

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: Jesse Parker Telephone Number: (615) 253-5200
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 07/01/24 to 06/30/25 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)
(Print Name and Title) Jesse Parker, CPA Partner
(Firm Name & Address) RubinBrown LLP 225 W Wacker Dr STE 1700, Chicago, IL 60606
(Telephone) (312) 425-1099 Fax # ()

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

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/24 Ending: 06/30/25

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,429							5,429	13
14	TOTALS	5,429							5,429	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.96%

D. How many bed reserve days during this year were paid by the Department? 194 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 certified beds.
number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 06/30/25 Fiscal Year: 06/30/25

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

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	73,634	4,403	1,735	79,772		79,772		79,772			1
2	Food Purchase		45,772		45,772		45,772	(768)	45,004			2
3	Housekeeping		2,220		2,220		2,220		2,220			3
4	Laundry		3,510		3,510		3,510		3,510			4
5	Heat and Other Utilities			2,076	2,076		2,076	859	2,935			5
6	Maintenance	23,488	11,409	131,355	166,252		166,252	(7,848)	158,404			6
7	Other (specify):*											7
8	TOTAL General Services	97,122	67,314	135,166	299,602		299,602	(7,757)	291,845			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	602,256	25,620	217,057	844,933		844,933	(538)	844,395			10
10a	Therapy											10a
11	Activities	32,762	1,468		34,230		34,230		34,230			11
12	Social Services			52,947	52,947		52,947		52,947			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	635,018	27,088	273,004	935,110		935,110	(538)	934,572			16
	C. General Administration											
17	Administrative	154,514			154,514		154,514	93,303	247,817			17
18	Directors Fees											18
19	Professional Services			290,499	290,499		290,499	(275,225)	15,274			19
20	Dues, Fees, Subscriptions & Promotions			2,223	2,223		2,223	2,408	4,631			20
21	Clerical & General Office Expenses		5,991	58,806	64,797		64,797	(39,855)	24,942			21
22	Employee Benefits & Payroll Taxes			197,618	197,618		197,618	18,694	216,312			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,813	3,813		3,813	3,655	7,468			24
25	Other Admin. Staff Transportation			2,653	2,653		2,653	1,555	4,208			25
26	Insurance-Prop.Liab.Malpractice			13,368	13,368		13,368	2,995	16,363			26
27	Other (specify):*											27
28	TOTAL General Administration	154,514	5,991	568,980	729,485		729,485	(192,470)	537,015			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	886,654	100,393	977,150	1,964,197		1,964,197	(200,765)	1,763,432			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			26,537	26,537		26,537	11,131	37,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			657	657		657	1,484	2,141			32
33	Real Estate Taxes							1,058	1,058			33
34	Rent-Facility & Grounds			15,728	15,728		15,728	(13,081)	2,647			34
35	Rent-Equipment & Vehicles							359	359			35
36	Other (specify):*			4,170	4,170		4,170	(4,170)				36
37	TOTAL Ownership			47,092	47,092		47,092	(3,219)	43,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			22,371	22,371		22,371		22,371			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,780	95,780		95,780		95,780			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			118,151	118,151		118,151		118,151			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	886,654	100,393	1,142,393	2,129,440		2,129,440	(203,983)	1,925,457			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	(768)	02		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	(5,086)	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	(94)	21		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	(48,200)	21		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	(21,883)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,031)		\$	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)	(127,952)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (127,952)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (203,983)		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			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	20
2	Other Expenses Related to Lobbying Activities		
3	Bank Service Charges	(735)	21
4	Amortization Expense	(4,170)	36
5	Clothing & Personal Supplies	(538)	10
6	Capitalized R&M	(16,440)	06
7			
8			
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46			
47			
48			
49	Total	(21,883)	

Summary A

06/30/25

[illegible]

Summary B

06/30/25

[illegible]

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 attached Board of Directors		Shady Oaks West	Lockport	See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	\$ 13,978	Vesper Management		\$	(13,978)	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			\$ 13,978			\$ 13,971	\$ * (7)	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 related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					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 (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		\$ 93,303	\$ 93,303	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		18,694	18,694	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		11,024	11,024	17
18	V	21	Supplies, Telephone, Postage		Lutheran Social Services of Illinois		6,073	6,073	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		897	897	19
20	V	5	Utilities		Lutheran Social Services of Illinois		859	859	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		2,115	2,115	21
22	V	32	Interest		Lutheran Social Services of Illinois		1,484	1,484	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois		1,058	1,058	23
24	V	26	Insurance		Lutheran Social Services of Illinois		2,995	2,995	24
25	V	25	Transportation		Lutheran Social Services of Illinois		1,555	1,555	25
26	V	35	Car Rental		Lutheran Social Services of Illinois		255	255	26
27	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		3,655	3,655	27
28	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		1,627	1,627	28
29	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois		501	501	29
30	V	6	Machinery & Equipment		Lutheran Social Services of Illinois		342	342	30
31	V	35	Equipment Rental		Lutheran Social Services of Illinois		104	104	31
32	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois		5,517	5,517	32
33	V	20	Employee Recruitment		Lutheran Social Services of Illinois		781	781	33
34	V	6	Security & Waste Removal		Lutheran Social Services of Illinois		117	117	34
35	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois		3,101	3,101	35
36	V	30	Depreciation		Lutheran Social Services of Illinois		2,246	2,246	36
37	V								37
38	V	19	Agency Management Allocation	286,249				(286,249)	38
39	Total			\$ 286,249			\$ 158,303	\$ * (127,946)	39

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

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	
						Hours	Percent	Description	Amount		
1	See attached Board of Directors								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shady Oaks East # 0039263 Report Period Beginning: 07/01/24 Ending: 06/30/25

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: 06/30/25

(847) 635-6764

	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	17	Salaries & Wages	Non-Capital Direct Costs	40,716,177	163	\$ 5,187,139	\$ 5,187,139	732,380	\$ 93,303	1
2	22	Empl Benefits & Taxes		40,716,177	163	1,039,263		732,380	18,694	2
3	19	Prof Fees & Contracts		40,716,177	163	612,860		732,380	11,024	3
4	21	Supplies, Telephone, Postage		40,716,177	163	337,599		732,380	6,073	4
5	34	Rental of Space		40,716,177	163	49,856		732,380	897	5
6	5	Utilities		40,716,177	163	47,757		732,380	859	6
7	6	Bldg Repairs & Maintenance		40,716,177	163	117,597		732,380	2,115	7
8	32	Interest		40,716,177	163	82,526		732,380	1,484	8
9	33	Real Estate Taxes		40,716,177	163	58,795		732,380	1,058	9
10	26	Insurance		40,716,177	163	166,481		732,380	2,995	10
11	25	Transportation		40,716,177	163	86,457		732,380	1,555	11
12	35	Car Rental		40,716,177	163	14,194		732,380	255	12
13	23	Conferences & Conventions		40,716,177	163	203,224		732,380	3,655	13
14	20	Subscriptions, Dues, Awards		40,716,177	163	90,460		732,380	1,627	14
15	6	Furniture & Fixtures		40,716,177	163	27,831		732,380	501	15
16	6	Machinery & Equipment		40,716,177	163	19,020		732,380	342	16
17	35	Equipment Rental		40,716,177	163	5,793		732,380	104	17
18	6	Equipment Repair & Maint.		40,716,177	163	306,717		732,380	5,517	18
19	20	Employee Recruitment		40,716,177	163	43,394		732,380	781	19
20	6	Security & Waste Removal		40,716,177	163	6,497		732,380	117	20
21	21	All Other Miscellaneous		40,716,177	163	172,423		732,380	3,101	21
22	30	Depreciation		40,716,177	163	124,886		732,380	2,246	22
23										23
24										24
25	TOTALS					\$ 8,800,769	\$ 5,187,139		\$ 158,303	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	Interest Expense		X									656	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	656	9
	B. Non-Facility Related*												
10	LSSI Allocation (Sch VIII)		X									1,484	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	1,484	14
15	TOTALS (line 9+line14)						\$				\$	2,140	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.)

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

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 (X) (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? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X 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	

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	\$	426,189	4	
5			2014	1998	100,000		40	2,500	2,500	30,000	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			20,585	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			20,578	16	
17	Various			2007	3,180		20			3,180	17	
18	Various			2011	13,917		20	696	696	9,939	18	
19	Various			2012	48,019		20	2,401	2,401	32,658	19	
20	Various			2013	15,950		20	798	798	9,576	20	
21	Various			2014	31,302		20	1,566	1,566	18,008	21	
22	Various			2015	2,800		20	140	140	1,400	22	
23	Various			2018	33,198		20	1,660	1,660	13,040	23	
24	Various			2019	47,273		20	2,364	2,364	15,470	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

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)			2,246			(2,246)		68
69	Financial Statement Depreciation			26,537			(26,537)		69
70	TOTAL (lines 4 thru 69)		\$ 1,009,265	\$ 42,754		\$ 26,096	\$ (16,658)	\$ 714,266	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:

07/01/24

Ending:

06/30/25

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		\$ 1,009,265	\$ 42,754		\$ 26,096	\$ (16,658)	\$ 714,266	1
2	Replacement of 2 Furnaces	2021	8,402		20	420	420	1,680	2
3	Fire Sprinkler - Float Valve for Water Tank	2022	3,036		20	152	152	608	3
4	Replacement of 2 Condensing Units	2022	12,000		20	600	600	2,400	4
5	Replacement 75 Gallon Hot Water Heater	2022	3,040		20	152	152	608	5
6	Replace Toilet Flush Valves In East Bldg Rooms 1 & 6	2023	3,206		20	160	160	481	6
7	Repair East Bldg Loose Sink on Wall	2023	3,885		20	194	194	583	7
8	Add Transformers to Rooftop Units w/ECM Motors	2023	4,480		20	224	224	672	8
9	Labor for Flooded Bathroom Reno - Door Replacement	2023	8,436		20	422	422	1,266	9
10	Replacement of Janitor Room Door	2023	4,125		20	206	206	412	10
11	Replace 75 Gallon Water heater in East Bldg Basement	2024	3,354		20	168	168	336	11
12	Replace Carpet in Dining and Gathering Room	2024	6,846		20	342	342	684	12
13	Install tile flooring, paint walls & ceiling in shower room	2024	13,420		20	671	671	671	13
14	Laundry room plumbing - add outlet, valves, and drain	2024	3,020		20	151	151	151	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)		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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)		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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)		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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)		\$ 1,086,515	\$ 42,754		\$ 29,959	\$ (12,795)	\$ 724,819	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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Management Assets - Security System	1999	9,905		20			9,905	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,905	\$		\$	\$	\$ 9,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from LSSI			2,246			(2,246)		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)		\$	\$ 2,246		\$	\$ (2,246)	\$	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
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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 12H, Carried Forward		\$	\$ 2,246		\$	\$ (2,246)	\$	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
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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)		\$	\$ 2,246		\$	\$ (2,246)	\$	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	\$ 72,629	\$	\$ 7,259	\$ 7,259	10	\$ 53,061	71
72	Current Year Purchases	4,500		450	450	10	450	72
73	Fully Depreciated Assets	87,814				10	87,814	73
74								74
75	TOTALS	\$ 164,943	\$	\$ 7,709	\$ 7,709		\$ 141,325	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		Dodge Braun Entervan	2013	\$ 43,569	\$	\$	\$	5	\$ 43,569	76
77										77
78										78
79										79
80	TOTALS			\$ 43,569	\$	\$	\$		\$ 43,569	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,295,027	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,754	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,668	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,086)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 909,713	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.

Shady Oaks East
0039263
Moveable Equipment Schedule
07/01/24
06/30/25

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Shady Oaks East	72,629		7,259	7,259	53,061
Total	72,629		7,259	7,259	53,061

Line 29: Current Year

Shady Oaks East	4,500		450		450
Total	4,500		450		450

Line 30: Fully Depreciated

Shady Oaks East	87,814				87,814
Total	87,814				87,814

Total (Should tie to page 13)

Shady Oaks East	164,943		7,709	7,709	141,325
Total	164,943		7,709	7,709	141,325

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	Facility Program Rent				1,750			5
6	LSSI Alloc. (Sch VIII)				897			6
7	TOTAL				\$ 2,647			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: \$ 104
- 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	LSSI Alloc. (Sch VIII)		\$	255	17
18					18
19					19
20					20
21	TOTAL		\$	255	21

* 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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

Supplemental Schedule of Equipment Rental

06/30/25

Description		Amount
16A	LSSI Alloc. (Sch VIII)	104
16B		
16C		
16D		
16E		
16F		
16G		
16H		
16I		
16J		
16K		
16L		
16M		
16N		
16O		
16P		
16Q		
16R		
16S		
16T		
Total		104

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	\$		\$ 300	\$		\$ 300	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			22,071			22,071	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			\$		\$ 22,371	\$		\$ 22,371	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.

Shady Oaks East
#0039263
6/30/2025
Note to Page 17 and Page 18

Lutheran Social Services of Illinois is unable to provide meaningful comparative Balance Sheet or Statements of Changes in Equity for the individual entities due to the commingling of cash, other assets, and most liabilities in a complex, multifunctional agency. Any Balance Sheet prepared with only those assets, liabilities and fund balances identifiable with specific programs would not balance or present a meaningful picture of that program's financial status.

Facility Name & ID Number Shady Oaks East

0039263

Report Period Beginning: 07/01/24

Ending: 06/30/25

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	\$ 1,795,065	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,795,065	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	78,197	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 78,197	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)	\$ 1,873,262	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	299,602	31
32	Health Care	935,110	32
33	General Administration	729,485	33
	B. Capital Expense		
34	Ownership	47,092	34
	C. Ancillary Expense		
35	Special Cost Centers	22,371	35
36	Provider Participation Fee	95,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,129,440	40
41	Income before Income Taxes (line 30 minus line 40)**	(256,178)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (256,178)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,795,065.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,795,065	56

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	2,639	2,838	110,014	38.76	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,187	1,276	32,762	25.68	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,935	4,231	73,634	17.40	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,087	1,169	23,488	20.09	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,064	1,144	45,168	39.48	20
21	Assistant Administrator					21
22	Other Administrative	3,318	3,567	109,346	30.65	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	2,334	2,510	69,537	27.70	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	18,531	19,926	422,705	21.21	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	34,095	36,661	\$ 886,654 *	\$ 24.19	34

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	\$ 1,735	01-03	35
36	Medical Director	As Needed	3,000	09-03	36
37	Medical Records Consultant		0	0	37
38	Nurse Consultant	As Needed	11,455	10-03	38
39	Pharmacist Consultant	As Needed	2,125	10-03	39
40	Physical Therapy Consultant		0	0	40
41	Occupational Therapy Consultant		0	0	41
42	Respiratory Therapy Consultant		0	0	42
43	Speech Therapy Consultant		0	0	43
44	Activity Consultant		0	0	44
45	Social Service Consultant		0	0	45
46	Other(specify) <u>Psychologist</u>	As Needed	52,947	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 71,262		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	19,635	10-03	51
52	Certified Nurse Assistants/Aides	As Needed	183,842	10-03	52
53	TOTAL (lines 50 - 52)		\$ 203,477		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberShady Oaks East# 0039263Report Period Beginning:07/01/24Ending:06/30/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brittany Jones	Administrator	0	\$ 45,168
Serrita/Laterria Bass	Other Admin	0	109,346
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 154,514

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
See Attached	Legal	\$ 1,160
Marcum LLP	Accounting	3,090
LSSI	Management Services	286,249
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 290,499

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 10,615
Unemployment Compensation Insurance	(1,785)
FICA Taxes	69,490
Employee Health Insurance	99,583
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	1,089
Life Insurance	942
Employer 403B Plan Contribution	17,684
LSSI Alloc. (Sch. VIII)	18,694
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	31
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Dues & Subscriptions	2,022
Licenses & Fees	170
LSSI Alloc. (Sch. VIII)	2,408
Less: Public Relations Expense	()
PAC and Lobbying payments	()
All non-allowable 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	3,813
LSSI Alloc. (Sch. VIII)	3,655
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,468

* Attach copy of IMRF notifications

**See instructions.

SHADY OAKS EAST

LEGAL SCHEDULE
07/01/24 - 06/30/25

DATE	G/L ACCT. #	PAYEE/VENDOR	TYPE OF SERVICE PROVIDED	AMOUNT	ADJUSTMENT	ADJUSTED AMOUNT
11/29/24	01-70001-2331-0-022-43	Law Offices of Pretzel & Stouffer	Dispute Settlement	1,160.33		1,160.33
		TOTAL:		1,160.33		1,160.33

07/01/24 - 06/30/25

DATE	G/L ACCT#	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
6/30/25	01-76001-2331-0-022-43	Lutheran Social Services of Illinois	Seminar Meals, Lodging, Misc.	Various	Various	IL	828.30
6/30/25	01-76001-2331-0-022-43	Lutheran Social Services of Illinois	General Seminar	Various	Various	IL	2,984.78
		Allocated from Lutheran Social Services of Illinois					3,655.00
Total							7,468.08

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 6,150 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 95,780

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs?

Yes Indicate the amount. \$ 768
- (12)

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?

N/A

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

No
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: Baker Tilly Virchow Krause LLC

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

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