FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 5/1/11 to 4/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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	112	Skilled (SNF)	112	40,992	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	112	TOTALS	112	40,992	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		678	16,134	16,812	8
9	SNF/PED					9
10	ICF	3,163	8,721	131	12,015	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,163	9,399	16,265	28,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.32%

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 64 and days of care provided 13,913

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: 4/30/12 Fiscal Year: 4/30/12

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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		102,077		102,077		102,077	282,811	384,888			1
2	Food Purchase		169,076		169,076		169,076	(3,256)	165,820			2
3	Housekeeping		19,762		19,762		19,762	126,188	145,950			3
4	Laundry		8,802		8,802		8,802	60,053	68,855			4
5	Heat and Other Utilities			141,463	141,463		141,463		141,463			5
6	Maintenance			135,965	135,965		135,965	59,209	195,174			6
7	Other (specify):*											7
8	TOTAL General Services		299,717	277,428	577,145		577,145	525,005	1,102,150			8
	B. Health Care and Programs											
9	Medical Director			34,450	34,450		34,450		34,450			9
10	Nursing and Medical Records	482,288	273,434	1,553,510	2,309,232		2,309,232	895,925	3,205,156			10
10a	Therapy											10a
11	Activities							100,349	100,349			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	482,288	273,434	1,587,960	2,343,682		2,343,682	996,274	3,339,955			16
	C. General Administration											
17	Administrative			54,133	54,133		54,133	147,751	201,884			17
18	Directors Fees											18
19	Professional Services			16,233	16,233		16,233	21,515	37,748			19
20	Dues, Fees, Subscriptions & Promotions			28,356	28,356		28,356	750	29,106			20
21	Clerical & General Office Expenses	3,488,205	6,942	60,264	3,555,411		3,555,411	(2,845,971)	709,441			21
22	Employee Benefits & Payroll Taxes			699,550	699,550		699,550		699,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,280	3,280		3,280	(70)	3,210			24
25	Other Admin. Staff Transportation			3,912	3,912		3,912		3,912			25
26	Insurance-Prop.Liab.Malpractice			344,028	344,028		344,028		344,028			26
27	Other (specify):*											27
28	TOTAL General Administration	3,488,205	6,942	1,209,755	4,704,902		4,704,902	(2,676,025)	2,028,878			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,970,494	580,093	3,075,142	7,625,729		7,625,729	(1,154,746)	6,470,983			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sherman West Court #0037507 **Report Period Beginning:** 5/1/11 **Ending:** 4/30/12

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			176,112	176,112		176,112	57,719	233,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			263,803	263,803		263,803	(4,256)	259,547			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,884	29,884		29,884		29,884			35
36	Other (specify):*											36
37	**TOTAL Ownership**			469,799	469,799		469,799	53,463	523,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,725	4,725		4,725		4,725			38
39	Ancillary Service Centers		950,976		950,976		950,976	1,352,813	2,303,789			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,843	162,843		162,843		162,843			42
43	Other (specify):* Non-Allowable Cos			172,323	172,323		172,323	(172,323)	0			43
44	**TOTAL Special Cost Centers**		950,976	339,891	1,290,867		1,290,867	1,180,490	2,471,358			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,970,494	1,531,069	3,884,832	9,386,395		9,386,395	79,207	9,465,602			45

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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	(3,256)	2		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	(2,778)	30		9
10	Interest and Other Investment Income	(4,256)	32		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	(10,000)	20		18
19	Entertainment	(543)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	4,599	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,696)	43		24
25	Fund Raising, Advertising and Promotional	(20,020)	43		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 See Pg 5A	(48,571)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (188,521)		$	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)	267,728		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 267,728		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 79,207		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

Sherman West Court

ID# 0037507

Report Period Beginning: 5/1/11

Ending: 4/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Reference Lab Expense	$ (41,220)	43	1
2	Disallow Residents Clothing Expense	(207)	43	2
3	Disallow Satellite Earth Terminal	(4,118)	43	3
4	Offset Misc Inc against Misc Exp	(437)	21	4
5	Reclass salaries to correct cost center	268,608	1	5
6	Reclass salaries to correct cost center	126,188	3	6
7	Reclass salaries to correct cost center	60,053	4	7
8	Reclass salaries to correct cost center	54,019	6	8
9	Reclass salaries to correct cost center	2,297,331	10	9
10	Reclass salaries to correct cost center	95,266	11	10
11	Reclass salaries to correct cost center	201,884	17	11
12	Reclass salaries to correct cost center	(3,103,438)	21	12
13	Reclass salaries to correct cost center	89	39	13
14	Reclass purchased services to correct cost centers	14,203	1	14
15	Reclass purchased services to correct cost centers	5,190	6	15
16	Reclass purchased services to correct cost centers	(1,401,407)	10	16
17	Reclass purchased services to correct cost centers	5,083	11	17
18	Reclass purchased services to correct cost centers	16,916	19	18
19	Reclass purchased services to correct cost centers	7,292	21	19
20	Reclass purchased services to correct cost centers	1,352,724	39	20
21				21
22	Gain/Loss on Asset Disposals	(2,519)	43	22
23	Disallow Non-Allowable Travel & Seminar Exp.	(70)	24	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**	(48,571)		49

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	$ 54,133	Sherman Health Systems	100.00%	$	$ (54,133)	1
2	V	21	Administrative Expense		Sherman Health Systems	100.00%	261,364	261,364	2
3	V	30	Depreciation Expense		Sherman Health Systems	100.00%	60,497	60,497	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 54,133			$ 321,861	$ * 267,728	14

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Michael Kenyon	Chairman	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	$ 1,000	L21, C3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	750	L21, C3	2
3	Al Pagorski	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	750	L21, C3	3
4	Ronald Pavlik	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	750	L21, C3	4
5	Richard Floyd	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	0	L21, C3	5
6	Dr. Michael Grassi	Medical Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	1,000	L21, C3	6
7	Dr. Todd Gephart	Medical Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	250	L21, C3	7
8	Tom Nitz	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	0	L21, C3	8
9	Lois Oberst	Elgin Women's Club	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	750	L21, C3	9
10	Audrey Reed	Secretary	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	0	L21, C3	10
11	Dr. Michael Berkson	Medical Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fees	750	L21, C3	11
12											12
13								TOTAL	$ 6,000		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: 5/1/11 Ending: 4/30/12

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	292,114,100	3	$ 8,226,897	$	9,280,180	$ 261,364	1
2	30	Depreciation Expense	Accumulated Costs	292,114,100	3	1,904,264		9,280,180	60,497	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					$ 10,131,161	$		$ 321,861	25

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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	$ 4,598,488	8/20/27	Various	$ 263,803	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	$ 4,598,488			$ 263,803	9
	B. Non-Facility Related*											
10								Interest Income Offset			(4,256)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,256)	14
15	TOTALS (line 9+line14)						$ 4,736,121	$ 4,598,488			$ 259,547	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.)**

**** 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:** 5/1/11 **Ending:** 4/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)	**2011**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 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:			
	2007		**8**
	2008		**9**
	2009		**10**
	2010		**11**
	2011		**12**

Facility is exempt from real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	**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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility is exempt from real estate taxes		$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 5/1/11 Ending: 4/30/12

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1991	1991	$ 2,486,860	$ 62,171	40	$ 62,171	$	$ 1,318,551	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		20			826,676	12
13	Building Improvements			1991	91,155	3,646	25	3,646		77,327	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	13,432	21
22	Building Improvements			1994	6,951	348	20	348		6,087	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		10			4,340	29
30	Cement Board & Ceramic Tile			1999	4,475		10			4,475	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		302,708	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)	20,904	35
36	Purchasing Department Ceiling Light Fixtures			2000	1,967		10			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: 5/1/11 Ending: 4/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2002	$ 19,785	$	5	$	$	$ 19,785	37
38	Wallpaper	2002	19,893		5			19,893	38
39	Roofing	2001	1,400	70	10	70		1,400	39
40	Door	2001	1,125	75	15	75		788	40
41	Carpeting	2003	5,732		5			5,732	41
42	Carpeting	2003	1,855		5			1,855	42
43	Wiring for therapy rooms	2003	4,431	443	10	443		4,209	43
44	HVAC upgrade and testing	2003	52,902	3,527	15	3,527		33,507	44
45	Fire sprinklers	2003	12,149	607	20	607		5,767	45
46	HVAC upgrade and testing	2003	51,875	4,589	10	5,171	582	51,875	46
47	Light fixtures and wiring for cafeteria	2004	3,967	397	10	397		3,374	47
48	Wallpaper	2004	6,868		5			6,868	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	5,049	51
52	Door holder	2004	1,046	71	15	70	(1)	595	52
53	Circuit breaker	2004	2,250		15	150	150	1,275	53
54	Door plate	2004	2,053		15	137	137	1,164	54
55	Sewer line and trap	2004	2,940		15	196	196	1,668	55
56	Drapes	2005	5,817		5			5,817	56
57	Carpeting	2005	11,175		5			11,175	57
58	Carpeting	2005	9,400	940	10	940		7,050	58
59	Light fixtures and wiring	2005	8,667	867	10	867		6,501	59
60	Sign for dining room	2005	2,039	204	10	204		1,530	60
61	Fire system	2005	12,230	815	15	815		5,706	61
62	Sewer line	2005	2,950	118	25	118		885	62
63									63
64	Fire Doors - 4	2006	5,670	378	15	378		2,457	64
65	Dining room doors/closures	2006	1,785	119	15	119		774	65
66	Cement sidewalk ramp	2006	1,950	130	15	130		845	66
67	Exit lights - 4	2006	3,600	240	15	240		1,560	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,321,173	$ 106,761		$ 107,353	$ 592	$ 3,414,167	70

**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: 5/1/11 Ending: 4/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,321,173	$ 106,761		$ 107,353	$ 592	$ 3,414,167	1
2	Upgrade firedoors per IDPH specification	2006	6,020	401	15	401		2,606	2
3	Sprinkler installation in attic	2006	4,414	294	15	294		1,911	3
4	Generator - 150 amp circuit breaker	2006	1,103	55	20	55		358	4
5	Installation of handrails	2006	6,400	320	20	320		2,080	5
6	Sprinkler system air compressor	2007	3,020	302	10	302		1,812	6
7	5 PTAC units & connections	2007	3,326	222	15	222		999	7
8	Roof shingles	2007	92,083	6,139	15	6,139		27,623	8
9	14 Smoke detectors and bases	2007	1,036	69	15	69		312	9
10									10
11	Wallpaper for resident rooms	2007	7,146	1,429	5	1,429		6,432	11
12	Repair dry pipe sprinkler system	2007	3,905	260	15	260		1,170	12
13	Hot Water Boiler	2008	17,742	1,183	15	1,183		5,322	13
14	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069	2,607	10	2,607		11,730	14
15									15
16	Replace 3, 4 &6" Sprinkler Main	2008	59,719	3,981	15	3,981		13,934	16
17	Ductwork-Sprinkler System Install	2008	2,952	197	15	197		689	17
18	Carrier-5 Ton A/C Condensing Unit	2008	3,310	331	10	331		1,159	18
19	Replace Nurse Station Cabinets	2009	4,484	299	15	299		1,046	19
20	Shower Rehab-plumbing, tile, hardware	2009	44,000	2,933	15	2,933		10,266	20
21									21
22	Furnish & Install New Doors	2011	4,575	458	10	458		687	22
23	Replace Trane HT Exchanger	2011	5,620	562	10	562		843	23
24									24
25	Install Plank Flooring	2011	91,661	4,583	10	4,583		4,583	25
26	Parking Lot: Remove & Replace Concrete Curbs & Walkway	2011	2,500	83	15	83		83	26
27	Installation of Water Lines	2011	4,436		15	148	148	148	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,716,694	$ 133,469		$ 134,209	$ 740	$ 3,509,960	34

**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: 5/1/11 Ending: 4/30/12

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 393,817	$ 42,065	$ 38,547	$ (3,518)	5-20	$ 234,080	71
72	Current Year Purchases	13,914	578	578		10-15	578	72
73	Fully Depreciated Assets	1,029,069					1,029,069	73
74	Allocated from Sherman Health Systems			60,497	60,497			74
75	TOTALS	$ 1,436,800	$ 42,643	$ 99,622	$ 56,979		$ 1,263,727	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	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)	$ 7,657,673	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 176,112	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 233,831	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 57,719	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,773,687	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: 5/1/11 Ending: 4/30/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 29,884 Description: $12,015-Copiers/Postage Meters, $360-Water Softener, $450-Knife & Sharpening, $17,059-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					18
19			N/A		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.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C7	2 hrs	89	18,788	1,352,724		18,790	1,352,813	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				848,159		848,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	See Sch 16A					102,817		102,817	12
13	Other (specify):									13
14	TOTAL			$ 89	18,788	$ 1,352,724	$ 950,976	18,790	$ 2,303,789	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.

Sherman West Court
Facility #0037507
4/30/2012

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Ref	Outside Units	Practitioner Cost	Supplies
Specialized Beds & Equipment	39(2)			44,759
Oxygen	39(2)			58,058
				102,817

STATE OF ILLINOIS

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 4/30/12 (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	$ 316,332	$ 316,332	1
2	Cash-Patient Deposits	185	185	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 79,677)	1,365,195	1,365,195	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,556	2,556	6
7	Other Prepaid Expenses	10,465	10,465	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,694,733	$ 1,694,733	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	209,003	209,003	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	2,329,313	3,229,835	15
16	Equipment, at Historical Cost	1,512,988	1,436,800	16
17	Accumulated Depreciation (book methods)	(4,801,287)	(4,773,687)	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 Schedule 17A	81,806	81,806	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,261,771	$ 3,174,796	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,956,504	$ 4,869,529	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 438,964	$ 438,964	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	302	302	28
29	Short-Term Notes Payable	184,369	184,369	29
30	Accrued Salaries Payable	257,273	257,273	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	62,275	62,275	33
34	Deferred Compensation	120,366	120,366	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	See Schedule 17A	284,653	284,653	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,348,201	$ 1,348,201	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,414,119	4,414,119	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Liability-Malpractice	341,778	341,778	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,755,897	$ 4,755,897	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,104,098	$ 6,104,098	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,147,594)	$ (1,234,569)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,956,504	$ 4,869,529	48

***(See instructions.)**

Sherman West Court
Facility #0037507
4/30/2012

Schedule 17A

XV - Balance Sheet: Line 23 - Other (specify):

Description	Operating	After Consolidation
Asset Clearing	21,764	21,764
Deferred Finance Charges - 97 Bond	60,042	60,042
	81,806	81,806

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

Description	Operating	After Consolidation
A/R - Medicare Settlements	66,227	66,227
Liability due to Blue Cross	109,703	109,703
Accrued Liability - Granny Tax	62,400	62,400
Accrued Liability - Nursing Home Provisions	4,175	4,175
Accrued Liability - Workmen's Comp	13,377	13,377
Accrued Liability - Health	27,178	27,178
Accrued Liability - Dental	1,577	1,577
Accrued Liability - Other	16	16
	284,653	284,653

Facility Name & ID Number Sherman West Court **#** 0037507 **Report Period Beginning:** 5/1/11 **Ending:** 4/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 640,330	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(2,846,993)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,206,663)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,059,069	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)**	$ 1,059,069	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)**	$ (1,147,594)	24 *

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,748,151	1
2	Discounts and Allowances for all Levels	(5,806,975)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,941,177	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	128,866	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 128,866	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	5,605	13
14	Non-Patient Meals	3,256	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	356,473	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 365,334	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,256	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,256	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	5,831	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,831	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,445,464	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	577,145	31
32	Health Care	2,343,682	32
33	General Administration	4,704,902	33
	B. Capital Expense		
34	Ownership	469,799	34
	C. Ancillary Expense		
35	Special Cost Centers	1,128,024	35
36	Provider Participation Fee	162,843	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,386,395	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,059,069	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,059,069	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,395,508	44
45	Private Pay - Net Inpatient Revenue	59,900	45
46	Medicare - Net Inpatient Revenue	6,677,084	46
47	Other-(specify) Insurance	808,685	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,941,177	49

* **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.**

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

Sherman West Court
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Schedule 19A

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

Description	Operating
Miscellaneous Income	437
Other Inc-Code Alert Security System	631
Other Inc-Wheelchair Revenue	4,764
	5,831

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,995	2,091	$ 89,023	$ 42.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,778	47,985	1,541,438	32.12	3
4	Licensed Practical Nurses	1,986	2,207	47,394	21.47	4
5	CNAs & Orderlies	51,229	55,128	750,305	13.61	5
6	CNA Trainees					6
7	Licensed Therapist	2	2	89	44.50	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,811	2,091	44,743	21.40	9
10	Activity Assistants	4,374	4,629	50,523	10.91	10
11	Social Service Workers					11
12	Dietician	744	808	18,216	22.54	12
13	Food Service Supervisor	1,939	2,091	43,683	20.89	13
14	Head Cook	6,220	6,512	90,155	13.84	14
15	Cook Helpers/Assistants	12,046	12,842	116,554	9.08	15
16	Dishwashers					16
17	Maintenance Workers	2,908	3,067	54,019	17.61	17
18	Housekeepers	11,913	12,677	126,188	9.95	18
19	Laundry	5,063	5,319	60,053	11.29	19
20	Administrator	1,987	2,091	116,506	55.72	20
21	Assistant Administrator	1,979	2,091	85,378	40.83	21
22	Other Administrative	12,930	13,868	206,277	14.87	22
23	Office Manager	616	2,123	77,760	36.63	23
24	Clerical	9,397	9,397	100,731	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	1,969	2,164	31,757	14.68	31
32	Other Health CSee Sch 20A	11,932	12,736	319,702	25.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,818	201,919	$ 3,970,494 *	$ 19.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	229	$ 14,203	L1 C7	35
36	Medical Director	120	34,450	L9 C3	36
37	Medical Records Consultant	34	2,386	L10 C7	37
38	Nurse Consultant				38
39	Pharmacist Consultant	129	8,397	L10 C7	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	98	5,083	L11 C7	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	610	$ 64,519		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	543	$ 25,804	L10 C3	50
51	Licensed Practical Nurses	350	13,479	L10 C3	51
52	Certified Nurse Assistants/Aides	5,233	102,037	L10 C3	52
53	TOTAL (lines 50 - 52)	6,126	$ 141,320		53

Sherman West Court
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Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	2,855	2,993	113,322	37.86
Unit Clerk/Secretary	3,827	4,110	60,253	14.66
Clinical Care Assistant	3,558	3,735	94,449	25.29
Case Manager	1,691	1,898	51,677	27.23
Total	11,932	12,736	319,702	25.10

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph McManus	Administrator	0	$ 116,506
Angela Lackowski	Asst. Administrator	0	85,378
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 201,884

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 54,133
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 54,133

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris, LLP	Legal	$ 784
Accumed Services	Data Processing	7,845
IVAN's	Data Processing	532
McKesson Medical	Data Processing	240
Nebo System Inc.	Data Processing	100
McGladrey LLP	Accounting	6,732
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 16,233

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,722
Unemployment Compensation Insurance	10,568
FICA Taxes	189,388
Employee Health Insurance	208,166
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
ST Disability	1,266
Employee Recognition	2,340
Other Employee Benefits	41,298
Pension Contributions	99,686
Employee Dental Benefits	13,116
TOTAL (agree to Schedule V, line 22, col.8)	$ 699,550

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 896	10,750
Life Service Netowrk of IL	6,465
JCAHO	1,990
Paddock Publishing-Resident Newspaper	2,889
Miscellaneous Membership Dues & Licenses	1,430
Miscellaneous Subscriptions	1,602
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,106

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,210
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,210

* Attach copy of IMRF notifications

**See instructions.

Sherman West Court
Facility #0037507
4/30/2012 Schedule 21A

Schedule XIX(C) Professional Services

Total (from Page 21C) agrees to Schedule V, Line 19, Column 3	16,233
Add: Sherman Hospital Medicare Billing	16,916
Add: Adjust legal fees to reflect client invoices	10,000
Less: Non-allowable legal (OOP)	(466)
Less: Non-allowable collection fees	(4,935)
Total (agrees to Schedule V, Line 19, Column 8)	37,748

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 5/1/11 Ending: 4/30/12

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- $6,465**

(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. $ **46,944** 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. $ **162,843**
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. $ **3,256**

(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 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.