

Date: 08/01/2006

To: Administrator/Cost Report Preparer

From: Bureau of Health Finance

Re: 2006 Long Term Care Cost Report and Instructions

This year the cost report will be available by download from the Internet or by Email. If you require a disk, please call Fred Sosman at 217-782-1630. The web site for the download of the cost report file and instructions is <http://www.hfs.illinois.gov/costreports/>. Click on the Nursing Home and ICF/DD link. Next right-click on the "Excel version" and select, "Save Target As". Then save the file on your computer system in the location where you want it. Next, right-click on the instructions file and select "Save Target As". Then save the file on your computer system.

When you have completed the cost report, send in the completed cost report file by email, CD or disk. **The EMAIL address for sending in the Excel file is HFS.HealthFinance@illinois.gov.** A signed paper copy must be sent in also. *In order to provide for the efficient and accurate processing of any 7/01/07 - 6/30/08 Medicaid rates, the completed Excel cost report file **must be sent in at the same time** as the paper copy of the cost report.*

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2006. It is due on October 31, 2006, or 90 days after the close of the facility's fiscal year, whichever comes later. Please refer to the instructions for the remainder of the filing requirements.

Please use the 2006 cost report file and instructions. Printed copies of the report from the 2005 cost report or earlier files will NOT be accepted. In order to print the instructions on legal paper, open the Instr06.pdf file. Then click File-Page Setup. Change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

IMPORTANT NOTICE for Those Facilities Receiving a Calendar 2005 Real Estate Tax Bill: Located after page 10 of the cost report on the worksheet named "RE_TAX" is the "2005 Long Term Care Real Estate Tax Statement." As in previous years, the real estate tax statement is being included in the cost report. A separate notice requesting the submittal of this statement and the calendar 2005 tax bill will not be sent. Please complete the "2005 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2005 real estate tax bills as an attachment to the fiscal 2006 cost report. **Please Note; Copies of the original tax bills must be provided.**

If both the "2005 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2006 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.

Cost Report File

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH ID# is correct.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.

Attachments

Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file. Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. Please do not change or delete the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.

Page 12 and Pages 12A through 12I

Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information. Print macros have been written that will print each individual page or the entire report.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ¼ by 14 image on the paper. Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image. After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Bureau of Health Finance. As part of the filing requirements, send the completed Excel file at the same time you send your paper copy. Also, please make sure both the completed file and the paper copy agree prior to sending them to our office.

Cost Report File and Extra Pages

The entire cost report is in one file named Report06.xls. In an Excel file that has been sealed, you can press the "Tab" key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the file, please call Randy Hulskotter at (217) 782-1630. You may also contact our office by email at the address located in the footer of this memo



Shortcut=

Hold down
Control Key and press m



Shortcut=

Hold down
Control Key and press q

To Stop Macro:

Hold down
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE
ACCOUNTANTS' COMPILATION REPORT"
AT THE BOTTOM OF EVERY PAGE, ENTER
THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B
to print, change cell E11 to zero.

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 _____

	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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,269			5,269
14	TOTALS	5,269			5,269

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.22%

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

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

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 5/17/1994

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	45,798	2,451	975	49,224		49,224		49,224		1
2	Food Purchase		26,770		26,770		26,770		26,770		2
3	Housekeeping		2,297		2,297		2,297		2,297		3
4	Laundry		7,831		7,831		7,831		7,831		4
5	Heat and Other Utilities			11,148	11,148		11,148	409	11,557		5
6	Maintenance	10,630	8,037	15,180	33,847		33,847	2,145	35,992		6
7	Other (specify):*							216	216		7
8	TOTAL General Services	56,428	47,386	27,303	131,117		131,117	2,770	133,887		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	448,678	21,909	265,257	735,844		735,844	(652)	735,192		10
10a	Therapy			88	88		88		88		10a
11	Activities	3,592	509		4,101		4,101		4,101		11
12	Social Services			83	83		83		83		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	452,270	22,418	268,428	743,116		743,116	(652)	742,464		16
	C. General Administration										
17	Administrative	28,594			28,594		28,594	126,799	155,393		17
18	Directors Fees										18
19	Professional Services			202,065	202,065		202,065	(191,117)	10,948		19
20	Dues, Fees, Subscriptions & Promotions							1,629	1,629		20
21	Clerical & General Office Expenses	396	2,578	5,744	8,718		8,718	3,982	12,700		21
22	Employee Benefits & Payroll Taxes			141,278	141,278		141,278		141,278		22
23	Inservice Training & Education										23
24	Travel and Seminar			450	450		450	2,659	3,109		24
25	Other Admin. Staff Transportation			9,776	9,776		9,776	4,290	14,066		25
26	Insurance-Prop.Liab.Malpractice			18,827	18,827		18,827	4,129	22,956		26
27	Other (specify):*							25,661	25,661		27
28	TOTAL General Administration	28,990	2,578	378,140	409,708		409,708	(21,968)	387,740		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	537,688	72,382	673,871	1,283,941		1,283,941	(19,850)	1,264,091		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:

07/01/05

Ending:

06/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,019	17,019		17,019	13,615	30,634			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,409	4,409		4,409	14,791	19,200			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			36,377	36,377		36,377	(24,367)	12,010			34
35	Rent-Equipment & Vehicles							455	455			35
36	Other (specify):*											36
37	TOTAL Ownership			57,805	57,805		57,805	4,494	62,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,103	1,103		1,103		1,103			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,953	58,953		58,953		58,953			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,056	60,056		60,056		60,056			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	537,688	72,382	791,732	1,401,802		1,401,802	(15,356)	1,386,446			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,841)	30		9
10	Interest and Other Investment Income	(60)	32		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)	(652)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(100)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,639)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,292)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,064)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (6,064)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (15,356)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Shady Oaks West ID# 0040E27
 Report Period Beginning: 07/01/05
 Ending: 06/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Prior Period Adjustment	\$ (2,639)	21
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
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85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100	Total	(2,639)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks West# 0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			358	3	48							409	5
6	Maintenance			2,106	17	22							2,145	6
7	Other (specify):*			213	1	2							216	7
8	TOTAL General Services			2,677	21	72							2,770	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(652)											(652)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(652)											(652)	16
	C. General Administration													
17	Administrative			45,685	14,306	66,821	(13)						126,799	17
18	Directors Fees													18
19	Professional Services			(79,612)	(20,684)	(90,741)	(80)						(191,117)	19
20	Fees, Subscriptions & Promotions			329	1,224	76							1,629	20
21	Clerical & General Office Expenses	(2,739)		3,622	916	2,086	97						3,982	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,362	103	194							2,659	24
25	Other Admin. Staff Transportation			809	277	3,205	(1)						4,290	25
26	Insurance-Prop.Liab.Malpractice			3,646	68	415							4,129	26
27	Other (specify):*			8,432	2,785	14,447	(3)						25,661	27
28	TOTAL General Administration	(2,739)		(14,727)	(1,005)	(3,497)							(21,968)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,391)		(12,050)	(984)	(3,425)							(19,850)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(5,841)	13,536	4,795	647	478							13,615	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(60)	12,679	1,755		417							14,791	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(32,414)	5,512	165	2,370							(24,367)	34
35	Rent-Equipment & Vehicles			154	140	161							455	35
36	Other (specify):*													36
37	TOTAL Ownership	(5,901)	(6,199)	12,216	952	3,426							4,494	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,292)	(6,199)	166	(32)	1							(15,356)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		Vesper Mgmt	Des Plaines	Mgmt Company
				Lutheran SS of IL	Des Plaines	Corporate Office

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental of Space	\$ 32,414	Vesper Management	100.00%	\$		(32,414) 1
2	V	32 Interest		Vesper Management	100.00%	12,679		12,679 2
3	V	30 Depreciation		Vesper Management	100.00%	13,536		13,536 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		\$ 32,414			\$ 26,215	\$ *	(6,199) 14

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

VII. RELATED PARTIES (continued)

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

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

1	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 and Wages		Lutheran Social Services of Illinois	100.00%	45,685	45,685	15
16	V	27 Empl. Benefits and Taxes		Lutheran Social Services of Illinois	100.00%	8,438	8,438	16
17	V	19 Prof. Fees and Contracts		Lutheran Social Services of Illinois	100.00%	5,728	5,728	17
18	V	21 Supp, Tele,Post, Out Printing		Lutheran Social Services of Illinois	100.00%	3,513	3,513	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	5,512	5,512	19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	358	358	20
21	V	6 Bldg Repairs and Maintenance		Lutheran Social Services of Illinois	100.00%	46	46	21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	1,755	1,755	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	3,646	3,646	24
25	V	27 Advertising and Promotions		Lutheran Social Services of Illinois	100.00%	(6)	(6)	25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	809	809	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	12	12	27
28	V	24 Conferences and Conventions		Lutheran Social Services of Illinois	100.00%	2,362	2,362	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	329	329	29
30	V	6 Furniture and Fixtures		Lutheran Social Services of Illinois	100.00%	51	51	30
31	V	6 Machinery and Equip		Lutheran Social Services of Illinois	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	142	142	32
33	V	6 Equipment Repair and Maint		Lutheran Social Services of Illinois	100.00%	2,009	2,009	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%			34
35	V	7 Securty and Waste Removal		Lutheran Social Services of Illinois	100.00%	213	213	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	109	109	36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	4,795	4,795	37
38	V	19 Management Allocation	85,340	Lutheran Social Services of Illinois	100.00%		(85,340)	38
39	Total		\$ 85,340			\$ 85,506	\$ * 166	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Salaries and Wages		Lutheran Social Services of Illinois	100.00%	14,306	14,306 15
16	V	27 Empl. Benefits and Taxes		Lutheran Social Services of Illinois	100.00%	2,785	2,785 16
17	V	19 Prof. Fees and Contracts		Lutheran Social Services of Illinois	100.00%	3,581	3,581 17
18	V	21 Supp, Tele,Post, Out Printing		Lutheran Social Services of Illinois	100.00%	891	891 18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	165	165 19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	3	3 20
21	V	6 Bldg Repairs and Maintenance		Lutheran Social Services of Illinois	100.00%		
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%		
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	68	68 24
25	V	27 Advertising and Promotions		Lutheran Social Services of Illinois	100.00%		
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	277	277 26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	28	28 27
28	V	24 Conferences and Conventions		Lutheran Social Services of Illinois	100.00%	103	103 28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	109	109 29
30	V	6 Furniture and Fixtures		Lutheran Social Services of Illinois	100.00%	9	9 30
31	V	6 Machinery and Equip		Lutheran Social Services of Illinois	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	112	112 32
33	V	6 Equipment Repair and Maint		Lutheran Social Services of Illinois	100.00%	8	8 33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%	1,115	1,115 34
35	V	7 Securty and Waste Removal		Lutheran Social Services of Illinois	100.00%	1	1 35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	25	25 36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	647	647 37
38	V	19 Human Resources Allocation	24,265	Lutheran Social Services of Illinois	100.00%		(24,265) 38
39	Total		\$ 24,265			\$ 24,233	\$ * (32) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Salaries and Wages		Lutheran Social Services of Illinois	100.00%	66,821	66,821	15
16	V	27 Empl. Benefits and Taxes		Lutheran Social Services of Illinois	100.00%	14,443	14,443	16
17	V	19 Prof. Fees and Contracts		Lutheran Social Services of Illinois	100.00%	709	709	17
18	V	21 Supp, Tele,Post, Out Printing		Lutheran Social Services of Illinois	100.00%	2,086	2,086	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	2,370	2,370	19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	48	48	20
21	V	6 Bldg Repairs and Maintenance		Lutheran Social Services of Illinois	100.00%	5	5	21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	417	417	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	415	415	24
25	V	27 Advertising and Promotions		Lutheran Social Services of Illinois	100.00%	4	4	25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	3,205	3,205	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	46	46	27
28	V	24 Conferences and Conventions		Lutheran Social Services of Illinois	100.00%	194	194	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	76	76	29
30	V	6 Furniture and Fixtures		Lutheran Social Services of Illinois	100.00%			30
31	V	6 Machinery and Equip		Lutheran Social Services of Illinois	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	115	115	32
33	V	6 Equipment Repair and Maint		Lutheran Social Services of Illinois	100.00%	17	17	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%			34
35	V	7 Securty and Waste Removal		Lutheran Social Services of Illinois	100.00%	2	2	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%			36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	478	478	37
38	V	19 Network Admin. Allocation	91,450	Lutheran Social Services of Illinois	100.00%		(91,450)	38
39	Total		\$ 91,450			\$ 91,451	\$ *	1 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Salaries and Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ (13)	\$ (13)
16	V	27 Empl. Benefits and Taxes		Lutheran Social Services of Illinois	100.00%	(3)	(3)
17	V	19 Prof. Fees and Contracts		Lutheran Social Services of Illinois	100.00%	(142)	(142)
18	V	21 Supp, Tele,Post, Out Printing		Lutheran Social Services of Illinois	100.00%	97	97
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%		
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%		
21	V	6 Bldg Repairs and Maintenance		Lutheran Social Services of Illinois	100.00%		
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%		
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%		
25	V	27 Advertising and Promotions		Lutheran Social Services of Illinois	100.00%		
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	(1)	(1)
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%		
28	V	24 Conferences and Conventions		Lutheran Social Services of Illinois	100.00%		
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%		
30	V	6 Furniture and Fixtures		Lutheran Social Services of Illinois	100.00%		
31	V	6 Machinery and Equip		Lutheran Social Services of Illinois	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%		
33	V	6 Equipment Repair and Maint		Lutheran Social Services of Illinois	100.00%		
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%		
35	V	7 Securty and Waste Removal		Lutheran Social Services of Illinois	100.00%		
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%		
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%		
38	V	19 Local Admin. Allocation	(62)	Lutheran Social Services of Illinois	100.00%		62
39	Total		\$ (62)			\$ (62)	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West# 0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lutheran Social Services of Illinois
 Street Address 1001 E. Touhy Avenue, Suite 50
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (847) 635-4600
 Fax Number (847) 635-6764

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries and Wages	52,461,326	218	1,105,382	1,105,382	678,983	14,306	1
2	27	Empl. Benefits and Taxes	52,461,326	218	215,157		678,983	2,785	2
3	19	Prof. Fees and Contracts	52,461,326	218	276,688		678,983	3,581	3
4	21	Supp, Tele,Post, Out Printing	52,461,326	218	68,860		678,983	891	4
5	34	Rental of Space	52,461,326	218	12,735		678,983	165	5
6	5	Utilities	52,461,326	218	233		678,983	3	6
7	6	Bldg Repairs and Maintenance	52,461,326	218			678,983		7
8	32	Interest	52,461,326	218			678,983		8
9	33	Real Estate Taxes	52,461,326	218			678,983		9
10	26	Insurance	52,461,326	218	5,274		678,983	68	10
11	27	Advertising and Promotions	52,461,326	218			678,983		11
12	25	Transportation	52,461,326	218	21,388		678,983	277	12
13	35	Car Rental	52,461,326	218	2,173		678,983	28	13
14	24	Conferences and Conventions	52,461,326	218	7,926		678,983	103	14
15	20	Subscriptions, Dues, Awards	52,461,326	218	8,447		678,983	109	15
16	6	Furniture and Fixtures	52,461,326	218	661		678,983	9	16
17	6	Machinery and Equip	52,461,326	218			678,983		17
18	35	Equipment Rental	52,461,326	218	8,648		678,983	112	18
19	6	Equipment Repair and Maint	52,461,326	218	620		678,983	8	19
20	20	Employee Recruitment	52,461,326	218	86,128		678,983	1,115	20
21	7	Securtiy and Waste Removal	52,461,326	218	60		678,983	1	21
22	21	All Other Miscellaneous	52,461,326	218	1,927		678,983	25	22
23	30	Depreciation	52,461,326	218	49,999		678,983	647	23
24									24
25	TOTALS				\$ 1,872,306	\$ 1,105,382		\$ 24,233	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending: 06/30/06

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries and Wages	32,568,454	224	2,973,157	2,973,157	500,445	45,685	1
2	27	Empl. Benefits and Taxes	32,568,454	224	549,142		500,445	8,438	2
3	19	Prof. Fees and Contracts	32,568,454	224	372,765		500,445	5,728	3
4	21	Supp, Tele,Post, Out Printing	32,568,454	224	228,636		500,445	3,513	4
5	34	Rental of Space	32,568,454	224	358,692		500,445	5,512	5
6	5	Utilities	32,568,454	224	23,282		500,445	358	6
7	6	Bldg Repairs and Maintenance	32,568,454	224	2,989		500,445	46	7
8	32	Interest	32,568,454	224	114,210		500,445	1,755	8
9	33	Real Estate Taxes	32,568,454	224			500,445		9
10	26	Insurance	32,568,454	224	237,309		500,445	3,646	10
11	27	Advertising and Promotions	32,568,454	224	(379)		500,445	(6)	11
12	25	Transportation	32,568,454	224	52,634		500,445	809	12
13	35	Car Rental	32,568,454	224	793		500,445	12	13
14	24	Conferences and Conventions	32,568,454	224	153,711		500,445	2,362	14
15	20	Subscriptions, Dues, Awards	32,568,454	224	21,401		500,445	329	15
16	6	Furniture and Fixtures	32,568,454	224	3,344		500,445	51	16
17	6	Machinery and Equip	32,568,454	224			500,445		17
18	35	Equipment Rental	32,568,454	224	9,234		500,445	142	18
19	6	Equipment Repair and Maint	32,568,454	224	130,757		500,445	2,009	19
20	20	Employee Recruitment	32,568,454	224			500,445		20
21	7	Securtiy and Waste Removal	32,568,454	224	13,877		500,445	213	21
22	21	All Other Miscellaneous	32,568,454	224	7,098		500,445	109	22
23	30	Depreciation	32,568,454	224	312,062		500,445	4,795	23
24									24
25	TOTALS				\$ 5,564,714	\$ 2,973,157		\$ 85,506	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending: 06/30/06

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries and Wages	4,705,039	58	628,236	628,236	500,445	66,821	1
2	27	Empl. Benefits and Taxes	4,705,039	58	135,788	628,236	500,445	14,443	2
3	19	Prof. Fees and Contracts	4,705,039	58	6,666	628,236	500,445	709	3
4	21	Supp, Tele,Post, Out Printing	4,705,039	58	19,612	628,236	500,445	2,086	4
5	34	Rental of Space	4,705,039	58	22,281	628,236	500,445	2,370	5
6	5	Utilities	4,705,039	58	447	628,236	500,445	48	6
7	6	Bldg Repairs and Maintenance	4,705,039	58	45	628,236	500,445	5	7
8	32	Interest	4,705,039	58	3,923	628,236	500,445	417	8
9	33	Real Estate Taxes	4,705,039	58		628,236	500,445		9
10	26	Insurance	4,705,039	58	3,904	628,236	500,445	415	10
11	27	Advertising and Promotions	4,705,039	58	40	628,236	500,445	4	11
12	25	Transportation	4,705,039	58	30,132	628,236	500,445	3,205	12
13	35	Car Rental	4,705,039	58	437	628,236	500,445	46	13
14	24	Conferences and Conventions	4,705,039	58	1,823	628,236	500,445	194	14
15	20	Subscriptions, Dues, Awards	4,705,039	58	710	628,236	500,445	76	15
16	6	Furniture and Fixtures	4,705,039	58		628,236	500,445		16
17	6	Machinery and Equip	4,705,039	58		628,236	500,445		17
18	35	Equipment Rental	4,705,039	58	1,080	628,236	500,445	115	18
19	6	Equipment Repair and Maint	4,705,039	58	158	628,236	500,445	17	19
20	20	Employee Recruitment	4,705,039	58		628,236	500,445		20
21	7	Securtiy and Waste Removal	4,705,039	58	19	628,236	500,445	2	21
22	21	All Other Miscellaneous	4,705,039	58	(3)	628,236	500,445		22
23	30	Depreciation	4,705,039	58	4,498	628,236	500,445	478	23
24									24
25	TOTALS				\$ 859,796	\$ 14,449,428		\$ 91,451	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending: 06/30/06

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries and Wages	4,292,610	44	\$ (114)	\$ (114)	500,445	\$ (13)	1
2	27	Empl. Benefits and Taxes	4,292,610	44	(25)		500,445	(3)	2
3	19	Prof. Fees and Contracts	4,292,610	44	(1,221)		500,445	(142)	3
4	21	Supp, Tele,Post, Out Printing	4,292,610	44	836		500,445	97	4
5	34	Rental of Space	4,292,610	44			500,445		5
6	5	Utilities	4,292,610	44	(4)		500,445		6
7	6	Bldg Repairs and Maintenance	4,292,610	44			500,445		7
8	32	Interest	4,292,610	44			500,445		8
9	33	Real Estate Taxes	4,292,610	44	1		500,445		9
10	26	Insurance	4,292,610	44			500,445		10
11	27	Advertising and Promotions	4,292,610	44			500,445		11
12	25	Transportation	4,292,610	44			500,445		12
13	35	Car Rental	4,292,610	44	(7)		500,445	(1)	13
14	24	Conferences and Conventions	4,292,610	44			500,445		14
15	20	Subscriptions, Dues, Awards	4,292,610	44			500,445		15
16	6	Furniture and Fixtures	4,292,610	44			500,445		16
17	6	Machinery and Equip	4,292,610	44			500,445		17
18	35	Equipment Rental	4,292,610	44			500,445		18
19	6	Equipment Repair and Maint	4,292,610	44			500,445		19
20	20	Employee Recruitment	4,292,610	44			500,445		20
21	7	Securtiy and Waste Removal	4,292,610	44			500,445		21
22	21	All Other Miscellaneous	4,292,610	44			500,445		22
23	30	Depreciation	4,292,610	44			500,445		23
24									24
25	TOTALS				\$	\$		\$ (62)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Tax-Exempt Bonds		X	Construction of Facility		09/23/93	\$ 442,173	\$	02/16/2006	0.0738	\$ 10,817	1						
2	Tax-Exempt Bonds		X	Construction of Facility		02/16/06	316,000	316,000	08/15/2028		6,271	2						
3												3						
4												4						
5	See Supplemental Schedule											5						
Working Capital																		
6	Management Alloc.(Sch VII)	X		Management Allocation							2,172	6						
7												7						
8	See Supplemental Schedule											8						
9	TOTAL Facility Related						\$ 758,173	\$ 316,000			\$ 19,260	9						
B. Non-Facility Related*																		
10	Interest on Bank Account		X								(60)	10						
11												11						
12												12						
13	See Supplemental Schedule											13						
14	TOTAL Non-Facility Related						\$	\$			\$ (60)	14						
15	TOTALS (line 9+line14)						\$ 758,173	\$ 316,000			\$ 19,200	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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:

07/01/05

Ending:

06/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8						\$	\$			\$	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks West COUNTY Will

FACILITY IDPH LICENSE NUMBER 0040527

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shady Oaks West COUNTY Will

FACILITY IDPH LICENSE NUMBER 0040527

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,243 B. General Construction Type: Exterior Face Brick/Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1994	775		20			775
10	Various		1998	21,295		20	532	532	4,435
11	Various		1999	15,803		20	1,580	1,580	11,674
12	Various		2002	2,592		20	259	259	917
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
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67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	550,745	13,536		13,573	37	155,769
68	Related Party Allocations (Pages 12-REP & 12A-REP)						
69	Financial Statement Depreciation		22,939			(22,939)	
70	TOTAL (lines 4 thru 69)	\$ 591,210	\$ 36,475		\$ 15,944	\$ (20,531)	\$ 173,570

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 591,210	\$ 36,475		\$ 15,944	\$ (20,531)	\$ 173,570	1
2	Handicap Accessible Doors	2003	2,591		20	259	259	788	2
3	Flooring	2004	54,276		20	5,428	5,428	12,553	3
4	Roof Repair	2005	32,507		20	3,251	3,251	3,635	4
5	Roof Repair	2006	5,985		20	574	574	574	5
6	Install Victorian Paver Patio	2006	1,450		20	127	127	127	6
7	Window	2006	5,000		20	104	104	104	7
8	Window Replacement	2006	6,373		20	80	80	80	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431
2							
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31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
3								3
4								4
5								5
6								6
7								7
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
3								3
4								4
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
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5								5
6								6
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
3								3
4								4
5								5
6								6
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33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
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33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
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32								32
33								33
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SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
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33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431
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33							
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431
2							
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32							
33							
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
2								2
3								3
4								4
5								5
6								6
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	1
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 699,392	\$ 36,475		\$ 25,767	\$ (10,708)	\$ 191,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1994	1994	\$ 541,423	\$ 13,536	40	\$ 13,536	\$	\$ 155,769
5									
6									
7									
8									
Improvement Type**									
9	Management Assets- Security System		1999	9,322		10	37	37	N/A
10									
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12									
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SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
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67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 550,745	\$ 13,536		\$ 13,573	\$ 37	\$ 155,769

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 31,558	\$	\$ 4,849	\$ 4,849	10	\$ 17,859	71
72	Current Year Purchases	3,138		18	18	10	18	72
73	Fully Depreciated Assets	36,625				10	36,625	73
74								74
75	TOTALS	\$ 71,321	\$	\$ 4,867	\$ 4,867		\$ 54,502	75

D. Vehicle Depreciation (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	Resident Transportation	1998 Chevy Passenger Van	1998	\$ 34,602	\$	\$	\$	5	\$ 34,602	76
77										77
78										78
79										79
80	TOTALS			\$ 34,602	\$	\$	\$		\$ 34,602	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)	\$ 805,315	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,475	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,634	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,841)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 280,535	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>Parker</u>				<u>3,963</u>			5
6	<u>Alloc. VIII</u>				<u>8,047</u>			6
7	TOTAL				\$ <u>12,010</u>			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: \$ 369 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Corp.Staff-AllocSchVII</u>	<u>Various</u>	\$	\$ <u>86</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>86</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					1,103			1,103	13
14	TOTAL			\$		\$ 1,103	\$		\$ 1,103	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning: 07/01/05

Ending:

06/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(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): See Attached Schedule			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): See Attached Schedule			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	See Attached Schedule			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	See Attached Schedule			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)	\$ (122,519)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (122,519)	\$	48

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,249,813	1
2	Discounts and Allowances for all Levels	2,639	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,252,452	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	26,771	24
25	Interest and Other Investment Income***	60	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,831	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		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)	\$ 1,279,283	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	131,117	31
32	Health Care	743,116	32
33	General Administration	409,708	33
	B. Capital Expense		
34	Ownership	57,805	34
	C. Ancillary Expense		
35	Special Cost Centers	1,103	35
36	Provider Participation Fee	58,953	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,401,802	40
41	Income before Income Taxes (line 30 minus line 40)**	(122,519)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (122,519)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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)	(122,519)	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)	\$ (122,519)	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)	\$ (122,519)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/05

Ending:

06/30/06

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	2,234	47,392	19.51	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	235	3,592	13.50	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	946	16,521	15.16	13
14	Head Cook	2,468	29,277	10.84	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	2,052	10,630	5.18	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	881	28,594	26.23	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	23	396	14.67	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,757	33,799	16.80	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	27,201	367,487	12.03	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Supplemental</u>				33
34	TOTAL (lines 1 - 33)	37,797	537,688 *	12.73	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	Monthly \$ 975	01-03	35
36	Medical Director	Monthly 3,000	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant	As Needed 1,391	10-03	38
39	Pharmacist Consultant	As Needed 111	10-03	39
40	Physical Therapy Consultant	As Needed 88	10a-03	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	As Needed 83	12-03	45
46	Other(specify)			46
47	<u>Developmental Training Service</u>	Monthly 232,925	10-03	47
48				48
49	TOTAL (lines 35 - 48)	\$ 238,573		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 7,017	10-03	51
52	Certified Nurse Assistants/Aides	As Needed 23,813	10-03	52
53	TOTAL (lines 50 - 52)	\$ 30,830		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Kristin Stockle	Program Director	0	\$ 28,594	Workers' Compensation Insurance	\$ 19,519	IDPH License Fee	\$		
				Unemployment Compensation Insurance	1,376	Advertising: Employee Recruitment			
				FICA Taxes	38,368	Health Care Worker Background Check			
				Employee Health Insurance	47,918	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Allocation (Sch. VIII)	1,629		
				Disability Insurance	1,119				
				Life Insurance	1,581				
				Pension-United Way of Chicago	31,397				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 28,594	TOTAL (agree to Schedule V, line 22, col.8)		\$ 141,278			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	450	
C. Professional Services							Allocation (Sch. VIII)		2,659
Vendor/Payee	Type		Amount				Entertainment Expense		()
Johnson and Colmar	Legal		\$ 321	TOTAL			(agree to Sch. V, line 24, col. 8)		\$ 3,109
Littler Mendelson	Legal		751						
LSSI	Management Services		200,993						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 202,065						

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West# 0040527Report Period Beginning: 07/01/05Ending: 06/30/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,465 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,953
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0%
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- 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?
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT