FOR BHF USE

LL1

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: 0040527

Facility Name: Shady Oaks West

Address: 16220 Parker Road (Number) Lockport (City) 60441 (Zip Code)

County: Will

Telephone Number: (708)301-0571 **Fax #** (708)301-0573

HFS ID Number:

Date of Initial License for Current Owners: 1995

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

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 West # 0040527 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,448							5,448	13
14	TOTALS	5,448							5,448	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.29%

D. How many bed reserve days during this year were paid by the Department?
242 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 5/17/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date January 1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter certified beds.
number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 West # 0040527 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	123,506	4,382	1,735	129,623		129,623		129,623			1
2	Food Purchase		44,668		44,668		44,668	(79)	44,589			2
3	Housekeeping		2,558		2,558		2,558		2,558			3
4	Laundry		3,520		3,520		3,520		3,520			4
5	Heat and Other Utilities			19,462	19,462		19,462	855	20,317			5
6	Maintenance	20,157	10,317	87,827	118,301		118,301	5,566	123,867			6
7	Other (specify):*											7
8	**TOTAL General Services**	143,663	65,445	109,024	318,132		318,132	6,342	324,474			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	578,558	27,049	125,908	731,515		731,515	(753)	730,762			10
10a	Therapy											10a
11	Activities	28,115	1,013		29,128		29,128		29,128			11
12	Social Services			68,328	68,328		68,328		68,328			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	606,673	28,062	197,236	831,971		831,971	(753)	831,218			16
	C. General Administration											
17	Administrative	173,744			173,744		173,744	92,813	266,557			17
18	Directors Fees											18
19	Professional Services			298,917	298,917		298,917	(283,701)	15,217			19
20	Dues, Fees, Subscriptions & Promotions			2,234	2,234		2,234	2,395	4,629			20
21	Clerical & General Office Expenses		1,780	158,339	160,119		160,119	(145,226)	14,893			21
22	Employee Benefits & Payroll Taxes			200,606	200,606		200,606	18,595	219,201			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,370	3,370		3,370	3,636	7,006			24
25	Other Admin. Staff Transportation			633	633		633	1,547	2,180			25
26	Insurance-Prop.Liab.Malpractice			16,189	16,189		16,189	2,979	19,168			26
27	Other (specify):*											27
28	**TOTAL General Administration**	173,744	1,780	680,288	855,812		855,812	(306,962)	548,851			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	924,080	95,287	986,548	2,005,915		2,005,915	(301,373)	1,704,543			29

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

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

Facility Name & ID Number Shady Oaks West #0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			12,258	12,258		12,258	15,385	27,643			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,109	2,109		2,109	1,477	3,586			32
33	Real Estate Taxes							1,052	1,052			33
34	Rent-Facility & Grounds			13,541	13,541		13,541	(12,649)	892			34
35	Rent-Equipment & Vehicles							358	358			35
36	Other (specify):*			15,229	15,229		15,229	(15,229)				36
37	**TOTAL Ownership**			43,137	43,137		43,137	(9,606)	33,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			16,627	16,627		16,627		16,627			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,210	96,210		96,210		96,210			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			112,837	112,837		112,837		112,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	924,080	95,287	1,142,522	2,161,889		2,161,889	(310,979)	1,850,910			45

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	(79)	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	(386)	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	(157)	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	(153,466)	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	(19,691)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (173,779)		$	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)	(137,200)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (137,200)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (310,979)		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

Shady Oaks West

ID# 0040527

Report Period Beginning: 07/01/24

Ending: 06/30/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Bank Service Charges	(729)	21	3
4	Amortization Expense	(15,229)	36	4
5	Clothing & Personal Supplies	(753)	10	5
6	Capitalized R&M	(2,980)	06	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(19,691)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(79)	0	0	0	0	0	0	0	0	0	0	(79)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	855	0	0	0	0	0	0	0	0	855	5
6	Maintenance	(2,980)	0	8,546	0	0	0	0	0	0	0	0	5,566	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,059)	0	9,401	0	0	0	0	0	0	0	0	6,342	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(753)	0	0	0	0	0	0	0	0	0	0	(753)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(753)	0	0	0	0	0	0	0	0	0	0	(753)	16
	C. General Administration													
17	Administrative	0	0	92,813	0	0	0	0	0	0	0	0	92,813	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(283,701)	0	0	0	0	0	0	0	0	(283,701)	19
20	Fees, Subscriptions & Promotions	0	0	2,395	0	0	0	0	0	0	0	0	2,395	20
21	Clerical & General Office Expenses	(154,352)	0	9,126	0	0	0	0	0	0	0	0	(145,226)	21
22	Employee Benefits & Payroll Taxes	0	0	18,595	0	0	0	0	0	0	0	0	18,595	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,636	0	0	0	0	0	0	0	0	3,636	24
25	Other Admin. Staff Transportation	0	0	1,547	0	0	0	0	0	0	0	0	1,547	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,979	0	0	0	0	0	0	0	0	2,979	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(154,352)	0	(152,610)	0	0	0	0	0	0	0	0	(306,962)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(158,164)	0	(143,209)	0	0	0	0	0	0	0	0	(301,373)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	(386)	13,536	2,235	0	0	0	0	0	0	0	0	15,385	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,477	0	0	0	0	0	0	0	0	1,477	32
33	Real Estate Taxes	0	0	1,052	0	0	0	0	0	0	0	0	1,052	33
34	Rent-Facility & Grounds	0	(13,541)	892	0	0	0	0	0	0	0	0	(12,649)	34
35	Rent-Equipment & Vehicles	0	0	358	0	0	0	0	0	0	0	0	358	35
36	Other (specify):*	(15,229)	0	0	0	0	0	0	0	0	0	0	(15,229)	36
37	**TOTAL Ownership**	(15,615)	(5)	6,014	0	0	0	0	0	0	0	0	(9,606)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(173,779)	(5)	(137,195)	0	0	0	0	0	0	0	0	(310,979)	45

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 East	Lockport	See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental of Space	$ 13,541	Vesper Management		$	$ (13,541)	1
2	V	30	Depreciation		Vesper Management		13,536	13,536	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 13,541			$ 13,536	$ * (5)	14

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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
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27								27
28								28
29								29
30								30

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages		Lutheran Social Services of Illinois		$ 92,813	$ 92,813	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois		18,595	18,595	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois		10,966	10,966	17
18	V	21	Supplies, Telephone, Postage		Lutheran Social Services of Illinois		6,041	6,041	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois		892	892	19
20	V	5	Utilities		Lutheran Social Services of Illinois		855	855	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois		2,104	2,104	21
22	V	32	Interest		Lutheran Social Services of Illinois		1,477	1,477	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois		1,052	1,052	23
24	V	26	Insurance		Lutheran Social Services of Illinois		2,979	2,979	24
25	V	25	Transportation		Lutheran Social Services of Illinois		1,547	1,547	25
26	V	35	Car Rental		Lutheran Social Services of Illinois		254	254	26
27	V	24	Conferences & Conventions		Lutheran Social Services of Illinois		3,636	3,636	27
28	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois		1,619	1,619	28
29	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois		498	498	29
30	V	6	Machinery & Equipment		Lutheran Social Services of Illinois		340	340	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		5,488	5,488	32
33	V	20	Employee Recruitment		Lutheran Social Services of Illinois		776	776	33
34	V	6	Security & Waste Removal		Lutheran Social Services of Illinois		116	116	34
35	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois		3,085	3,085	35
36	V	30	Depreciation		Lutheran Social Services of Illinois		2,235	2,235	36
37	V								37
38	V	19	Agency Management Allocation	294,667				(294,667)	38
39	Total			$ 294,667			$ 157,472	$ * (137,195)	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Shady Oaks West

ID# **0040527**

Report Period Beginning: **07/01/24** N/A

Ending: **06/30/25** N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Board Members:								1
2	Kathie	B	Schwich	Park Ridge	IL	0.00000			2
3	Esther	M.I.	Macchione	Berwyn	IL	0.00000			3
4	Youngshim	E	Pitcher	Macomb	IL	0.00000			4
5	Beth	N	Chase	Morris	IL	0.00000			5
6	Judy	K	Dalhaus	Litchfield	IL	0.00000			6
7	Ron		Kok-Alblas	Downers Grove	IL	0.00000			7
8	Donald	B	Erickson	Glen Ellyn	IL	0.00000			8
9	Rhonda	L	Pruitt	Plainfield	IL	0.00000			9
10	James	E	Harney	Woodridge	IL	0.00000			10
11	Greg		Busboom	Springfield	IL	0.00000			11
12	Stacie		Fidlar	Rockford	IL	0.00000			12
13	Yehiel		Curry	Chicago	IL	0.00000			13
14	Susan		Boin	Chicago	IL	0.00000			14
15	Mark		Schwiebert	Rock Island	IL	0.00000			15
16									16
17									17
18									18
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70									70
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72									72
73									73
74									74
75									75

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 West # 0040527 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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shady Oaks West # 0040527 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 [X] 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 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	249	$ 5,187,139	$ 5,187,139	728,527	$ 92,813	1
2	22	Empl Benefits & Taxes		40,716,177	249	1,039,263		728,527	18,595	2
3	19	Prof Fees & Contracts		40,716,177	249	612,860		728,527	10,966	3
4	21	Supplies, Telephone, Postage		40,716,177	249	337,599		728,527	6,041	4
5	34	Rental of Space		40,716,177	249	49,856		728,527	892	5
6	5	Utilities		40,716,177	249	47,757		728,527	855	6
7	6	Bldg Repairs & Maintenance		40,716,177	249	117,597		728,527	2,104	7
8	32	Interest		40,716,177	249	82,526		728,527	1,477	8
9	33	Real Estate Taxes		40,716,177	249	58,795		728,527	1,052	9
10	26	Insurance		40,716,177	249	166,481		728,527	2,979	10
11	25	Transportation		40,716,177	249	86,457		728,527	1,547	11
12	35	Car Rental		40,716,177	249	14,194		728,527	254	12
13	23	Conferences & Conventions		40,716,177	249	203,224		728,527	3,636	13
14	20	Subscriptions, Dues, Awards		40,716,177	249	90,460		728,527	1,619	14
15	6	Furniture & Fixtures		40,716,177	249	27,831		728,527	498	15
16	6	Machinery & Equipment		40,716,177	249	19,020		728,527	340	16
17	35	Equipment Rental		40,716,177	249	5,793		728,527	104	17
18	6	Equipment Repair & Maint.		40,716,177	249	306,717		728,527	5,488	18
19	20	Employee Recruitment		40,716,177	249	43,394		728,527	776	19
20	6	Security & Waste Removal		40,716,177	249	6,497		728,527	116	20
21	21	All Other Miscellaneous		40,716,177	249	172,423		728,527	3,085	21
22	30	Depreciation		40,716,177	249	124,886		728,527	2,235	22
23										23
24										24
25	TOTALS					$ 8,800,769	$ 5,187,139		$ 157,472	25

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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								2,109	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 2,109	9
	B. Non-Facility Related*											
10	LSSI Allocation (Sch VIII)		X								1,477	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,477	14
15	TOTALS (line 9+line14)						$	$			$ 3,586	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 & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	1,052	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,052	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	1,052	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

Allocated from LSSI: $1,052

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

NOTES:

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

Facility Name & ID Numb Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,234 B. General Construction Type: Exterior Face Brick/Siding 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Shady Oaks West # 0040527 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1994	$ 541,423	$ 13,536	40	$ 13,536	$ (0)	$ 413,484	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	775		20			775	9
10	Various			1998	21,295		20	531	531	14,527	10
11	Various			1999	15,803		20			15,803	11
12	Various			2002	2,592		20			2,592	12
13	Various			2003	2,591		20			2,591	13
14	Various			2004	54,276		20			54,276	14
15	Various			2005	39,942		20			39,942	15
16	Various			2006	11,373		20			11,373	16
17	Various			2007	4,185		20			4,185	17
18	Various			2010	7,950		20	232	232	3,712	18
19	Various			2011	14,125		20	706	706	9,376	19
20	Various			2012	39,962		20	1,999	1,999	27,438	20
21	Various			2013	32,560		20	1,628	1,628	20,171	21
22	Various			2017	43,554		20	2,178	2,178	18,585	22
23	Various			2019	32,322		20	1,616	1,616	10,982	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		9,322					9,322	67
68	Related Party Allocations (Pages 12H & 12I)			2,235			(2,235)		68
69	Financial Statement Depreciation			12,258			(12,258)		69
70	TOTAL (lines 4 thru 69)		$ 974,050	$ 28,029		$ 24,926	$ (3,103)	$ 689,134	70

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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		$ 974,050	$ 28,029		$ 24,926	$ (3,103)	$ 689,134	1
2	Replacement of Hot Water Heater	2021	4,250		20	213	213	851	2
3	Installation of Furnace and Air Conditioning Unit	2023	8,771		20	439	439	1,316	3
4	Replace 4 Shower 2" Valves in West Bldg	2023	2,755		20	138	138	413	4
5	Repair West Bldg Loose Sink on the Wall	2023	3,885		20	194	194	583	5
6	Grease Trap Installation	2024	3,760		20	188	188	376	6
7	Plumbing - new washer box, frp board in laundry area	2025	2,980		20	149	149	149	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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 12B, Carried Forward		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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 12C, Carried Forward		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	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
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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)		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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 12D, Carried Forward		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,000,451	$ 28,029		$ 26,246	$ (1,783)	$ 692,821	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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	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	9,322		20			9,322	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,322	$		$	$	$ 9,322	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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 12F, Carried Forward		$ 9,322	$		$	$	$ 9,322	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,322	$		$	$	$ 9,322	34

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

Facility Name & ID Number Shady Oaks West # 0040527 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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from LSSI			2,235			(2,235)		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)		$	$ 2,235		$	$ (2,235)	$	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 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 12H, Carried Forward		$	$ 2,235		$	$ (2,235)	$	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)		$	$ 2,235		$	$ (2,235)	$	34

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	$ 13,985	$	$ 1,397	$ 1,397	10	$ 9,174	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	75,347				10	75,347	73
74								74
75	TOTALS	$ 89,332	$	$ 1,397	$ 1,397		$ 84,521	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,089,783	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,029	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,643	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (386)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 777,342	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 West
0040527
Moveable Equipment Schedule
07/01/24
06/30/25

Line 28: Prior Years

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Shady Oaks West	13,985		1,397	1,397	9,174
Total	13,985		1,397	1,397	9,174

Line 29: Current Year

Shady Oaks West					
Total					

Line 30: Fully Depreciated

Shady Oaks West	75,347				75,347
Total	75,347				75,347

Total (Should tie to page 13)

Shady Oaks West	89,332		1,397	1,397	84,521
Total	89,332		1,397	1,397	84,521

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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								5
6	LSSI Alloc. (Sch VIII)				892			6
7	TOTAL				$ 892 **			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: *

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	$

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)		$	$ 254	17
18					18
19					19
20					20
21	TOTAL		$	$ 254	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.

Facility Name & ID Number Shady Oaks West # 0040527 **Report Period Beginning:** 07/01/24 **Ending:** 06/30/25

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Shady Oaks West

STATE OF ILLINOIS
0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 840	$		$ 840	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			15,787			15,787	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			$		$ 16,627	$		$ 16,627	14

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/25 (last day of reporting year)

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

		1 Operating	2 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 Operating	2 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.)**

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 West
#0040527
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 West # 0040527 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,804,085	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,804,085	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	87,170	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87,170	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	1,750	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,750	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,893,005	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	318,132	31
32	Health Care	831,971	32
33	General Administration	855,812	33
	B. Capital Expense		
34	Ownership	43,137	34
	C. Ancillary Expense		
35	Special Cost Centers	16,627	35
36	Provider Participation Fee	96,210	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,161,889	40
41	**Income before Income Taxes (line 30 minus line 40)****	(268,884)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (268,884)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,804,085.00	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)	$ 1,804,085	56

Facility Name & ID Number Shady Oaks West # 0040527 **Report Period Beginning:** 07/01/24 **Ending:** 06/30/25

Supplemental Schedule of Revenues
06/30/25

	Description	Amount
28A	Facility Program Rent	1,750
28B		-
28C		-
28D		-
28E		-
28F		-
28G		-
28H		-
28I		-
28J		-
28K		-
28L		-
28M		-
28N		-
28O		-
28P		-
28Q		-
28R		-
28S		-
28T		-
	Total	1,750

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	2,306	2,480	84,580	34.10	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,019	1,095	28,115	25.68	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,479	2,666	64,977	24.37	13
14	Head Cook	3,189	3,429	58,529	17.07	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	933	1,003	20,157	20.10	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	913	982	38,761	39.47	20
21	Assistant Administrator					21
22	Other Administrative	4,023	4,326	134,983	31.20	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)	1,943	2,090	58,765	28.12	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	18,541	19,937	435,213	21.83	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	35,346	38,008	$ 924,080 *	$ 24.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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				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				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) Psychologist	As Needed	68,328	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 86,643		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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	92,693	10-03	52
53	TOTAL (lines 50 - 52)		$ 112,328		53

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/24 Ending: 06/30/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brittany Jones	Administrator	0	$ 38,761
Serrita/Laterria Bass	Other Admin	0	134,983
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 173,744

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	294,667
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 298,917

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,948
Unemployment Compensation Insurance	
FICA Taxes	75,832
Employee Health Insurance	72,788
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	1,189
Life Insurance	1,052
Employer 403B Plan Contribution	19,797
LSSI Alloc. (Sch. VIII)	18,595
TOTAL (agree to Schedule V, line 22, col.8)	$ 219,201

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 & Subcriptions	2,032
Licenses & Fees	170
LSSI Alloc. (Sch. VIII)	2,395
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,370
LSSI Alloc. (Sch. VIII)	3,636
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,006

* Attach copy of IMRF notifications

**See instructions.

SHADY OAKS WEST

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	01-70001-2332-0-022-43	Law Offices of Pretzel & Stouffer	Dispute Settlement	1,160.33		1,160.33
		TOTAL:		1,160.33		1,160.33

SHADY OAKS WEST

SEMINAR EXPENSE
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

Facility Name & ID Number Shady Oaks West # 0040527 **Report Period Beginning:** 07/01/24 **Ending:** 06/30/25

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. $ **96,210**
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. $ **79**

(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? **N/A**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(13) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly Virchow Krause LLC**

(14) Have all costs which do not relate to the provision of long term care been adjusted out 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.