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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 2/18/1991

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: Carolyn Cekal **Telephone Number:** (630)929-5769
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 01/01/2014 to 12/31/2014 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) James Doheny
(Title) Assistant Treasurer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 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	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	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		42	17,962	18,004	8
9	SNF/PED					9
10	ICF	2,298	6,346	700	9,344	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,298	6,388	18,662	27,348	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.90%

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 [ ]

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 02/18/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/18/1991 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 13,247

Medicare Intermediary National Governmebt Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 2014 Fiscal Year: 2014

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	349,133	20,153	11,184	380,470		380,470	(7,720)	372,750			1
2	Food Purchase		191,722		191,722		191,722		191,722			2
3	Housekeeping		294	20,485	20,779	159,632	180,411		180,411			3
4	Laundry		9,929	4,065	13,994		13,994		13,994			4
5	Heat and Other Utilities			126,128	126,128		126,128		126,128			5
6	Maintenance	252,514	194	167,183	419,891	(160,854)	259,037		259,037			6
7	Other (specify):*											7
8	TOTAL General Services	601,647	222,292	329,045	1,152,984	(1,222)	1,151,762	(7,720)	1,144,042			8
	B. Health Care and Programs											
9	Medical Director					30,761	30,761		30,761			9
10	Nursing and Medical Records	2,516,741	220,754	340,284	3,077,779	(74,825)	3,002,954	(11,648)	2,991,306			10
10a	Therapy					24,711	24,711		24,711			10a
11	Activities	83,375	898	9,897	94,170		94,170		94,170			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,600,116	221,652	350,181	3,171,949	(19,353)	3,152,596	(11,648)	3,140,948			16
	C. General Administration											
17	Administrative	709,426			709,426	(501,896)	207,530		207,530			17
18	Directors Fees					4,000	4,000		4,000			18
19	Professional Services			250,092	250,092		250,092	94,016	344,108			19
20	Dues, Fees, Subscriptions & Promotions			34,514	34,514		34,514	(13,972)	20,542			20
21	Clerical & General Office Expenses		11,024	199,101	210,125	497,718	707,843	(7,002)	700,841			21
22	Employee Benefits & Payroll Taxes			1,262,320	1,262,320		1,262,320	112,911	1,375,231			22
23	Inservice Training & Education											23
24	Travel and Seminar					1,400	1,400		1,400			24
25	Other Admin. Staff Transportation			1,907	1,907		1,907		1,907			25
26	Insurance-Prop.Liab.Malpractice			242,343	242,343		242,343		242,343			26
27	Other (specify):*											27
28	TOTAL General Administration	709,426	11,024	1,990,277	2,710,727	1,222	2,711,949	185,953	2,897,902			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,911,189	454,968	2,669,503	7,035,660	(19,353)	7,016,307	166,585	7,182,892			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:** 01/01/2014 **Ending:** 12/31/2014

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			196,678	196,678		196,678	43,408	240,086			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,238	86,238		86,238	(12,835)	73,403			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			48,402	48,402		48,402		48,402			35
36	Other (specify):*											36
37	**TOTAL Ownership**			331,318	331,318		331,318	30,573	361,891			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,129,429	924,614	137,748	2,191,791	19,353	2,211,144		2,211,144			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,530	142,530		142,530		142,530			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,129,429	924,614	280,278	2,334,321	19,353	2,353,674		2,353,674			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,040,618	1,379,582	3,281,099	9,701,299		9,701,299	197,158	9,898,457			45

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

Sherman West Court
Facility #0037507
12/31/2014

Schedule 4A

RECLASSIFICATIONS

Description	Line Ref	Increase	Decrease
HOUSEKEEPING SALARIES	3	159,632	
HOUSEKEEPING SALARIES	6		159,632
CLERICAL/GENERAL OFFICE SALARIES	21	501,896	
CLERICAL/GENERAL OFFICE SALARIES	17		501,896
THERAPY ASST SALARIES	10a	24,711	
THERAPY ASST SALARIES	39		24,711
MEDICAL DIRECTOR SALARIES	9	30,761	
MEDICAL DIRECTOR SALARIES	10		30,761
DIRECTORS MEETING FEES	18	4,000	
DIRECTORS MEETING FEES	21		4,000
TRAVEL & SEMINAR EXPENSE	24	1,400	
TRAVEL & SEMINAR EXPENSE	21		1,400
SATELLITE TV EXPENSE	21	1,222	
SATELLITE TV EXPENSE	6		1,222
REFERENCE LAB EXPENSE	39	44,064	
REFERENCE LAB EXPENSE	10		44,064
	TOTAL	**767,686**	**767,686**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(7,720)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,889)	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	(38,542)	30		9
10	Interest and Other Investment Income	(12,835)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,309)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,479)	20		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	(14,254)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (94,028)		$	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)	291,186		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 291,186		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 197,158		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		44,064	10	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)**			$ 44,064		47

Sherman West Court

ID# 0037507

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Alcoholic Beverages	$ (113)	21	1
2	Lobbying Expense	(2,493)	20	2
3	Patient Reimbursement	(9,104)	10	3
4	Medical Records Revenue	(1,325)	10	4
5	Revenues Misc	(1,219)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49		(14,254)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(7,720)	0	0	0	0	0	0	0	0	0	0	(7,720)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,720)	0	0	0	0	0	0	0	0	0	0	(7,720)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11,648)	0	0	0	0	0	0	0	0	0	0	(11,648)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(11,648)	0	0	0	0	0	0	0	0	0	0	(11,648)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,309)	96,325	0	0	0	0	0	0	0	0	0	94,016	19
20	Fees, Subscriptions & Promotions	(13,972)	0	0	0	0	0	0	0	0	0	0	(13,972)	20
21	Clerical & General Office Expenses	(7,002)	0	0	0	0	0	0	0	0	0	0	(7,002)	21
22	Employee Benefits & Payroll Taxes	0	112,911	0	0	0	0	0	0	0	0	0	112,911	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,283)	209,236	0	0	0	0	0	0	0	0	0	185,953	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,651)	209,236	0	0	0	0	0	0	0	0	0	166,585	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(38,542)	81,950	0	0	0	0	0	0	0	0	0	43,408	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,835)	0	0	0	0	0	0	0	0	0	0	(12,835)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(51,377)	81,950	0	0	0	0	0	0	0	0	0	30,573	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(94,028)	291,186	0	0	0	0	0	0	0	0	0	197,158	45

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
Advocate Health Care	100	N/A	N/A	various	various	Management Co

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

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

	1 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	19	Management Fees	$ 216,528	Advocate Health Care	100.00%	$ 312,853	$ 96,325	1
2	V	22	Employee Benefits	83,652	Advocate Health Care	100.00%	196,563	112,911	2
3	V	30	Capital Costs		Advocate Health Care	100.00%	81,950	81,950	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			$ 300,180			$ 591,366	$ * 291,186	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: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Brd Mtg Fee	$ 1,000	L21,C3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	500	L21,C3	2
3	Linda Deering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	3
4	Dr. Michael Grassi	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	4
5	Dr. Todd Gephart	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	5
6	Tom Nitz	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	6
7	Audrey Reed	Secretary	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	7
8	Dr. Michael Berkson	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	750	L21,C3	8
9	Patricia Gering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	750	L21,C3	9
10	Pat Crawford	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	L21,C3	10
11	Denise Keefe	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	L21,C3	11
12											12
13								TOTAL	$ 4,000		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: 01/01/2014 Ending: 2/31/2014

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: Advoate Health Care
Street Address: 3075 Highland Parkway, Suite 600
City / State / Zip Code: Downers Grove, IL 60515
Phone Number: (1-800-3-ADVOCATE
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Cost	4,371,053	18	$ 116,638,751	$	9,700	$ 258,838	1
2	19	Management Fees IS	Revenue	14,589,188	18	44,121,887		17,858	54,008	2
3	22	Employee Benefits	Salaries	1,920,369	18	69,654,698		5,419	196,555	3
4	30	Depreciation Expense	Total Cost	4,371,053	18	36,927,679		9,700	81,948	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					$ 267,343,015	$		$ 591,349	25

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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				AHC Corporate Allocation			$	$			$ 86,238	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 86,238	9
	B. Non-Facility Related*											
10								Interest Income Offset			(12,835)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,835)	14
15	TOTALS (line 9+line14)						$	$			$ 73,403	15

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

*** 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:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 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:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 (630)929-5769 FAX #: (630)929-9908

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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 _____ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	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: 01/01/2014 Ending: 12/31/2014

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	$ 62,172	40	$ 62,172	$	$ 1,505,065	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	0	87,050	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	62	12	14,705	21
22	Building Improvements			1994	6,951	348	20	284	(64)	6,951	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	(0)	365,303	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)	25,548	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: 01/01/2014 Ending: 12/31/2014

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		10			1,400	39
40	Door	2001	1,125	75	15	75		988	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		10			4,431	43
44	HVAC upgrade and testing	2003	52,902	3,527	15	3,527	(0)	42,912	44
45	Fire sprinklers	2003	12,149	607	20	607	0	7,386	45
46	HVAC upgrade and testing	2003	51,875		10			51,875	46
47	Light fixtures and wiring for cafeteria	2004	3,967		10			3,967	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	594	15	594	(0)	6,633	51
52	Door holder	2004	1,046	71	15	70	(1)	781	52
53	Circuit breaker	2004	2,250		15	150	150	1,525	53
54	Door plate	2004	2,053		15	137	137	1,529	54
55	Sewer line and trap	2004	2,940		15	196	196	2,191	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		9,557	58
59	Light fixtures and wiring	2005	8,667	867	10	867	(0)	8,813	59
60	Sign for dining room	2005	2,039	204	10	204	(0)	2,074	60
61	Fire system	2005	12,230	815	15	815	0	7,880	61
62	Sewer line	2005	2,950	118	25	118		1,200	62
63									63
64	Fire Doors - 4	2006	5,670	378	15	378		3,465	64
65	Dining room doors/closures	2006	1,785	119	15	119		1,091	65
66	Cement sidewalk ramp	2006	1,950	130	15	130		1,192	66
67	Exit lights - 4	2006	3,600	240	15	240		2,200	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,321,173	$ 101,856		$ 100,545	$ (1,312)	$ 3,704,890	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: 01/01/2014 Ending: 12/31/2014

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	$ 101,856		$ 100,545	$ (1,312)	$ 3,704,890	1
2	Upgrade firedoors per IDPH specification	2006	6,020	401	15	401	0	3,676	2
3	Sprinkler installation in attic	2006	4,414	294	15	294	0	2,695	3
4	Generator - 150 amp circuit breaker	2006	1,103	55	20	55	0	505	4
5	Installation of handrails	2006	6,400	320	20	320		2,933	5
6	Sprinkler system air compressor	2007	3,020	302	10	302		2,617	6
7	5 PTAC units & connections	2007	3,326	222	15	222	(0)	1,591	7
8	Roof shingles	2007	92,083	6,139	15	6,139	(0)	43,994	8
9	14 Smoke detectors and bases	2007	1,036	69	15	69	0	496	9
10	Wallpaper for resident rooms	2007	7,146		5			7,146	10
11	Repair dry pipe sprinkler system	2007	3,905	260	15	260	0	1,864	11
12	Hot Water Boiler	2008	17,742	1,183	15	1,183	(0)	8,477	12
13	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069	2,607	10	2,607	(0)	18,682	13
14	Replace 3, 4 &6" Sprinkler Main	2008	59,719	3,981	15	3,981	0	24,550	14
15	Ductwork-Sprinkler System Install	2008	2,952	197	15	197	(0)	1,214	15
16	Carrier-5 Ton A/C Condensing Unit	2008	3,310	331	10	331		2,042	16
17	Replace Nurse Station Cabinets	2009	4,484	299	15	299	(0)	1,843	17
18	Shower Rehab-plumbing, tile, hardware	2009	44,000	2,933	15	2,933	0	18,088	18
19									19
20	Furnish & Install New Doors	2011	4,575	458	10	458		1,907	20
21	Replace Trane HT Exchanger	2011	5,620	562	10	562		2,342	21
22	Install Plank Flooring	2011	91,661	9,166	10	9,166		29,026	22
23	Parking Lot: Remove & Replace Concrete Curbs & Walkway	2011	2,500	167	15	167	(0)	528	23
24	Installation of Water Lines	2011	4,436	296	15	296	0	937	24
25	Install Kitchen Damper Box & Filter	2013	6,692	446	15	446	0	966	25
26	Install Cornice Boards in Resident Rooms	2012	11,917	794	15	794	0	1,721	26
27	Install Cabinets in S, N & SW Nurses' Station & Dining Rm.	2012	43,528	2,902	15	2,902	(0)	6,288	27
28	Install Cabinets & Counters in Activity Room	2012	10,630	708	15	709	1	1,535	28
29									29
30	Patient Room & Bath Flooring-Vinyl (rooms 103,107,204,206,	2014	46,175	770	10	770		770	30
31	208,209,306,314,315,405,406,414,100,201,202,203,300,301,400,404)								31
32	Paving-Front Parking Lot-Resurface	2014	43,977	5,497	8	5,497	0	5,497	32
33	RECONCILING ITEM TO AGREE WITH FS			37,232			(37,232)		33
34	TOTAL (lines 1 thru 33)		$ 5,879,613	$ 180,446		$ 141,905	$ (38,542)	$ 3,898,820	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: 01/01/2014 Ending: 12/31/2014

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	$ 477,285	$ 16,232	$ 16,232	$	5-20	$ 307,715	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,101,637					1,011,637	73
74	Allocated from Advocate Health Care			81,950	81,950			74
75	TOTALS	$ 1,578,922	$ 16,232	$ 98,182	$ 81,950		$ 1,319,352	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)	$ 7,962,714	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 196,678	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 240,087	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,408	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,218,172	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: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 48,402 Description: 10,730 Admin-Copiers / 29,152 Nursing-Beds&Mattresses / 8,100 PT-Equip / 420 Facilities
    (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			$ N/A	$	17
18					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.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	L39, C1 and 8	9074 hrs	$ 365,598	937	$ 61,041	$	10,011	$ 426,639	1
2	Licensed Speech and Language Development Therapist	L39, C1 and 8	3115 hrs	129,965			237	3,115	130,202	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C1 and 8	14114 hrs	609,154	1,152	69,255	1,951	15,266	680,360	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 and 8	# of prescrpts				837,761		837,761	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): OxygenGases						84,666		84,666	12
13	Other (specify): Reference Lab					44,065			44,065	13
14	TOTAL			$ 1,104,717	2,089	$ 174,361	$ 924,615	28,392	$ 2,203,693	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.

STATE OF ILLINOIS

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 2,283,954	$ 2,283,954	1
2	Cash-Patient Deposits	185	185	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,095,420	1,095,420	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): AHC Intercompany Rec	111,689	111,689	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,491,248	$ 3,491,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	770,000	770,000	13
14	Buildings, at Historical Cost	2,561,956	2,561,956	14
15	Leasehold Improvements, at Historical Cost	388,116	388,116	15
16	Equipment, at Historical Cost	70,171	70,171	16
17	Accumulated Depreciation (book methods)	(307,643)	(307,643)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,482,600	$ 3,482,600	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,973,848	$ 6,973,848	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,100	$ 432,100	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	502,228	502,228	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	436,375	436,375	36
37	Current Portion LTD	282,705	282,705	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,653,408	$ 1,653,408	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,150,198	4,150,198	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Current Portion LTD	(282,705)	(282,705)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,867,493	$ 3,867,493	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,520,901	$ 5,520,901	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,452,947	$ 1,452,947	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,973,848	$ 6,973,848	48

***(See instructions.)**

Sherman West Court
Facility #0037507
12/31/2014

Schedule 17A

XV - Balance Sheet: Line 36 - Other Current Liabilities (specify):

Description	Operating	After Consolidation
AHC Intercompany Payables	256,621	256,621
Accrued Audit and Legal Fees	22,000	22,000
Local and Other Tax Accrual	29,025	29,025
Deferred Revenue-Advance Fees	128,729	128,729
	436,375	**436,375**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 899,469	1
2	Restatements (describe):		2
3	**Reconciling Item - prior period adj**	(59,403)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 840,066	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	612,881	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)**	$ 612,881	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)**	$ 1,452,947	24 *

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 17,857,793	1
2	Discounts and Allowances for all Levels	(7,580,692)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,277,101	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,667	13
14	Non-Patient Meals	7,720	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,387	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,835	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,835	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	12,857	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,857	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,314,180	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,151,762	31
32	Health Care	3,152,596	32
33	General Administration	2,711,949	33
	B. Capital Expense		
34	Ownership	331,318	34
	C. Ancillary Expense		
35	Special Cost Centers	2,211,144	35
36	Provider Participation Fee	142,530	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,701,299	40
41	**Income before Income Taxes (line 30 minus line 40)****	612,881	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 612,881	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 344,700	44
45	Private Pay - Net Inpatient Revenue	4,041,272	45
46	Medicare - Net Inpatient Revenue	6,191,900	46
47	Other-(specify) Bad Debt & Charity	(300,771)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,277,101	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
Facility #0037507
12/31/2014

Schedule 19A

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

	Description	**Operating**
Other Operating	Miscellaneous Income	400
Other Operating	Activities & Outings Income	(4,219)
Other Operating	Wheelchair Revenue	2,676
Other Operating	Medical Records	1,325
Other Operating	Bedhold Revenue	11,647
Other Operating	I/C Purchase Services	1,028
		12,857

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2,086	2,086	$ 97,295	$ 46.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,761	44,761	1,459,990	32.62	3
4	Licensed Practical Nurses	1,926	1,926	41,260	21.42	4
5	CNAs & Orderlies	50,394	50,394	684,880	13.59	5
6	CNA Trainees					6
7	Licensed Therapist	26,303	26,303	1,104,717	42.00	7
8	Rehab/Therapy Aides	751	751	24,711	32.90	8
9	Activity Director	1,743	1,743	34,704	19.91	9
10	Activity Assistants	4,543	4,543	48,671	10.71	10
11	Social Service Workers					11
12	Dietician	2,066	2,066	40,336	19.52	12
13	Food Service Supervisor	2,086	2,086	66,581	31.92	13
14	Head Cook	7,065	7,065	108,257	15.32	14
15	Cook Helpers/Assistants	13,529	13,529	133,959	9.90	15
16	Dishwashers					16
17	Maintenance Workers	4,365	4,365	92,882	21.28	17
18	Housekeepers	13,450	13,450	159,632	11.87	18
19	Laundry					19
20	Administrator	2,086	2,086	118,134	56.63	20
21	Assistant Administrator	2,086	2,086	89,396	42.86	21
22	Other Administrative	7,415	7,415	183,298	24.72	22
23	Office Manager					23
24	Clerical	13,993	13,993	222,621	15.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	256	256	30,761	120.16	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,094	2,094	30,661	14.64	31
32	Other Health Care(specify)					32
33	Other(specify) See Sched 20A	5,807	5,807	267,693	46.10	33
34	TOTAL (lines 1 - 33)	208,805	208,805	$ 5,040,439 *	$ 24.14	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		$		35
36	Medical Director				36
37	Medical Records Consultant	33	2,351	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	33	$ 2,351		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,933	$ 101,206	L10 C3	50
51	Licensed Practical Nurses	361	17,400	L10 C3	51
52	Certified Nurse Assistants/Aides	5,421	115,955		52
53	TOTAL (lines 50 - 52)	7,715	$ 234,561		53

Sherman West Court
Facility #0037507
12/31/2014

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
FTE's in Nursing Cost Center				
Superviser Clinical Operations	2,064	2,064	82,912	40.17
Unit Secretary	1,900	1,900	27,165	14.30
Coord Medical Supplies	1,742	1,742	30,149	17.31
Other Misc	101	101	2,022	20.02
Reconciling Item			29,466	
Emp Bonus		-	95,979	
Total	**5,807**	**5,807**	**267,693**	**46.10**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph McManus	Administrator	0	$ 118,134
Angela Lackowski	Asst. Adimimistrator	0	89,396
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 207,530

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AHC-Home Office	Management Fees	$ 216,528
E&Y	Audit Fees	31,255
Scheflow & Rydell	Legal	2,309
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 250,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,700
Unemployment Compensation Insurance	189
FICA Taxes	364,992
Employee Health Insurance	453,762
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Employer Contributions/ Plan Admin Fees	92,723
Prescription Drug Plan	122,382
Dental / Vision	21,975
Life Insurance	5,610
Disability Insurance	55,536
Tuition Reimbursement / Other	10,799
Home Office Allocation	196,563
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,375,231

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Rehab Optima (license/support fee)	3,125
Joint Commission	5,415
LeadingAge IL (LSN dues)	10,437
See Schedule 21A	15,537
Less: Lobbying Expense	(2,493)
Less: Public Relations Expense	(3,161)
Non-allowable advertising	(8,318)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,400
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,400

**See instructions.

Sherman West Court
Facility #0037507
12/31/2014 **Schedule 21A**

Schedule XIX(F) Dues, Fees, Subscriptions and Promotions

Misc General Advertising/Marketing	11,479	offset
Employee Books/Subscriptions	2,989	
City of Elgin (business license)	665	
IL Emergency Mgmt (fee)	175	
Basis (software fee)	204	
Misc Other	25	
	15,537	

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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													
4													
5							N/A						
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: 01/01/2014 Ending: 12/31/2014

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. **LeadingAge 10,437**

(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. $ **50,927** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **142,530**
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. $ **7,720**

(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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Legal fees offset**
Attach invoices and a summary of services for all architect and appraisal fees.