FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0037507

Facility Name: Sherman West Court

Address: 1950 Larkin Avenue (Number) Elgin (City) 60123 (Zip Code)

County: Kane

Telephone Number: (847) 742-7070 **Fax #** (847) 742-7248

HFS ID Number:

Date of Initial License for Current Owners: 02/18/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 5/1/09 to 4/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		883	13,401	14,284	8
9	SNF/PED					9
10	ICF	3,020	12,692	269	15,981	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,020	13,575	13,670	30,265	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.10%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 2/18/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/18/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 12,394

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 4/30/10 Fiscal Year: 4/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		99,841		99,841		99,841	283,545	383,386			1
2	Food Purchase		162,339		162,339		162,339	(3,619)	158,720			2
3	Housekeeping		23,384		23,384		23,384	115,864	139,248			3
4	Laundry		4,027		4,027		4,027	39,063	43,090			4
5	Heat and Other Utilities			179,260	179,260		179,260		179,260			5
6	Maintenance			99,162	99,162		99,162	107,715	206,877			6
7	Other (specify):*											7
8	**TOTAL General Services**		289,591	278,422	568,013		568,013	542,568	1,110,581			8
	B. Health Care and Programs											
9	Medical Director			30,050	30,050		30,050		30,050			9
10	Nursing and Medical Records	1,377,001	273,984	1,467,199	3,118,184		3,118,184	(59,634)	3,058,550			10
10a	Therapy							1,138,006	1,138,006			10a
11	Activities							100,059	100,059			11
12	Social Services							77,020	77,020			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,377,001	273,984	1,497,249	3,148,234		3,148,234	1,255,451	4,403,685			16
	C. General Administration											
17	Administrative			216,533	216,533		216,533	(115,142)	101,391			17
18	Directors Fees											18
19	Professional Services			153,960	153,960		153,960	(18,448)	135,512			19
20	Dues, Fees, Subscriptions & Promotions			15,105	15,105		15,105	6,600	21,705			20
21	Clerical & General Office Expenses	2,431,493	7,579	54,739	2,493,811		2,493,811	(1,628,111)	865,700			21
22	Employee Benefits & Payroll Taxes			637,955	637,955		637,955		637,955			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,055	4,055		4,055	(211)	3,844			24
25	Other Admin. Staff Transportation			2,216	2,216		2,216	211	2,427			25
26	Insurance-Prop.Liab.Malpractice			309,180	309,180		309,180		309,180			26
27	Other (specify):*											27
28	**TOTAL General Administration**	2,431,493	7,579	1,393,743	3,832,815		3,832,815	(1,755,101)	2,077,714			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,808,494	571,154	3,169,414	7,549,062		7,549,062	42,918	7,591,980			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 Sherman West Court #0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			226,119	226,119		226,119	69,157	295,276			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			297,144	297,144		297,144		297,144			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,877	22,877		22,877		22,877			35
36	Other (specify):*											36
37	**TOTAL Ownership**			546,140	546,140		546,140	69,157	615,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,070	2,070		2,070		2,070			38
39	Ancillary Service Centers		847,755		847,755		847,755		847,755			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* Non-Allowable Cos			129,992	129,992		129,992	(129,991)	1			43
44	**TOTAL Special Cost Centers**		847,755	197,762	1,045,517		1,045,517	(129,991)	915,526			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,808,494	1,418,909	3,913,316	9,140,719		9,140,719	(17,916)	9,122,803			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 Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,619)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,941)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,622)	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				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	(1,566)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(39,159)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,986)	43		24
25	Fund Raising, Advertising and Promotional	(11,642)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(382)	21		28
29	Other-Attach Schedule See Pg 5A	(51,812)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,729)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	168,813		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 168,813		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (17,916)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court

ID# 0037507

Report Period Beginning: 5/1/09

Ending: 4/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Reference Lab Expense	$ (42,484)	43	1
2	Disallow Residents Clothing Expense	(1,097)	43	2
3	Offset Other Inc Against Misc Expense	(40)	21	3
4	Offset Code Alert Income against Related Exp	(1,371)	10	4
5				5
6	Offset Misc Inc against Misc Exp	(2,404)	21	6
7	Reclass salaries to correct cost center	273,579	1	7
8	Reclass salaries to correct cost center	115,864	3	8
9	Reclass salaries to correct cost center	39,063	4	9
10	Reclass salaries to correct cost center	102,128	6	10
11	Reclass salaries to correct cost center	1,124,010	10	11
12	Reclass salaries to correct cost center	93,752	11	12
13	Reclass salaries to correct cost center	77,020	12	13
14	Reclass salaries to correct cost center	101,391	17	14
15	Reclass salaries to correct cost center	(1,926,807)	21	15
16	Reclass purchased services to correct cost centers	9,966	1	16
17	Reclass purchased services to correct cost centers	5,587	6	17
18	Reclass purchased services to correct cost centers	(1,182,274)	10	18
19	Reclass purchased services to correct cost centers	6,507	11	19
20	Reclass purchased services to correct cost centers	1,138,006	10A	20
21	Reclass purchased services to correct cost centers	20,710	19	21
22	Reclass purchased services to correct cost centers	1,498	21	22
23	Offset Activities & Outings Income agains rel exp	(200)	11	23
24	Disallow Satellite Earth Terminal	(4,216)	43	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**	(51,812)		49

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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
Sherman Health Systems	100	N/A		Sherman Hospital	Elgin	Hospital
				Sherman Home	Elgin	Home Health
				Care Partners		Agency
				Sherman Health	Elgin	Management Co.
				Systems		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 216,533	Sherman Health Systems	100.00%	$	$ (216,533)	1
2	V	21	Administrative Expense		Sherman Health Systems	100.00%	312,565	312,565	2
3	V	30	Depreciation Expense		Sherman Health Systems	100.00%	72,781	72,781	3
4	V	22	Fringe Benefits	2,032	Sherman Hospital	0.00%	2,032		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			$ 218,565			$ 387,378	$ * 168,813	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
4/30/2010

Schedule 6A

List of Board of Directors

Page 6: VII - Schedule A - Non-Profit required attachment:

Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Michael Kenyon	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Lois Oberst	No	N/A	N/A	N/A
Audrey Reed	No	N/A	N/A	N/A
Ronald Pavlik	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Michael Grassi, M.D.	No	N/A	N/A	N/A
Todd Gephart, M.D.	No	N/A	N/A	N/A
Tom Nitz	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Kenyon	Chairman	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fee	$ 1,250	L21, C3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	250	L21, C3	2
3	Al Pagorski	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	500	L21, C3	3
4	Ronald Pavlik	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	750	L21, C3	4
5	Richard Floyd	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L21, C3	5
6	Dr. Michael Grassi	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L21, C3	6
7	Dr. Todd Gephart	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L21, C3	7
8	Tom Nitz	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L21, C3	8
9	Lois Oberst	Elgin Women's Club	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	1,000	L21, C3	9
10	Audrey Reed		Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L21, C3	10
11											11
12											12
13								TOTAL	$ 3,750		13

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

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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 [X] NO [ ]

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

Name of Related Organization: Sherman Health Systems
Street Address: 1019 East Chicago Street
City / State / Zip Code: Elgin, IL 60120-6822
Phone Number: (847) 608-6114
Fax Number: (847) 608-6117

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Administrative Expense	Accumulated Costs	243,410,830	3	$ 8,404,350	$	9,052,661	$ 312,565	1
2	30	Depreciation Expense	Accumulated Costs	243,410,830	3	1,956,949		9,052,661	72,781	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					$ 10,361,299	$		$ 385,346	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Illinois Health Facilities		X	Refinance Construction	$24,326.00	10/15/97	$ 4,736,121	$ 4,946,280	8/20/27	Various	$ 297,144	1
2	Authority			Bond								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,326.00		$ 4,736,121	$ 4,946,280			$ 297,144	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,736,121	$ 4,946,280			$ 297,144	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 Sherman West Court # 0037507 **Report Period Beginning:** 5/1/09 **Ending:** 4/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2009**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		**8**
	2006		**9**
	2007		**10**
	2008		**11**
	2009		**12**

No real estate taxes paid as facility has been granted real estate tax exempt status.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Carolyn Cekal

TELEPHONE (224) 783-1217 FAX #: (847) 742-7248

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	No real estate taxes paid as facility has been granted real estate tax exempt		$	$
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 X NO

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

C. **Tax Bills**

Attach a copy of the original 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 Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,260 B. General Construction Type: Exterior Brick Frame Wood/Masonry Number of Stories One

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. 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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	115,500	1991	$ 504,179	1
2					2
3	TOTALS	115,500		$ 504,179	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1991	1991	$ 2,486,860	$ 62,171	40	$ 62,171	$	$ 1,194,209	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1991	99,031		5			99,031	9
10	Building Improvements			1991	219,089		10			219,089	10
11	Building Improvements			1991	205,843		15			205,843	11
12	Building Improvements			1991	826,676	41,334	20	41,334		793,956	12
13	Building Improvements			1991	91,155	3,646	25	3,646		70,035	13
14	Building Improvements			1991	21,960		10			21,960	14
15	Building Improvements			1991	3,398		15			3,398	15
16	Building Improvements			1992	22,980		10			22,980	16
17	Building Improvements			1992	2,000		15			2,000	17
18	Building Improvements			1993	962		5			962	18
19	Building Improvements			1993	13,219		10			13,219	19
20	Building Improvements			1993	3,750		15			3,750	20
21	Building Improvements			1993	14,525	50	20	726	676	11,980	21
22	Building Improvements			1994	6,951	348	20	348		5,391	22
23	Carpet Tiles			1995	1,500		10			1,500	23
24	Sliding Doors			1996	3,345		10			3,345	24
25	Resurface Parking Lot			1996	4,800		5			4,800	25
26	Carpeting			1997	3,930		5			3,930	26
27	Carpet/tile Base			1997	12,580		5			12,580	27
28	Kickplates			1997	4,165		5			4,165	28
29	Carpet Living Room			1998	4,340	6	10	6		4,340	29
30	Cement Board & Ceramic Tile			1999	4,475		10			4,480	30
31	Wallpaper			1999	1,819		5			1,819	31
32	Landscaping			1999	893		5			893	32
33	Construction contract for new entrance & nursing station			1999	938,914	23,473	40	23,473		255,762	33
34	Kitchen Wall Boards			2000	1,365		5			1,365	34
35	Parking Lot Improvements			2000	52,250	3,483	30	1,742	(1,741)	17,420	35
36	Purchasing Department Ceiling Light Fixtures			2000	1,967	194	10	194		1,967	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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	
37	Carpeting	2002	$ 19,785	$	5	$	$	$ 19,785	37
38	Wallpaper	2002	19,893		5			19,893	38
39	Roofing	2001	1,400	140	10	140		1,190	39
40	Door	2001	1,125	75	15	75		638	40
41	Carpeting	2003	5,732		5			5,732	41
42	Carpeting	2003	1,855		5			2,040	42
43	Wiring for therapy rooms	2003	4,431	443	10	443		3,323	43
44	HVAC upgrade and testing	2003	52,902	3,527	15	3,527		26,453	44
45	Fire sprinklers	2003	12,149	607	20	607		4,553	45
46	HVAC upgrade and testing	2003	51,875	4,589	10	5,188	599	41,516	46
47	Light fixtures and wiring for cafeteria	2004	3,967	397	10	397		2,580	47
48	Wallpaper	2004	6,868		5			7,557	48
49	Vent pipe	2004	1,068		5			1,068	49
50	Vinyl base	2004	900		5			900	50
51	HVAC upgrade and testing	2004	8,909		15	594	594	3,861	51
52	Door holder	2004	1,046	71	15	70	(1)	455	52
53	Circuit breaker	2004	2,250		15	150	150	975	53
54	Door plate	2004	2,053		15	137	137	890	54
55	Sewer line and trap	2004	2,940		15	196	196	1,276	55
56	Drapes	2005	5,817	582	5	582		5,817	56
57	Carpeting	2005	11,175	1,119	5	1,119		11,175	57
58	Carpeting	2005	9,400	940	10	940		5,170	58
59	Light fixtures and wiring	2005	8,667	867	10	867		4,767	59
60	Sign for dining room	2005	2,039	204	10	204		1,122	60
61	Fire system	2005	12,230	815	15	815		4,076	61
62	Sewer line	2005	2,950	118	25	118		649	62
63									63
64	Fire Doors - 4	2006	5,670	378	15	378		1,701	64
65	Dining room doors/closures	2006	1,785	119	15	119		536	65
66	Cement sidewalk ramp	2006	1,950	130	15	130		585	66
67	Exit lights - 4	2006	3,600	240	15	240		1,080	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,321,173	$ 150,066		$ 150,675	$ 609	$ 3,167,532	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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		$ 5,321,173	$ 150,066		$ 150,675	$ 609	$ 3,167,532	1
2	Upgrade firedoors per IDPH specification	2006	6,020	401	15	401	0	1,804	2
3	Sprinkler installation in attic	2006	4,414	294	15	294	0	1,323	3
4	Generator - 150 amp circuit breaker	2006	1,103	55	20	55	0	248	4
5	Installation of handrails	2006	6,400	320	20	320		1,440	5
6	Sprinkler system air compressor	2007	3,020	302	10	302		1,208	6
7	5 PTAC units & connections	2007	3,326	222	15	222		555	7
8	Roof shingles	2007	92,083	6,139	15	6,139		15,345	8
9	14 Smoke detectors and bases	2007	1,036	69	15	69		174	9
10									10
11	Wallpaper for resident rooms	2007	7,146	1,429	5	1,429		3,574	11
12	Repair dry pipe sprinkler system	2007	3,905	260	15	260		650	12
13	Hot Water Boiler	2008	17,742	1,183	15	1,183		2,956	13
14	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069	2,607	10	2,607		6,516	14
15									15
16	Replace 3, 4 &6" Sprinkler Main	2008	59,719	3,981	15	3,981		5,972	16
17	Ductwork-Sprinkler System Install	2008	2,952	197	15	197		295	17
18	Carrier-5 Ton A/C Condensing Unit	2008	3,310	331	10	331		497	18
19	Replace Nurse Station Cabinets	2009	4,484	299	15	299		448	19
20	Shower Rehab-plumbing, tile, hardware	2009	44,000	2,933	15	2,933		4,400	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)		$ 5,607,902	$ 171,088		$ 171,698	$ 610	$ 3,214,937	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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	$ 493,692	$ 54,699	$ 50,465	$ (4,234)	5-20	$ 576,281	71
72	Current Year Purchases	4,129	332	332		5-10	332	72
73	Fully Depreciated Assets	968,445					968,445	73
74	Allocated from Sherman Health Systems			72,781	72,781			74
75	TOTALS	$ 1,466,266	$ 55,031	$ 123,578	$ 68,547		$ 1,545,058	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,578,347	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,119	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 295,276	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 69,157	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,759,995	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 22,877 Description: $11,181-Copiers, $360-Water Softener, $472-Knife & Sharpening, $10,864-Therapy Equipment
(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			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

STATE OF ILLINOIS
0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,963	1,138,006		16,963	1,138,006	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				737,841		737,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	See Sch 16A					109,914		109,914	12
13	Other (specify):									13
14	TOTAL			$	16,963	$ 1,138,006	$ 847,755	16,963	$ 1,985,761	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

Sherman West Court
Facility #0037507
4/30/2010

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Ref	Outside Units	Practitioner Cost	Supplies
Specialized Beds & Equipment	39(2)			44,145
Oxygen	39(2)			65,769
				109,914

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Sherman West Court **#** 0037507 **Report Period Beginning:** 5/1/09 **Ending:** 4/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 4/30/10 **(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	$ 666,063	$ 666,063	1
2	Cash-Patient Deposits	245	245	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (168,034))	1,207,587	1,207,587	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,648	65,648	6
7	Other Prepaid Expenses	9,648	9,648	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,949,191	$ 1,949,191	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	199,154	199,154	12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	3,425,769	2,486,860	14
15	Leasehold Improvements, at Historical Cost	2,224,957	3,121,042	15
16	Equipment, at Historical Cost	1,474,952	1,466,266	16
17	Accumulated Depreciation (book methods)	(4,431,534)	(4,759,995)	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): Deferred Finance Charges	69,890	69,890	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,467,367	$ 3,087,396	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,416,558	$ 5,036,587	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 511,979	$ 511,979	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	245	245	28
29	Short-Term Notes Payable	170,462	170,462	29
30	Accrued Salaries Payable	392,880	392,880	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	67,245	67,245	33
34	Deferred Compensation	195,000	195,000	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	See Schedule 17A	113,404	113,404	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,451,215	$ 1,451,215	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,775,818	4,775,818	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Liability-Malpractice	312,855	312,855	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,088,673	$ 5,088,673	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,539,888	$ 6,539,888	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,123,330)	$ (1,503,301)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,416,558	$ 5,036,587	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Sherman West Court
Facility #0037507
4/30/2010

Schedule 17A

XV - Balance Sheet: Line 37 - Other Current Liabilities (specify):

Description	Operating	After Consolidation
A/R - Medicare Settlements	19,542	19,542
Liability due to Blue Cross	40,362	40,362
Accrued Liability - Nursing Home Provisions	4,567	4,567
Accrued Liability - Workmen's Comp	13,377	13,377
Accrued Liability - Health	26,836	26,836
Accrued Liability - Long Term Disability	80	80
Accrued Liability - Dental	1,227	1,227
Accrued Liability - Other	7,413	7,413
	113,404	113,404

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (773,743)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(664,923)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,438,666)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,335	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) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 315,336	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)**	$ (1,123,330)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,473,697	1
2	Discounts and Allowances for all Levels	(3,518,741)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,954,956	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	172,304	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 172,304	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	4,246	13
14	Non-Patient Meals	3,619	14
15	Telephone, Television and Radio	5,690	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	307,932	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 321,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	7,307	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,307	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,456,054	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	568,013	31
32	Health Care	3,148,234	32
33	General Administration	3,832,815	33
	B. Capital Expense		
34	Ownership	546,140	34
	C. Ancillary Expense		
35	Special Cost Centers	979,817	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,140,719	40
41	**Income before Income Taxes (line 30 minus line 40)****	315,335	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 315,335	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

Sherman West Court
Facility #0037507
4/30/2010

Schedule 19A

XVII - Income Statement: Line 28 - Other Revenue (specify):

Description	Operating
Pt	40
Miscellaneous Income	2,404
Other Inc-Code Alert Security System	1,371
Other Inc-Wheelchair Revenue	3,292
Activities & Outings Income	200
	7,307

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,340	4,631	$ 166,810	$ 36.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,401	41,763	1,287,144	30.82	3
4	Licensed Practical Nurses	4,071	4,525	89,857	19.86	4
5	CNAs & Orderlies	50,756	54,125	717,320	13.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,889	2,086	42,561	20.40	9
10	Activity Assistants	3,741	4,113	51,191	12.45	10
11	Social Service Workers	2,824	3,032	77,020	25.40	11
12	Dietician	1,240	1,387	33,681	24.28	12
13	Food Service Supervisor	1,853	2,086	43,312	20.76	13
14	Head Cook	6,622	6,901	102,266	14.82	14
15	Cook Helpers/Assistants	10,420	10,751	94,320	8.77	15
16	Dishwashers					16
17	Maintenance Workers	4,014	4,332	102,128	23.58	17
18	Housekeepers	11,563	12,428	115,864	9.32	18
19	Laundry	4,000	4,360	39,063	8.96	19
20	Administrator	1,949	2,086	101,391	48.61	20
21	Assistant Administrator					21
22	Other Administrative	15,662	16,514	310,301	18.79	22
23	Office Manager					23
24	Clerical	8,234	8,234	88,264	10.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,860	2,123	30,335	14.29	31
32	Other Health C: See Sch 20A	9,748	10,303	209,545	20.34	32
33	Other(specify) Admissions Coord	3,805	4,176	106,121	25.41	33
34	TOTAL (lines 1 - 33)	187,992	199,956	$ 3,808,494 *	$ 19.05	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 9,966	L1 C3	35
36	Medical Director	120	30,050	L9 C3	36
37	Medical Records Consultant	31	1,994	L10 C3	37
38	Nurse Consultant	10	743		38
39	Pharmacist Consultant	151	9,792	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	121	6,307	L11 C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	594	$ 58,852		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,315	$ 60,792	L10 C3	50
51	Licensed Practical Nurses	393	16,419	L10 C3	51
52	Certified Nurse Assistants/Aides	8,241	195,186	L10 C3	52
53	TOTAL (lines 50 - 52)	9,949	$ 272,397		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Sherman West Court
IDPH Facility ID # 0037507
4/30/2010

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	2,978	3,105	115,452	37.18
Unit Clerk	3,962	4,168	57,821	13.87
Resident Assistants	2,808	3,030	36,272	11.97
Total	**9,748**	**10,303**	**209,545**	**20.34**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph McManus	Administrator	0	$ 101,391
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,391

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 216,533
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 216,533

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris, LLP	Legal	$ 116,600
Accumed Services	Data Processing	8,420
IVAN's	Data Processing	701
McKesson Medical	Data Processing	122
Nebo System Inc.	Data Processing	240
Cbord Group Inc	Data Processing	737
McGladrey & Pullen, LLP	Accounting	23,575
Schelflow & Rydell	Collection	3,566
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 153,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,834
Unemployment Compensation Insurance	23,058
FICA Taxes	284,140
Employee Health Insurance	163,679
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LT Disability	1,895
Employee Recognition	3,943
Other Employee Benefits	14,133
Pension Contributions	50,208
Employee Dental Benefits	7,066
TOTAL (agree to Schedule V, line 22, col.8)	$ 637,956

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 550	6,600
Life Service Netowrk of IL	5,790
JCAHO	1,655
Paddock Publishing-Resident Newspaper	3,074
Miscellaneous Membership Dues & Licenses	1,821
Miscellaneous Subscriptions	1,770
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,705

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,844
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,844

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
4/30/2010 Schedule 21A

Schedule XIX(C) Professional Services

Total (from Page 21C) agrees to Schedule V, Line 19, Column 3	153,961
Add: Sherman Hospital Medicare Billing	20,711
Less: Non-allowable legal	(35,593)
Less: Non-allowable collection fees	(3,566)
Total (agrees to Schedule V, Line 19, Column 8)	135,513

Schedule XIX(G) Travel and Seminar

Total agrees to Schedule V, Line 24, Column 3	4,055
Less: Disallow Travel & Seminar	(211)
Total (agrees to Schedule V, Line 24, Column 8)	3,844

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
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 Sherman West Court # 0037507 Report Period Beginning: 5/1/09 Ending: 4/30/10

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? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois-$5,790**

(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? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **59,617** Line **L10, C2**

(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. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,619**

(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? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
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: **McGladrey & Pullen, 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT