

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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
Number City Zip Code

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:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/19 to 06/30/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date) _____
* Subject to the attached Accountants' Consulting Report
(Print Name and Title) Steven N. Lavenda, CPA Partner
(Firm Name & Address) Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

#	0039263	Report Period Beginning:	07/01/19	Ending:	06/30/20
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D. How many bed reserve days during this year were paid by the Department?

294 (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 5/17/1993

YES ☒ Date **January 1993** NO ☐

YES ☐ NO ☒ If YES, enter number
of beds certified and days of care provided N/A

IV. ACCOUNTING BASIS

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

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

	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	5,353			5,353	13
14	TOTALS	5,353			5,353	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **91.41 %**

Facility Name & ID Number Shady Oaks East # 0039263 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	123,518	3,719	1,582	128,819		128,819		128,819			1
2	Food Purchase		40,151		40,151		40,151		40,151			2
3	Housekeeping		3,281		3,281		3,281		3,281			3
4	Laundry		2,683		2,683		2,683		2,683			4
5	Heat and Other Utilities			1,562	1,562		1,562	2,450	4,012			5
6	Maintenance	18,286	7,259	136,019	161,564		161,564	21,988	183,552			6
7	Other (specify):*											7
8	TOTAL General Services	141,804	57,093	139,163	338,060		338,060	24,438	362,498			8
	B. Health Care and Programs											
9	Medical Director			3,106	3,106		3,106		3,106			9
10	Nursing and Medical Records	453,117	31,813	81,282	566,212		566,212	(217)	565,995			10
10a	Therapy											10a
11	Activities	78,231	107		78,338		78,338		78,338			11
12	Social Services			14,456	14,456		14,456		14,456			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Dev. Disabilities			60,505	60,505		60,505		60,505			15
16	TOTAL Health Care and Programs	531,348	31,920	159,349	722,617		722,617	(217)	722,400			16
	C. General Administration											
17	Administrative	92,089			92,089		92,089	232,193	324,282			17
18	Directors Fees											18
19	Professional Services			433,557	433,557		433,557	(402,706)	30,851			19
20	Dues, Fees, Subscriptions & Promotions			99	99		99	7,272	7,371			20
21	Clerical & General Office Expenses		414	14,069	14,483		14,483	13,132	27,615			21
22	Employee Benefits & Payroll Taxes			176,308	176,308		176,308	73,024	249,332			22
23	Inservice Training & Education											23
24	Travel and Seminar			443	443		443	3,524	3,967			24
25	Other Admin. Staff Transportation			371	371		371	2,911	3,282			25
26	Insurance-Prop.Liab.Malpractice			23,592	23,592		23,592	7,278	30,870			26
27	Other (specify):*											27
28	TOTAL General Administration	92,089	414	648,439	740,942		740,942	(63,372)	677,570			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	765,241	89,427	946,951	1,801,619		1,801,619	(39,151)	1,762,468			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			33,698	33,698		33,698	1,270	34,968			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							10,877	10,877			32
33	Real Estate Taxes							1,704	1,704			33
34	Rent-Facility & Grounds			17,016	17,016		17,016	(11,890)	5,126			34
35	Rent-Equipment & Vehicles			5,698	5,698		5,698	235	5,933			35
36	Other (specify):*			170	170		170		170			36
37	TOTAL Ownership			56,582	56,582		56,582	2,196	58,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			934	934		934		934			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,126	74,126		74,126		74,126			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			75,060	75,060		75,060		75,060			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	765,241	89,427	1,078,593	1,933,261		1,933,261	(36,955)	1,896,306			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	(29,811)	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	2,370			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,441)		\$	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)	(9,514)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (9,514)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (36,955)		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	Clothing & Personal Supplies	\$ (82)	10	1
2	Other Personal Needs	(135)	10	2
3	Additional R&M	2,587	06	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,370		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks East # 0039263 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			1,148	13	1,289							2,450	5
6	Maintenance	2,587		4,528	4,079	10,794							21,988	6
7	Other (specify):*													7
8	TOTAL General Services	2,587		5,676	4,092	12,083							24,438	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(217)											(217)	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	(217)											(217)	16
	C. General Administration													
17	Administrative			47,255	18,878	166,060							232,193	17
18	Directors Fees													18
19	Professional Services			(90,950)	(32,965)	(278,792)							(402,706)	19
20	Fees, Subscriptions & Promotions			1,380	296	5,596							7,272	20
21	Clerical & General Office Expenses			7,944	663	4,525							13,132	21
22	Employee Benefits & Payroll Taxes			12,129	5,845	55,050							73,024	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,257	745	1,522							3,524	24
25	Other Admin. Staff Transportation			832	163	1,916							2,911	25
26	Insurance-Prop.Liab.Malpractice			2,921	698	3,659							7,278	26
27	Other (specify):*													27
28	TOTAL General Administration			(17,232)	(5,677)	(40,464)							(63,372)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	2,370		(11,556)	(1,585)	(28,381)							(39,151)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks East # 0039263 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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(29,811)	13,971	7,551	1,609	7,950							1,270	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			2,137	28	8,712							10,877	32
33	Real Estate Taxes			698	12	994							1,704	33
34	Rent-Facility & Grounds		(14,016)	1,076	6	1,044							(11,890)	34
35	Rent-Equipment & Vehicles			93		142							235	35
36	Other (specify):*													36
37	TOTAL Ownership	(29,811)	(45)	11,555	1,655	18,842							2,196	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)	(27,441)	(45)	(1)	70	(9,539)							(36,955)	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 Page 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	\$ 14,016	Vesper Management		\$	\$ (14,016)	1
2	V	30	Depreciation		Vesper Management		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			\$ 14,016			\$ 13,971	\$ * (45)	14

* 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
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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
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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		\$ 47,255	\$ 47,255	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		12,129	12,129	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		6,565	6,565	17
18	V	21	Supplies, Telephone, Postage		Lutheran Social Services of Illinois		3,306	3,306	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		1,076	1,076	19
20	V	5	Utilities		Lutheran Social Services of Illinois		1,148	1,148	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		2,137	2,137	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois		698	698	23
24	V	26	Insurance		Lutheran Social Services of Illinois		2,921	2,921	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois				25
26	V	25	Transportation		Lutheran Social Services of Illinois		832	832	26
27	V	35	Car Rental		Lutheran Social Services of Illinois		17	17	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		1,257	1,257	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		1,380	1,380	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois				30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois		85	85	31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois		76	76	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois		2,482	2,482	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois				34
35	V	6	Security & Waste Removal		Lutheran Social Services of Illinois		388	388	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois		4,638	4,638	36
37	V	30	Depreciation		Lutheran Social Services of Illinois		7,551	7,551	37
38	V	19	Agency Management Allocation	97,515	Lutheran Social Services of Illinois			(97,515)	38
39	Total			\$ 97,515			\$ 97,514	\$ * (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		\$ 18,878	\$ 18,878	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		5,845	5,845	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		2,147	2,147	17
18	V	21	Supplies, Telephone, Postage		Lutheran Social Services of Illinois		579	579	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		6	6	19
20	V	5	Utilities		Lutheran Social Services of Illinois		13	13	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		15	15	21
22	V	32	Interest		Lutheran Social Services of Illinois		28	28	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois		12	12	23
24	V	26	Insurance		Lutheran Social Services of Illinois		698	698	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois				25
26	V	25	Transportation		Lutheran Social Services of Illinois		163	163	26
27	V	35	Car Rental		Lutheran Social Services of Illinois				27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		745	745	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		112	112	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				32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois		4,063	4,063	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois		184	184	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		84	84	36
37	V	30	Depreciation		Lutheran Social Services of Illinois		1,609	1,609	37
38	V	19	HR Allocation	35,112	Lutheran Social Services of Illinois			(35,112)	38
39	Total			\$ 35,112			\$ 35,182	\$ * 70	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		\$ 166,060	\$ 166,060	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		55,050	55,050	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		18,313	18,313	17
18	V	21	Supplies, Telephone, Postage		Lutheran Social Services of Illinois		4,460	4,460	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		1,044	1,044	19
20	V	5	Utilities		Lutheran Social Services of Illinois		1,289	1,289	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		1,311	1,311	21
22	V	32	Interest		Lutheran Social Services of Illinois		8,712	8,712	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois		994	994	23
24	V	26	Insurance		Lutheran Social Services of Illinois		3,659	3,659	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois		59	59	25
26	V	25	Transportation		Lutheran Social Services of Illinois		1,916	1,916	26
27	V	35	Car Rental		Lutheran Social Services of Illinois		123	123	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		1,522	1,522	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		1,919	1,919	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois		9	9	30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois				31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois		19	19	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois		9,359	9,359	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois		3,618	3,618	34
35	V	6	Security & Waste Removal		Lutheran Social Services of Illinois		115	115	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois		65	65	36
37	V	30	Depreciation		Lutheran Social Services of Illinois		7,950	7,950	37
38	V	19	Service Network Admin Alloc	297,105	Lutheran Social Services of Illinois			(297,105)	38
39	Total			\$ 297,105			\$ 287,566	\$ * (9,539)	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.

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.

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.

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.

Facility Name & ID Number Shady Oaks East # 0039263 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
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 East# 0039263

Report Period Beginning:

07/01/19Ending: 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		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	27,323,461	261	\$ 2,760,107	\$ 2,760,107	467,793	\$ 47,255	1
2	22	Empl Benefits & Taxes		27,323,461	261	708,439		467,793	12,129	2
3	19	Prof Fees & Contracts		27,323,461	261	383,458		467,793	6,565	3
4	21	Supplies, Telephone, Postage		27,323,461	261	193,080		467,793	3,306	4
5	34	Rental of Space		27,323,461	261	62,871		467,793	1,076	5
6	5	Utilities		27,323,461	261	67,064		467,793	1,148	6
7	6	Bldg Repairs & Maintenance		27,323,461	261	91,899		467,793	1,573	7
8	32	Interest		27,323,461	261	124,799		467,793	2,137	8
9	33	Real Estate Taxes		27,323,461	261	40,769		467,793	698	9
10	26	Insurance		27,323,461	261	170,596		467,793	2,921	10
11	20	Advertising & Promotions		27,323,461	261			467,793		11
12	25	Transportation		27,323,461	261	48,572		467,793	832	12
13	35	Car Rental		27,323,461	261	988		467,793	17	13
14	24	Conferences & Conventions		27,323,461	261	73,406		467,793	1,257	14
15	20	Subscriptions, Dues, Awards		27,323,461	261	80,607		467,793	1,380	15
16	6	Furniture & Fixtures		27,323,461	261			467,793		16
17	6	Machinery & Equipment		27,323,461	261	4,972		467,793	85	17
18	35	Equipment Rental		27,323,461	261	4,467		467,793	76	18
19	6	Equipment Repair & Maint.		27,323,461	261	144,978		467,793	2,482	19
20	20	Employee Recruitment		27,323,461	261			467,793		20
21	6	Security & Waste Removal		27,323,461	261	22,658		467,793	388	21
22	21	All Other Miscellaneous		27,323,461	261	270,916		467,793	4,638	22
23	30	Depreciation		27,323,461	261	441,071		467,793	7,551	23
24										24
25	TOTALS					\$ 5,695,717	\$ 2,760,107		\$ 97,514	25

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/19Ending: 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		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	46,883,610	261	\$ 940,027	\$ 940,027	941,553	\$ 18,878	1
2	22	Empl Benefits & Taxes		46,883,610	261	291,029		941,553	5,845	2
3	19	Prof Fees & Contracts		46,883,610	261	106,899		941,553	2,147	3
4	21	Supplies, Telephone, Postage		46,883,610	261	28,816		941,553	579	4
5	34	Rental of Space		46,883,610	261	300		941,553	6	5
6	5	Utilities		46,883,610	261	654		941,553	13	6
7	6	Bldg Repairs & Maintenance		46,883,610	261	743		941,553	15	7
8	32	Interest		46,883,610	261	1,398		941,553	28	8
9	33	Real Estate Taxes		46,883,610	261	606		941,553	12	9
10	26	Insurance		46,883,610	261	34,773		941,553	698	10
11	20	Advertising & Promotions		46,883,610	261			941,553		11
12	25	Transportation		46,883,610	261	8,135		941,553	163	12
13	35	Car Rental		46,883,610	261			941,553		13
14	24	Conferences & Conventions		46,883,610	261	37,098		941,553	745	14
15	20	Subscriptions, Dues, Awards		46,883,610	261	5,567		941,553	112	15
16	6	Furniture & Fixtures		46,883,610	261			941,553		16
17	6	Machinery & Equipment		46,883,610	261			941,553		17
18	35	Equipment Rental		46,883,610	261			941,553		18
19	6	Equipment Repair & Maint.		46,883,610	261	202,324		941,553	4,063	19
20	20	Employee Recruitment		46,883,610	261	9,143		941,553	184	20
21	6	Security & Waste Removal		46,883,610	261	50		941,553	1	21
22	21	All Other Miscellaneous		46,883,610	261	4,201		941,553	84	22
23	30	Depreciation		46,883,610	261	80,136		941,553	1,609	23
24										24
25	TOTALS					\$ 1,751,899	\$ 940,027		\$ 35,182	25

Facility Name & ID Number Shady Oaks East# 0039263

Report Period Beginning:

07/01/19Ending: 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		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	5,346,349	95	\$ 1,897,884	\$ 1,897,884	467,793	\$ 166,060	1
2	22	Empl Benefits & Taxes		5,346,349	95	629,164		467,793	55,050	2
3	19	Prof Fees & Contracts		5,346,349	95	209,302		467,793	18,313	3
4	21	Supplies, Telephone, Postage		5,346,349	95	50,977		467,793	4,460	4
5	34	Rental of Space		5,346,349	95	11,936		467,793	1,044	5
6	5	Utilities		5,346,349	95	14,729		467,793	1,289	6
7	6	Bldg Repairs & Maintenance		5,346,349	95	14,986		467,793	1,311	7
8	32	Interest		5,346,349	95	99,563		467,793	8,712	8
9	33	Real Estate Taxes		5,346,349	95	11,361		467,793	994	9
10	26	Insurance		5,346,349	95	41,820		467,793	3,659	10
11	20	Advertising & Promotions		5,346,349	95	678		467,793	59	11
12	25	Transportation		5,346,349	95	21,897		467,793	1,916	12
13	35	Car Rental		5,346,349	95	1,411		467,793	123	13
14	24	Conferences & Conventions		5,346,349	95	17,397		467,793	1,522	14
15	20	Subscriptions, Dues, Awards		5,346,349	95	21,929		467,793	1,919	15
16	6	Furniture & Fixtures		5,346,349	95	100		467,793	9	16
17	6	Machinery & Equipment		5,346,349	95			467,793		17
18	35	Equipment Rental		5,346,349	95	215		467,793	19	18
19	6	Equipment Repair & Maint.		5,346,349	95	106,958		467,793	9,359	19
20	20	Employee Recruitment		5,346,349	95	41,347		467,793	3,618	20
21	6	Security & Waste Removal		5,346,349	95	1,319		467,793	115	21
22	21	All Other Miscellaneous		5,346,349	95	737		467,793	65	22
23	30	Depreciation		5,346,349	95	90,865		467,793	7,950	23
24										24
25	TOTALS					\$ 3,286,577	\$ 1,897,884		\$ 287,566	25

Ending: 06/30/20

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IL478-2471

Ending: 06/30/20

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

IL478-2471

Ending: 06/30/20

Ending: 06/30/20

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IL478-2471

Ending: 06/30/20

	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

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													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	LSSI Allocation (Sch VIII)		X									10,877	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ 10,877	14
15	TOTALS (line 9+line14)						\$		\$			\$ 10,877	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.)

FACILITY NAME Shady Oaks East COUNTY Will

FACILITY IDPH LICENSE NUMBER 0039263

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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 East COUNTY Will
FACILITY IDPH LICENSE NUMBER 0039263
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</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:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1					\$		1
2							2
3	TOTALS				\$		3

XL. 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	Related Building Company (Pages 12F & 12G)		9,905					9,905	67
68	Related Party Allocations (Pages 12H & 12I)			17,110			(17,110)		68
69	Financial Statement Depreciation			33,698			(33,698)		69
70	TOTAL (lines 4 thru 69)		\$ 928,794	\$ 64,779		\$ 22,958	\$ (41,821)	\$ 586,964	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:

07/01/19

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 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		\$ 928,794	\$ 64,779		\$ 22,958	\$ (41,821)	\$ 586,964	1
2	Kitchen Demolition: New Cabinets,Sinks,Walls,Lighting,Floors,Pa	2018	28,416		20	1,421	1,421	4,262	2
3	Water Heater/Circulating Pump - Installation And Plumbing	2018	4,782		20	239	239	478	3
4	Commercial Metal Door Replacement - East 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 - East	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	Painting - East Campus	2019	21,551		20	1,078	1,078	1,078	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)		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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 12B, Carried Forward		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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)		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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 12C, Carried Forward		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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)		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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:

07/01/19

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 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		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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)		\$ 1,009,264	\$ 64,779		\$ 26,982	\$ (37,797)	\$ 595,354	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	9,905		20			9,905	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,905	\$		\$	\$	\$ 9,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocation From LSSI			17,110			(17,110)		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)		\$	\$ 17,110		\$	\$ (17,110)	\$	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		\$	\$ 17,110		\$	\$ (17,110)	\$	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)		\$	\$ 17,110		\$	\$ (17,110)	\$	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	\$ 79,849	\$	\$ 7,986	\$ 7,986	10	\$ 25,866	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	83,137				10	83,137	73
74								74
75	TOTALS	\$ 162,986	\$	\$ 7,986	\$ 7,986		\$ 109,003	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				5	43,569	77
78										78
79										79
80	TOTALS			\$ 77,825	\$	\$	\$		\$ 77,825	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)	\$ 1,250,075	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,779	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,968	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,811)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 782,182	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)				2,126			6
7	TOTAL				\$ 5,126			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: \$ 95
- 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		\$	\$ 5,698	17
18	LSSI Alloc. (Sch VIII)			140	18
19					19
20					20
21	TOTAL		\$	\$ 5,838	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.

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			724			724	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
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 934	\$		\$ 934	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.

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 East

0039263

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	\$ 1,283,849	1
2	Discounts and Allowances for all Levels	(2,315)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,281,534	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	5,000	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,000	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		72,763	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 72,763	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,359,297	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	338,060	31
32	Health Care	722,617	32
33	General Administration	740,942	33
	B. Capital Expense		
34	Ownership	56,582	34
	C. Ancillary Expense		
35	Special Cost Centers	934	35
36	Provider Participation Fee	74,126	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,933,261	40
41	Income before Income Taxes (line 30 minus line 40)**	(573,964)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (573,964)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,148,623	44
45	Private Pay - Net Inpatient Revenue	132,911	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)	\$ 1,281,534	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	3,812	4,348	113,791	26.17	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,283	4,790	78,231	16.33	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,402	1,581	30,790	19.48	13
14	Head Cook	6,785	7,526	92,728	12.32	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	780	982	18,286	18.62	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	786	870	25,352	29.14	20
21	Assistant Administrator					21
22	Other Administrative	2,956	3,225	66,737	20.69	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)	1,791	2,019	43,629	21.61	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	19,077	20,869	295,697	14.17	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	41,672	46,210	\$ 765,241 *	\$ 16.56	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	\$ 1,582	01-03	35
36	Medical Director	As Needed	3,106	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	9,563	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	14,456	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,358		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	45,322	10-03	52
53	TOTAL (lines 50 - 52)		\$ 71,068		53

STATE OF ILLINOIS

Facility Name & ID NumberShady Oaks East# 0039263Report Period Beginning:07/01/19Ending:06/30/20Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel Asencio	Administrator		\$ 25,352
Patricia Ramos	Other Admin		23,539
Laterria Bass	Other Admin		37,163
Robert Mcneal	Other Admin		6,035
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,090

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	\$ 2,575
Gale Healthcare Solutions	Accounting	1,250
LSSI	Management Services	429,731
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 433,556

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 42,065	
Unemployment Compensation Insurance		
FICA Taxes	58,540	
Employee Health Insurance	49,784	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Disability Insurance	1,312	
Life Insurance	1,031	
Pension Expense	23,576	
LSSI Alloc. (Sch. VIII)	73,024	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 249,332

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		
Dues & Subscriptions	99	
LSSI Alloc. (Sch. VIII)	7,272	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,371

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	443
LSSI Alloc. (Sch. VIII)	3,524
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,967

* 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,344 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. \$ 74,126
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? 100% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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.