agency Management Allocation</u>	67,568	<u>Lutheran Social Services of Illinois</u>	100.00%		(67,568)	38
39	Total		\$ 67,568			\$ 67,570	\$ * 2	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 <u>Salaries & Wages</u>	\$	<u>Lutheran Social Services of Illinois</u>	100.00%	\$ 13,277	\$ 13,277	15
16	V	22 <u>Empl Benefits & Taxes</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	4,240	4,240	16
17	V	19 <u>Prof Fees & Contracts</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	4,983	4,983	17
18	V	21 <u>Supplies, Telephone,</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	548	548	18
19	V	34 <u>Rental of Space</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	358	358	19
20	V	5 <u>Utilities</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			20
21	V	6 <u>Bldg Repairs & Maintenance</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			21
22	V	32 <u>Interest</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	4	4	22
23	V	33 <u>Real Estate Taxes</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			23
24	V	26 <u>Insurance</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	143	143	24
25	V	20 <u>Advertising & Promotions</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			25
26	V	25 <u>Transportation</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	94	94	26
27	V	35 <u>Car Rental</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	4	4	27
28	V	24 <u>Conferences & Conventions</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	491	491	28
29	V	20 <u>Subscriptions, Dues, Awards</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	47	47	29
30	V	6 <u>Furniture & Fixtures</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			30
31	V	6 <u>Machinery & Equipment</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			31
32	V	35 <u>Equipment Rental</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			32
33	V	6 <u>Equipment Repair & Maint.</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	222	222	33
34	V	20 <u>Employee Recruitment</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	2,132	2,132	34
35	V	7 <u>Security & Waste Removal</u>		<u>Lutheran Social Services of Illinois</u>	100.00%			35
36	V	21 <u>All Other Miscellaneous</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	165	165	36
37	V	30 <u>Depreciation</u>		<u>Lutheran Social Services of Illinois</u>	100.00%	126	126	37
38	V	19 <u>HR Allocation</u>	26,832	<u>Lutheran Social Services of Illinois</u>	100.00%		(26,832)	38
39	Total		\$ 26,832			\$ 26,834	\$ * 2	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.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		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		\$ 77,550	\$ 77,550	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		19,026	19,026	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		11,572	11,572	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois		2,039	2,039	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		4,782	4,782	19
20	V	5	Utilities		Lutheran Social Services of Illinois				20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		25	25	21
22	V	32	Interest		Lutheran Social Services of Illinois		2,959	2,959	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois				23
24	V	26	Insurance		Lutheran Social Services of Illinois		803	803	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois				25
26	V	25	Transportation		Lutheran Social Services of Illinois		1,711	1,711	26
27	V	35	Car Rental		Lutheran Social Services of Illinois		239	239	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		12,509	12,509	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		691	691	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois				30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois				31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois		15	15	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois		3,126	3,126	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois				34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois		118	118	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois		20	20	36
37	V	30	Depreciation		Lutheran Social Services of Illinois		1,404	1,404	37
38	V	19	Service Network Admin Alloc	140,183	Lutheran Social Services of Illinois			(140,183)	38
39	Total			\$ 140,183			\$ 138,589	\$ * (1,594)	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.

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.

YESNO

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.

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.

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.

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.

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.

YESNO

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.

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

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)

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
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0039263

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	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 East# 0039263

Report Period Beginning:

07/01/15Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	17	Salaries & Wages	Non-Capital Direct Costs	26,151,510	185	\$ 2,535,351	\$ 2,535,351	316,422	\$ 30,677	1
2	22	Empl Benefits & Taxes		26,151,510	185	726,725		316,422	8,793	2
3	19	Prof Fees & Contracts		26,151,510	185	624,795		316,422	7,560	3
4	21	Supplies, Telephone,		26,151,510	185	138,099		316,422	1,671	4
5	34	Rental of Space		26,151,510	185	544,960		316,422	6,594	5
6	5	Utilities		26,151,510	185	18,444		316,422	223	6
7	6	Bldg Repairs & Maintenance		26,151,510	185	3,418		316,422	41	7
8	32	Interest		26,151,510	185	32,453		316,422	393	8
9	33	Real Estate Taxes		26,151,510	185			316,422		9
10	26	Insurance		26,151,510	185	165,492		316,422	2,002	10
11	20	Advertising & Promotions		26,151,510	185			316,422		11
12	25	Transportation		26,151,510	185	47,915		316,422	580	12
13	35	Car Rental		26,151,510	185	1,379		316,422	17	13
14	24	Conferences & Conventions		26,151,510	185	21,217		316,422	257	14
15	20	Subscriptions, Dues, Awards		26,151,510	185	26,634		316,422	322	15
16	6	Furniture & Fixtures		26,151,510	185			316,422		16
17	6	Machinery & Equipment		26,151,510	185	440		316,422	5	17
18	35	Equipment Rental		26,151,510	185	7,257		316,422	88	18
19	6	Equipment Repair & Maint.		26,151,510	185	195,435		316,422	2,365	19
20	20	Employee Recruitment		26,151,510	185			316,422		20
21	7	Security & Waste Removal		26,151,510	185	28,584		316,422	346	21
22	21	All Other Miscellaneous		26,151,510	185	176,048		316,422	2,130	22
23	30	Depreciation		26,151,510	185	289,744		316,422	3,506	23
24										24
25	TOTALS					\$ 5,584,390	\$ 2,535,351		\$ 67,570	25

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/15Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	17	Salaries & Wages	Salaries & Benefits	46,846,035	185	\$ 896,911	\$ 896,911	693,457	\$ 13,277	1
2	22	Empl Benefits & Taxes		46,846,035	185	286,421		693,457	4,240	2
3	19	Prof Fees & Contracts		46,846,035	185	336,598		693,457	4,983	3
4	21	Supplies, Telephone,		46,846,035	185	37,031		693,457	548	4
5	34	Rental of Space		46,846,035	185	24,169		693,457	358	5
6	5	Utilities		46,846,035	185			693,457		6
7	6	Bldg Repairs & Maintenance		46,846,035	185			693,457		7
8	32	Interest		46,846,035	185	294		693,457	4	8
9	33	Real Estate Taxes		46,846,035	185			693,457		9
10	26	Insurance		46,846,035	185	9,645		693,457	143	10
11	20	Advertising & Promotions		46,846,035	185			693,457		11
12	25	Transportation		46,846,035	185	6,329		693,457	94	12
13	35	Car Rental		46,846,035	185	272		693,457	4	13
14	24	Conferences & Conventions		46,846,035	185	33,157		693,457	491	14
15	20	Subscriptions, Dues, Awards		46,846,035	185	3,177		693,457	47	15
16	6	Furniture & Fixtures		46,846,035	185			693,457		16
17	6	Machinery & Equipment		46,846,035	185			693,457		17
18	35	Equipment Rental		46,846,035	185			693,457		18
19	6	Equipment Repair & Maint.		46,846,035	185	14,968		693,457	222	19
20	20	Employee Recruitment		46,846,035	185	144,033		693,457	2,132	20
21	7	Security & Waste Removal		46,846,035	185			693,457		21
22	21	All Other Miscellaneous		46,846,035	185	11,173		693,457	165	22
23	30	Depreciation		46,846,035	185	8,500		693,457	126	23
24										24
25	TOTALS					\$ 1,812,678	\$ 896,911		\$ 26,834	25

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/15Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	17	Salaries & Wages	Non-Capital Direct Costs	4,061,226	60	\$ 995,341	\$ 995,341	316,422	\$ 77,550	1
2	22	Empl Benefits & Taxes		4,061,226	60	244,201		316,422	19,026	2
3	19	Prof Fees & Contracts		4,061,226	60	148,524		316,422	11,572	3
4	21	Supplies, Telephone,		4,061,226	60	26,167		316,422	2,039	4
5	34	Rental of Space		4,061,226	60	61,379		316,422	4,782	5
6	5	Utilities		4,061,226	60			316,422		6
7	6	Bldg Repairs & Maintenance		4,061,226	60	325		316,422	25	7
8	32	Interest		4,061,226	60	37,981		316,422	2,959	8
9	33	Real Estate Taxes		4,061,226	60			316,422		9
10	26	Insurance		4,061,226	60	10,305		316,422	803	10
11	20	Advertising & Promotions		4,061,226	60			316,422		11
12	25	Transportation		4,061,226	60	21,960		316,422	1,711	12
13	35	Car Rental		4,061,226	60	3,066		316,422	239	13
14	24	Conferences & Conventions		4,061,226	60	160,554		316,422	12,509	14
15	20	Subscriptions, Dues, Awards		4,061,226	60	8,870		316,422	691	15
16	6	Furniture & Fixtures		4,061,226	60			316,422		16
17	6	Machinery & Equipment		4,061,226	60			316,422		17
18	35	Equipment Rental		4,061,226	60	198		316,422	15	18
19	6	Equipment Repair & Maint.		4,061,226	60	40,125		316,422	3,126	19
20	20	Employee Recruitment		4,061,226	60			316,422		20
21	7	Security & Waste Removal		4,061,226	60	1,513		316,422	118	21
22	21	All Other Miscellaneous		4,061,226	60	263		316,422	20	22
23	30	Depreciation		4,061,226	60	18,025		316,422	1,404	23
24										24
25	TOTALS					\$ 1,778,796	\$ 995,341		\$ 138,589	25

Ending: 06/30/16

Ending: 06/30/16

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

IL478-2471

Ending: 06/30/16

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

Ending: 06/30/16

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	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

Ending: 06/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		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	LSSI Allocation (Sch VIII)		X									3,356	6
7													7
8					-								8
9	TOTAL Facility Related						\$					\$ 3,356	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 3,356	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 - 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				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							\$				\$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							\$				\$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

2015 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) 236-6300 FAX #: (847) 236-6301

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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 providecopies of their original second installment tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 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) 236-6300

FAX #:

(847) 236-6301

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</u> <u>Applicable to</u> <u>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.

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

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	\$ 2,500	\$ 314,421	4	
5			2014	1998	100,000		40	2,500		7,500	5	
6											6	
7											7	
8											8	
	Improvement Type**											
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	14,638	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			37,125	15	
16	Various			2006	20,578		20	1,454	1,454	20,578	16	
17	Various			2007	3,180		20	318	318	2,955	17	
18	Various			2011	13,917		20	696	696	3,675	18	
19	Various			2012	48,019		20	2,401	2,401	11,049	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

Facility Name & ID Number Shady Oaks East

0039263

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		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	Related Building Company (Pages 12F & 12G)		9,905					9,905	67
68	Related Party Allocations (Pages 12H & 12I)			5,036			(5,036)		68
69	Financial Statement Depreciation			23,892			(23,892)		69
70	TOTAL (lines 4 thru 69)		\$ 878,742	\$ 42,899		\$ 22,226	\$ (20,673)	\$ 488,458	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:

07/01/15

Ending:

06/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 878,742	\$ 42,899		\$ 22,226	\$ (20,673)	\$ 488,458	1
2	Plumbing Work	2013	15,950		20	798	798	2,394	2
3	Paving Of Driveway & Parking Areas	2014	15,651		20	783	783	2,349	3
4	Repave Driveway/Parking Areas	2014	15,651		20	783	783	1,565	4
5	Condenser Replacement	2015	2,800		20	140	140	140	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)		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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:

07/01/15

Ending:

06/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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
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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)		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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	Totals from Page 12C, Carried Forward		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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)		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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	Totals from Page 12D, Carried Forward		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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)		\$ 928,794	\$ 42,899		\$ 24,730	\$ (18,170)	\$ 494,905	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:

07/01/15

Ending:

06/30/16

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	9,905		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 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 12F, Carried Forward		\$ 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	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 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			5,036			(5,036)		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)		\$	\$ 5,036		\$	\$ (5,036)	\$	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	Totals from Page 12H, Carried Forward		\$	\$ 5,036		\$	\$ (5,036)	\$	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)		\$	\$ 5,036		\$	\$ (5,036)	\$	34

**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	\$ 29,748	\$	\$ 2,976	\$ 2,976	10	\$ 14,823	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	73,617				10	73,617	73
74								74
75	TOTALS	\$ 103,365	\$	\$ 2,976	\$ 2,976		\$ 88,440	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	26,142	77
78										78
79										79
80	TOTALS			\$ 77,825	\$	\$ 8,714	\$ 8,714		\$ 60,398	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)	\$ 1,109,984	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,899	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,419	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,480)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 643,743	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				3,073			5
6	LSSI Alloc. (Sch VIII)				11,734			6
7	TOTAL				\$ 14,807			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: \$ 103
- 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	Car Rental		\$	\$ 8	17
18	LSSI Alloc. (Sch VIII)			260	18
19					19
20					20
21	TOTAL		\$ -	\$ 268	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. /2017 \$
13. /2018 \$
14. /2019 \$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 210	\$		\$ 210	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			1,294			1,294	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$ 1,504	\$		\$ 1,504	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.
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
36	Other Current Liabilities(specify):			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
43	Other Long-Term Liabilities(specify):			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 East

0039263

Report Period Beginning: 07/01/15

Ending: 06/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,021,072	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,021,072	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	23,045	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,045	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,044,117	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	157,980	31
32	Health Care	452,158	32
33	General Administration	552,260	33
	B. Capital Expense		
34	Ownership	40,944	34
	C. Ancillary Expense		
35	Special Cost Centers	1,504	35
36	Provider Participation Fee	63,432	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,268,278	40
41	Income before Income Taxes (line 30 minus line 40)**	(224,161)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (224,161)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 865,062	44
45	Private Pay - Net Inpatient Revenue	156,010	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)	\$ 1,021,072	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.

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	1,891	2,185	49,538	22.67	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	954	1,112	19,232	17.29	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	814	975	18,629	19.11	13
14	Head Cook	2,088	2,361	25,536	10.82	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	577	663	13,577	20.48	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	569	724	22,897	31.63	20
21	Assistant Administrator					21
22	Other Administrative	2,808	3,167	60,570	19.13	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)	1,260	1,468	32,182	21.92	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,605	19,508	240,416	12.32	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,566	32,163	\$ 482,577 *	\$ 15.00	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	\$ 1,535	01-03	35
36	Medical Director	As Needed	4,704	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	7,802	10-03	38
39	Pharmacist Consultant	As Needed	309	10-03	39
40	Physical Therapy Consultant	As Needed	210	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					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,560		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	26,746	10-03	51
52	Certified Nurse Assistants/Aides	As Needed	54,584	10-03	52
53	TOTAL (lines 50 - 52)		\$ 81,330		53

STATE OF ILLINOIS

Facility Name & ID NumberShady Oaks East# 0039263Report Period Beginning: 07/01/15Ending: 06/30/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristen Stockle	Administrator	0	\$ 11,791
Daniel Asensio	Administrator	0	11,106
Kevin Bercaw	Assoc. Exec. Dir.	0	5,945
Laterria Bass	Other Admin	0	20,473
Amy Bandstra	Other Admin	0	21,718
Tetyana Kostyshyna	Other Admin	0	4,589
See Supplemental Schedule			7,845
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,468

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 2,500
LSSI	Management Services	234,584
Johnson & Colmar	Legal (Adj.out p. 5A)	499
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 237,582

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 37,677
Unemployment Compensation Insurance	41,160
FICA Taxes	35,405
Employee Health Insurance	67,429
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability/Life Insurance	1,471
Pension Expense	27,742
LSSI Alloc. (Sch. VIII)	32,059
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Membership Dues	100
Licenses	150
LSSI Alloc. (Sch. VIII)	3,192
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	298
LSSI Alloc. (Sch. VIII)	13,257
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 13,555

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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.

\$

5,711

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.

\$

63,432

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 benefit on Schedule V.

\$

N/A

Has any meal income been offset against related costs?

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.

N/A

Attach invoices and a summary of services for all architect and appraisal fees

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