

Facility Name & ID Number Shady Oaks West

0040527 Report Period Beginning: 07/01/09 Ending: 06/30/10

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,475			5,475	13
14	TOTALS	5,475			5,475	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.75%

D. How many bed-hold days during this year were paid by the Department? 28 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2010 Fiscal Year: 6/30/2010

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

Facility Name & ID Number Shady Oaks West # 0040527 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	43,626	3,329	2,188	49,143		49,143		49,143		1
2	Food Purchase		35,070		35,070		35,070		35,070		2
3	Housekeeping	10,388	1,221		11,609		11,609		11,609		3
4	Laundry		2,445		2,445		2,445		2,445		4
5	Heat and Other Utilities			11,844	11,844		11,844	320	12,164		5
6	Maintenance		6,861	34,973	41,834		41,834	2,898	44,732		6
7	Other (specify):*							382	382		7
8	TOTAL General Services	54,014	48,926	49,005	151,945		151,945	3,600	155,545		8
	B. Health Care and Programs										
9	Medical Director			1,750	1,750		1,750		1,750		9
10	Nursing and Medical Records	455,897	21,645	329,207	806,749		806,749		806,749		10
10a	Therapy										10a
11	Activities	13,823	1,025		14,848		14,848		14,848		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	469,720	22,670	330,957	823,347		823,347		823,347		16
	C. General Administration										
17	Administrative	66,875			66,875		66,875	88,013	154,888		17
18	Directors Fees										18
19	Professional Services			162,978	162,978		162,978	(150,734)	12,244		19
20	Dues, Fees, Subscriptions & Promotions			50	50		50	1,400	1,450		20
21	Clerical & General Office Expenses	13,817	1,745	7,340	22,902		22,902	4,368	27,270		21
22	Employee Benefits & Payroll Taxes			141,397	141,397		141,397	17,467	158,864		22
23	Inservice Training & Education										23
24	Travel and Seminar			353	353		353	1,187	1,540		24
25	Other Admin. Staff Transportation			3,997	3,997		3,997	1,674	5,671		25
26	Insurance-Prop.Liab.Malpractice			8,886	8,886		8,886	3,460	12,346		26
27	Other (specify):*										27
28	TOTAL General Administration	80,692	1,745	325,001	407,438		407,438	(33,165)	374,273		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	604,426	73,341	704,963	1,382,730		1,382,730	(29,565)	1,353,165		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:

07/01/09

Ending:

06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			20,227	20,227		20,227	13,450	33,677			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,304	5,304		5,304	12,901	18,205			32
33	Real Estate Taxes							2	2			33
34	Rent-Facility & Grounds			30,879	30,879		30,879	(13,905)	16,974			34
35	Rent-Equipment & Vehicles			483	483		483	333	816			35
36	Other (specify):*			116	116		116		116			36
37	TOTAL Ownership			57,009	57,009		57,009	12,781	69,790			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,466	1,466		1,466		1,466			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,371	60,371		60,371		60,371			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			61,837	61,837		61,837		61,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	604,426	73,341	823,809	1,501,576		1,501,576	(16,784)	1,484,792			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,212)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,692)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,219)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,123)		\$	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)	(2,661)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,661)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (16,784)		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						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# 0040527

Report Period Beginning: 07/01/09

Ending: 06/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Tootsie Roll Sale Revenue	\$ (802)	21	1
2	Storage Refund	(218)	06	2
3	Non-Allowable Legal Fees	(3,199)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,219)		49

Shady Oaks West

ID# 0040527

Report Period Beginning: 07/01/09

Ending: 06/30/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shady Oaks West# 0040527

Report Period Beginning:

07/01/09

Ending:

06/30/10

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			307		13							320	5
6	Maintenance	(218)		2,659	162	295							2,898	6
7	Other (specify):*			300		82							382	7
8	TOTAL General Services	(218)		3,266	162	390							3,600	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			48,903	12,483	26,627							88,013	17
18	Directors Fees													18
19	Professional Services	(3,199)		(83,217)	(19,212)	(45,106)							(150,734)	19
20	Fees, Subscriptions & Promotions			344	917	139							1,400	20
21	Clerical & General Office Expenses	(2,494)		4,692	467	1,703							4,368	21
22	Employee Benefits & Payroll Taxes			9,047	2,875	5,545							17,467	22
23	Inservice Training & Education													23
24	Travel and Seminar			401	512	274							1,187	24
25	Other Admin. Staff Transportation			813	109	752							1,674	25
26	Insurance-Prop.Liab.Malpractice			2,350	37	1,073							3,460	26
27	Other (specify):*													27
28	TOTAL General Administration	(5,693)		(16,667)	(1,812)	(8,993)							(33,165)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,911)		(13,401)	(1,650)	(8,603)							(29,565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(8,212)	13,536	5,793	1,207	1,126							13,450	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		8,679	1,341	122	2,759							12,901	32
33	Real Estate Taxes			2									2	33
34	Rent-Facility & Grounds		(27,371)	5,951	281	7,234							(13,905)	34
35	Rent-Equipment & Vehicles			174	7	152							333	35
36	Other (specify):*													36
37	TOTAL Ownership	(8,212)	(5,156)	13,261	1,617	11,271							12,781	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)	(14,123)	(5,156)	(140)	(33)	2,668							(16,784)	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
LSSI	100%	N/A		Vesper Management	Des Plaines	Mgmt. Company
				LSSI	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	\$ 27,371	Vesper Management	100.00%	\$		(27,371) 1
2	V	32 Interest		Vesper Management	100.00%	8,679		8,679 2
3	V	30 Depreciation		Vesper Management	100.00%	13,536		13,536 3
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 27,371			\$ 22,215	\$ *	(5,156) 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 & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 48,903	\$	48,903	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	9,047		9,047	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	4,111		4,111	17
18	V	21 Supplies, Telephone, Postage, Out Printing		Lutheran Social Services of Illinois	100.00%	2,865		2,865	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	5,951		5,951	19
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	307		307	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%	1		1	21
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	1,341		1,341	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%	2		2	23
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	2,350		2,350	24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%	(2)		(2)	25
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	813		813	26
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	62		62	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	401		401	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	346		346	29
30	V	21 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%				30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%				31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	112		112	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	2,658		2,658	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%				34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%	300		300	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	1,827		1,827	36
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	5,793		5,793	37
38	V	19 Agency Management Allocation	87,328	Lutheran Social Services of Illinois	100.00%			(87,328)	38
39	Total		\$ 87,328			\$ 87,188	\$ *	(140)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 12,483	\$ 12,483
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	2,875	2,875
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	5,242	5,242
18	V	21 Supplies, Telephone, Postage, Out. Printing		Lutheran Social Services of Illinois	100.00%	458	458
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	281	281
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%		
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%		
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	122	122
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	37	37
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%		
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	109	109
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%	7	7
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	512	512
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	49	49
30	V	21 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%		
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%		
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	162	162
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%	868	868
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%		
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	9	9
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	1,207	1,207
38	V	19 Human Resource Allocation	24,454	Lutheran Social Services of Illinois	100.00%		(24,454)
39	Total		\$ 24,454			\$ 24,421	\$ * (33)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois	100.00%	\$ 26,627	\$ 26,627
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois	100.00%	5,545	5,545
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois	100.00%	391	391
18	V	21 Supplies, Telephone, Postage, Out. Printing		Lutheran Social Services of Illinois	100.00%	1,701	1,701
19	V	34 Rental of Space		Lutheran Social Services of Illinois	100.00%	7,234	7,234
20	V	5 Utilities		Lutheran Social Services of Illinois	100.00%	13	13
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois	100.00%	4	4
22	V	32 Interest		Lutheran Social Services of Illinois	100.00%	2,759	2,759
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois	100.00%		
24	V	26 Insurance		Lutheran Social Services of Illinois	100.00%	1,073	1,073
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois	100.00%		
26	V	25 Transportation		Lutheran Social Services of Illinois	100.00%	752	752
27	V	35 Car Rental		Lutheran Social Services of Illinois	100.00%		
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois	100.00%	274	274
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois	100.00%	139	139
30	V	21 Furniture & Fixtures		Lutheran Social Services of Illinois	100.00%		
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois	100.00%		
32	V	35 Equipment Rental		Lutheran Social Services of Illinois	100.00%	152	152
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois	100.00%	291	291
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois	100.00%		
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois	100.00%	82	82
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois	100.00%	2	2
37	V	30 Depreciation		Lutheran Social Services of Illinois	100.00%	1,126	1,126
38	V	19 Service Network Administration	45,497	Lutheran Social Services of Illinois	100.00%		(45,497)
39	Total		\$ 45,497			\$ 48,165	\$ * 2,668

* 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.

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: 07/01/09 Ending: 06/30/10

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:

07/01/09

Ending: 06/30/10

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:

07/01/09

Ending: 06/30/10

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

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 & Wages	Non-Capital Direct Costs	36,454,205	285	\$ 3,120,995	\$ 3,120,995	571,207	\$ 48,903	1
2	22	Empl Benefits & Taxes		36,454,205	285	577,346	571,207	9,047		2
3	19	Prof Fees & Contracts		36,454,205	285	262,382	571,207	4,111		3
4	21	Supplies, Telephone, Postage, Out Printing		36,454,205	285	182,863	571,207	2,865		4
5	34	Rental of Space		36,454,205	285	379,819	571,207	5,951		5
6	5	Utilities		36,454,205	285	19,607	571,207	307		6
7	6	Bldg Repairs & Maintenance		36,454,205	285	59	571,207	1		7
8	32	Interest		36,454,205	285	85,612	571,207	1,341		8
9	33	Real Estate Taxes		36,454,205	285	144	571,207	2		9
10	26	Insurance		36,454,205	285	149,947	571,207	2,350		10
11	20	Advertising & Promotions		36,454,205	285	(143)	571,207	(2)		11
12	25	Transportation		36,454,205	285	51,875	571,207	813		12
13	35	Car Rental		36,454,205	285	3,947	571,207	62		13
14	24	Conferences & Conventions		36,454,205	285	25,603	571,207	401		14
15	20	Subscriptions, Dues, Awards		36,454,205	285	22,070	571,207	346		15
16	21	Furniture & Fixtures		36,454,205	285		571,207			16
17	6	Machinery & Equipment		36,454,205	285		571,207			17
18	35	Equipment Rental		36,454,205	285	7,171	571,207	112		18
19	6	Equipment Repair & Maint.		36,454,205	285	169,637	571,207	2,658		19
20	20	Employee Recruitment		36,454,205	285		571,207			20
21	7	Security & Waste Removal		36,454,205	285	19,162	571,207	300		21
22	21	All Other Miscellaneous		36,454,205	285	116,590	571,207	1,827		22
23	30	Depreciation		36,454,205	285	369,734	571,207	5,793		23
24	19	Adv / Comm Alloc		36,454,205	285		571,207			24
25	TOTALS					\$ 5,564,420	\$ 3,120,995		\$ 87,188	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending: 06/30/10

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

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 & Wages	56,594,127	264	\$ 945,145	\$ 945,145	747,458	\$ 12,483	1
2	22	Empl Benefits & Taxes	56,594,127	264	217,664		747,458	2,875	2
3	19	Prof Fees & Contracts	56,594,127	264	396,906		747,458	5,242	3
4	21	Supplies, Telephone,Postage, Out. Printing	56,594,127	264	34,691		747,458	458	4
5	34	Rental of Space	56,594,127	264	21,271		747,458	281	5
6	5	Utilities	56,594,127	264			747,458		6
7	6	Bldg Repairs & Maintenance	56,594,127	264			747,458		7
8	32	Interest	56,594,127	264	9,206		747,458	122	8
9	33	Real Estate Taxes	56,594,127	264			747,458		9
10	26	Insurance	56,594,127	264	2,818		747,458	37	10
11	20	Advertising & Promotions	56,594,127	264			747,458		11
12	25	Transportation	56,594,127	264	8,268		747,458	109	12
13	35	Car Rental	56,594,127	264	562		747,458	7	13
14	24	Conferences & Conventions	56,594,127	264	38,790		747,458	512	14
15	20	Subscriptions, Dues, Awards	56,594,127	264	3,729		747,458	49	15
16	21	Furniture & Fixtures	56,594,127	264			747,458		16
17	6	Machinery & Equipment	56,594,127	264			747,458		17
18	35	Equipment Rental	56,594,127	264			747,458		18
19	6	Equipment Repair & Maint.	56,594,127	264	12,264		747,458	162	19
20	20	Employee Recruitment	56,594,127	264	65,704		747,458	868	20
21	7	Security & Waste Removal	56,594,127	264	26		747,458		21
22	21	All Other Miscellaneous	56,594,127	264	663		747,458	9	22
23	30	Depreciation	56,594,127	264	91,380		747,458	1,207	23
24	19	Adv / Comm Alloc	56,594,127	264			747,458		24
25	TOTALS				\$ 1,849,087	\$ 945,145		\$ 24,421	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending: 06/30/10

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

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 & Wages	4,224,354	59	\$ 196,917	\$ 196,917	571,207	\$ 26,627	1
2	22	Empl Benefits & Taxes	4,224,354	59	41,006		571,207	5,545	2
3	19	Prof Fees & Contracts	4,224,354	59	2,893		571,207	391	3
4	21	Supplies, Telephone,Postage, Out. Printing	4,224,354	59	12,582		571,207	1,701	4
5	34	Rental of Space	4,224,354	59	53,499		571,207	7,234	5
6	5	Utilities	4,224,354	59	95		571,207	13	6
7	6	Bldg Repairs & Maintenance	4,224,354	59	33		571,207	4	7
8	32	Interest	4,224,354	59	20,406		571,207	2,759	8
9	33	Real Estate Taxes	4,224,354	59			571,207		9
10	26	Insurance	4,224,354	59	7,936		571,207	1,073	10
11	20	Advertising & Promotions	4,224,354	59			571,207		11
12	25	Transportation	4,224,354	59	5,565		571,207	752	12
13	35	Car Rental	4,224,354	59			571,207		13
14	24	Conferences & Conventions	4,224,354	59	2,026		571,207	274	14
15	20	Subscriptions, Dues, Awards	4,224,354	59	1,025		571,207	139	15
16	21	Furniture & Fixtures	4,224,354	59	3		571,207		16
17	6	Machinery & Equipment	4,224,354	59			571,207		17
18	35	Equipment Rental	4,224,354	59	1,122		571,207	152	18
19	6	Equipment Repair & Maint.	4,224,354	59	2,150		571,207	291	19
20	20	Employee Recruitment	4,224,354	59			571,207		20
21	7	Security & Waste Removal	4,224,354	59	609		571,207	82	21
22	21	All Other Miscellaneous	4,224,354	59	15		571,207	2	22
23	30	Depreciation	4,224,354	59	8,325		571,207	1,126	23
24									24
25	TOTALS				\$ 356,207	\$ 196,917		\$ 48,165	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending: 06/30/10

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:

07/01/09

Ending: 06/30/10

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:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

07/01/09

Ending: 06/30/10

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: 07/01/09 Ending: 06/30/10

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:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

07/01/09

Ending:

06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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		2/16/2006	\$ 316,000	\$ 286,612	2/16/2028	0.0523	\$ 13,355	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
Working Capital																			
6	LSSI Alloc. (Sch VIII)		X								4,222	6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$ 316,000	\$ 286,612			\$ 17,577	9							
B. Non-Facility Related*																			
10	Misc. Interest- Bank Acct.		X								628	10							
11												11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ 628	14							
15	TOTALS (line 9+line14)						\$ 316,000	\$ 286,612			\$ 18,205	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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:

07/01/09

Ending:

06/30/10

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

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

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

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

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	2	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	_____	8	FOR BHF USE ONLY	
	2006	_____	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	_____	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2008	_____	11	15	LESS REFUND FROM LINE 6 \$
	2009	_____	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Not Applicable					
Allocation from LSSI: \$2					

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 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 2009 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 2009.

	(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 X 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.**

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending:

06/30/10

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1994	775		20			775	9
10	Various		1998	21,295		20	531	531	6,562	10
11	Various		1999	15,803		20			15,803	11
12	Various		2002	2,592		20	259	259	1,955	12
13	Various		2003	2,591		20	259	259	1,824	13
14	Various		2004	54,276		20	5,424	5,424	34,264	14
15	Various		2005	39,942		20	3,992	3,992	20,314	15
16	Various		2006	11,373		20	1,137	1,137	4,733	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	550,745	13,536		13,536		219,766	67
68	Related Party Allocations (Pages 12H & 12I)		8,126			(8,126)		68
69	Financial Statement Depreciation		12,252			(12,252)		69
70	TOTAL (lines 4 thru 69)	\$ 699,391	\$ 33,914		\$ 25,138	\$ (8,776)	\$ 305,995	70

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		\$ 699,391	\$ 33,914		\$ 25,138	\$ (8,776)	\$ 305,995	1
2	Window Replacement	2007	1,270		20	127	127	418	2
3	Doors, Door Jambs And Locks	2007	2,915		20	292	292	960	3
4	Concrete Pad & Enclosure	2010	3,850		20	112	112	112	4
5	Concrete Pad & Enclosure	2010	4,100		20	120	120	120	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	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		\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	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		\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	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:

07/01/09

Ending:

06/30/10

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		\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 711,526	\$ 33,914		\$ 25,789	\$ (8,125)	\$ 307,605	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Building -16 Beds	1994	541,423	13,536	40	13,536		210,444	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Management Assets- Security System	1999	9,322		10			9,322	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 550,745	\$ 13,536		\$ 13,536	\$	\$ 219,766	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation From LSSI			8,126			(8,126)		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12H & 12I lines 1 thru 33)	\$	\$ 8,126		\$	\$ (8,126)	\$

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:

07/01/09

Ending:

06/30/10

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	\$ 20,318	\$ 3,081	\$ 3,081	\$ (0)	10	\$ 14,050	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	49,697				10	49,697	73
74								74
75	TOTALS	\$ 70,015	\$ 3,081	\$ 3,081	\$ (0)		\$ 63,747	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	98 CHEVY PASSENGER VAN F	1998	\$ 34,602	\$	\$	\$	5	\$ 34,602	76
77	Transit	2006 FORD/BRAUN PARA TRA	2006	34,256	4,894	4,808	(86)	5	19,032	77
78										78
79										79
80	TOTALS			\$ 68,858	\$ 4,894	\$ 4,808	\$ (86)		\$ 53,634	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)	\$ 850,399	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,889	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,677	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,212)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 424,986	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	Parker Storage			3,508			5
6	LSSI Alloc. (Sch VII)			13,466			6
7	TOTAL			\$ 16,974			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: \$ 514 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	Facility		\$	233	17
18	Corp Staff Alloc. (Sch VII)			69	18
19					19
20					20
21	TOTAL		\$	302	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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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	<u>39 - 03</u>	visits			<u>1,466</u>			<u>1,466</u>	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	Other (specify): _____									12
13	Other (specify): <u>See Supplemental</u>									13
14	TOTAL			\$		\$ <u>1,466</u>	\$		\$ <u>1,466</u>	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: 07/01/09

Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): 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	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	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)	\$	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(129,851)	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)	\$ (129,851)	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)	\$ (129,851)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shady Oaks West# 0040527Report Period Beginning: 07/01/09Ending: 06/30/10**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	\$ 1,348,529	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,348,529	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	12,177	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,177	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	11,019	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,019	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,371,725	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	151,945	31
32	Health Care	823,347	32
33	General Administration	407,438	33
B. Capital Expense			
34	Ownership	57,009	34
C. Ancillary Expense			
35	Special Cost Centers	1,466	35
36	Provider Participation Fee	60,371	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,501,576	40
41	Income before Income Taxes (line 30 minus line 40)**	(129,851)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (129,851)	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.

Facility Name & ID Number Shady Oaks West

0040527

Report Period Beginning:

07/01/09

Ending:

06/30/10

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	2,150	49,458	20.66	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	881	13,823	13.84	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,956	36,309	10.97	14
15	Cook Helpers/Assistants	636	7,317	10.74	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	931	10,388	9.50	18
19	Laundry				19
20	Administrator	855	27,615	27.81	20
21	Assistant Administrator	1,792	34,618	16.56	21
22	Other Administrative	119	4,642	34.90	22
23	Office Manager	563	13,817	20.59	23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,320	34,757	17.82	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	27,311	371,682	12.28	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Supplemental</u>				33
34	TOTAL (lines 1 - 33)	39,514	604,426 *	\$ 13.56	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	As Needed	\$ 2,188	01-03	35
36	Medical Director	As Needed	1,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	As Needed	1,916	10-03	38
39	Pharmacist Consultant	As Needed	420	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Developmental Training Services</u>	As Needed	269,029	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 275,303		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	14,436	10-03	51
52	Certified Nurse Assistants/Aides	As Needed	43,406	10-03	52
53	TOTAL (lines 50 - 52)		\$ 57,842		53

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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

0040527

Report Period Beginning: 07/01/09

Ending: 06/30/10

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. \$ 12,306 Line 10-2
- (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. \$ 60,371
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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Baker Tilly Virchow Krause LLP
- (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 \$5,000, 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.