FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 2/18/1991

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(c)(3)

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 01/01/2015 to 12/31/2015 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) RSM US 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: 01/01/2015 Ending: 12/31/2015

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	40,880	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	40,880	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	2,201	7,990	17,896	28,087	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,201	7,990	17,896	28,087	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.71%

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 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 74 and days of care provided 13,672

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	374,286	22,419	8,091	404,796		404,796	(13,401)	391,395			1
2	Food Purchase		205,145		205,145		205,145		205,145			2
3	Housekeeping	186,800		26,547	213,347		213,347		213,347			3
4	Laundry		12,589	1,693	14,282		14,282		14,282			4
5	Heat and Other Utilities			141,172	141,172		141,172		141,172			5
6	Maintenance	90,970	14,120	181,728	286,818		286,818	(28,386)	258,432			6
7	Other (specify):*											7
8	**TOTAL General Services**	652,056	254,273	359,231	1,265,560		1,265,560	(41,787)	1,223,773			8
	B. Health Care and Programs											
9	Medical Director	15,477			15,477		15,477		15,477			9
10	Nursing and Medical Records	2,790,595	254,308	191,875	3,236,778		3,236,778		3,236,778			10
10a	Therapy											10a
11	Activities	95,823	2,517	1,042	99,382		99,382		99,382			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,901,895	256,825	192,917	3,351,637		3,351,637		3,351,637			16
	C. General Administration											
17	Administrative	213,250		221,278	434,528		434,528	141,587	576,115			17
18	Directors Fees											18
19	Professional Services			44,791	44,791		44,791	(5,327)	39,464			19
20	Dues, Fees, Subscriptions & Promotions			15,336	15,336		15,336	19,760	35,096			20
21	Clerical & General Office Expenses	555,228		182,853	738,081		738,081	(203,837)	534,244			21
22	Employee Benefits & Payroll Taxes			1,335,760	1,335,760		1,335,760	84,651	1,420,411			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,655	4,655		4,655		4,655			24
25	Other Admin. Staff Transportation			2,575	2,575		2,575		2,575			25
26	Insurance-Prop.Liab.Malpractice			275,516	275,516		275,516		275,516			26
27	Other (specify):*											27
28	**TOTAL General Administration**	768,478		2,082,764	2,851,242		2,851,242	36,834	2,888,076			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,322,429	511,098	2,634,912	7,468,439		7,468,439	(4,953)	7,463,486			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:** 01/01/2015 **Ending:** 12/31/2015

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			200,756	200,756		200,756	52,337	253,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,648	80,648		80,648	(5,407)	75,241			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,417	49,417		49,417		49,417			35
36	Other (specify):*											36
37	**TOTAL Ownership**			330,821	330,821		330,821	46,930	377,751			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,142,207	1,064,747	186,962	2,393,916		2,393,916		2,393,916			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,770	151,770		151,770		151,770			42
43	Other (specify):* Non-Allowable Cos			662,440	662,440		662,440	(662,440)				43
44	**TOTAL Special Cost Centers**	1,142,207	1,064,747	1,001,172	3,208,126		3,208,126	(662,440)	2,545,686			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,464,636	1,575,845	3,966,905	11,007,386		11,007,386	(620,463)	10,386,923			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: 01/01/2015 Ending: 12/31/2015

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	(13,401)	1		4
5	Telephone, TV & Radio in Resident Rooms	(5,515)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,435)	30		9
10	Interest and Other Investment Income	(5,407)	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	(8,360)	43		18
19	Entertainment	(2,575)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(629,477)	43		24
25	Fund Raising, Advertising and Promotional	(12,896)	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 Page 5A	(221,407)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (938,473)		$	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)	318,010		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 318,010		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (620,463)		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: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Alcoholic Beverages	$ (81)	43	1
2	Lobbying Expense	(2,918)	43	2
3	Sales Representative	(101,814)	21	3
4	Marketing	(69,148)	21	4
5	Revenues Misc	(13,115)	10	5
6	Non-allowable Legal	(5,327)	19	6
7	Capitalize Repairs and Maintenance	(28,386)	30	7
8	Non-allowable Purchased Services	(618)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(221,407)		49

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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		17	Management Fees	$ 216,528	Advocate Health Care	100.00%	$ 358,115	$ 141,587	1
2	V		22	Employee Benefits	126,084	Advocate Health Care	100.00%	210,735	84,651	2
3	V		30	Depreciation Expense - Bldg		Advocate Health Care	100.00%	17,990	17,990	3
4	V		30	Depreciation Expense - Equip		Advocate Health Care	100.00%	73,782	73,782	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				$ 342,612			$ 660,622	$ * 318,010	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: 01/01/2015 Ending: 12/31/2015

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 Fee	$ 1,000	17(3)	1
2	Mary Martini	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	2
3	Linda Deering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	3
4	Dr. Todd Gephart	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	4
5	Kenneth Kohler	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	5
6	Audrey Reed	Secretary	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	17(3)	6
7	Dr. Michael Berkson	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	17(3)	7
8	Patricia Gering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	750	17(3)	8
9	Pat Crawford	Treasurer	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	17(3)	9
10	Denise Keefe	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	10
11											11
12	Note: Pat Crawford provides medical transportation to the facility through Elgin Medi Transport.										12
13								TOTAL	$ 4,750		13

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

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	17	Management Fees	Total Cost	4,762,552,673	18	$ 136,528,933	$	10,321,327	$ 295,883	1
2	17	Management Fees IS	Revenue	15,241,921,157	18	51,952,137		18,257,985	62,232	2
3	22	Employee Benefits	Salaries	2,004,132,423	18	73,457,736		5,749,428	210,735	3
4	30	Depreciation Expense - Bldg	Total Cost	4,762,552,673	18	8,301,118		10,321,327	17,990	4
5	30	Depreciation Expense - Equip	Total Cost	4,762,552,673	18	34,045,134		10,321,327	73,782	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					$ 304,285,058	$		$ 660,622	25

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Advocate Sherman Hospital	X		Working Capital	Demand	8/1/13	4,427,360	3,867,494	8/1/27	0.0200	80,648	6
7												7
8												8
9	TOTAL Facility Related						$ 4,427,360	$ 3,867,494			$ 80,648	9
	B. Non-Facility Related*											
10								Interest Income Offset			(5,407)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,407)	14
15	TOTALS (line 9+line14)						$ 4,427,360	$ 3,867,494			$ 75,241	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:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)	**2014**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 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.)**	**Allocated from Managment Co.**	$	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:			
	2010		**8**
	2011		**9**
	2012		**10**
	2013		**11**
	2014		**12**

Facility is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	**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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Michael Volante

TELEPHONE (630)929-5771 FAX #: (630)929-9908

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$ 139,766	40	$ 62,172	$ (77,594)	$ 1,567,236	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		25	3,646	3,646	90,696	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		20			14,525	21
22	Building Improvements			1994	6,951		20			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		40	23,473	23,473	388,776	33
34	Kitchen Wall Boards			2000	1,365		5			1,365	34
35	Parking Lot Improvements			2000	52,250		30	1,742	1,742	27,289	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: 01/01/2015 Ending: 12/31/2015

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		15	75	75	1,063	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		15	3,527	3,527	46,439	44
45	Fire sprinklers	2003	12,149		20	607	607	7,994	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		15	594	594	7,227	51
52	Door holder	2004	1,046		15	70	70	850	52
53	Circuit breaker	2004	2,250		15	150	150	1,675	53
54	Door plate	2004	2,053		15	137	137	1,666	54
55	Sewer line and trap	2004	2,940		15	196	196	2,387	55
56	Drapes	2005	5,817		5			5,817	56
57	Carpeting	2005	11,175		5			11,175	57
58	Carpeting	2005	9,400		10			9,400	58
59	Light fixtures and wiring	2005	8,667		10			8,667	59
60	Sign for dining room	2005	2,039		10			2,039	60
61	Fire system	2005	12,230		15	815	815	8,696	61
62	Sewer line	2005	2,950		25	118	118	1,318	62
63									63
64	Fire Doors - 4	2006	5,670		15	378	378	3,843	64
65	Dining room doors/closures	2006	1,785		15	119	119	1,210	65
66	Cement sidewalk ramp	2006	1,950		15	130	130	1,322	66
67	Exit lights - 4	2006	3,600		15	240	240	2,440	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,321,173	$ 139,766		$ 98,188	$ (41,577)	$ 3,802,561	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: 01/01/2015 Ending: 12/31/2015

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	$ 139,766		$ 98,188	$ (41,577)	$ 3,802,561	1
2	Upgrade firedoors per IDPH specification	2006	6,020		15	401	401	4,077	2
3	Sprinkler installation in attic	2006	4,414		15	294	294	2,989	3
4	Generator - 150 amp circuit breaker	2006	1,103		20	55	55	560	4
5	Installation of handrails	2006	6,400		20	320	320	3,253	5
6	Sprinkler system air compressor	2007	3,020		10	302	302	2,919	6
7	5 PTAC units & connections	2007	3,326		15	222	222	1,813	7
8	Roof shingles	2007	92,083		15	6,139	6,139	50,133	8
9	14 Smoke detectors and bases	2007	1,036		15	69	69	565	9
10	Wallpaper for resident rooms	2007	7,146		5			7,146	10
11	Repair dry pipe sprinkler system	2007	3,905		15	260	260	2,124	11
12	Hot Water Boiler	2008	17,742		15	1,183	1,183	9,660	12
13	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069		10	2,607	2,607	21,289	13
14	Replace 3, 4 &6" Sprinkler Main	2008	59,719		15	3,981	3,981	28,531	14
15	Ductwork-Sprinkler System Install	2008	2,952		15	197	197	1,411	15
16	Carrier-5 Ton A/C Condensing Unit	2008	3,310		10	331	331	2,373	16
17	Replace Nurse Station Cabinets	2009	4,484		15	299	299	2,142	17
18	Shower Rehab-plumbing, tile, hardware	2009	44,000		15	2,933	2,933	21,021	18
19									19
20	Furnish & Install New Doors	2011	4,575		10	458	458	2,364	20
21	Replace Trane HT Exchanger	2011	5,620		10	562	562	2,904	21
22	Install Plank Flooring	2011	91,661		10	9,166	9,166	38,192	22
23	Parking Lot: Remove & Replace Concrete Curbs & Walkway	2011	2,500		15	167	167	694	23
24	Installation of Water Lines	2011	4,436		15	296	296	1,232	24
25	Install Kitchen Damper Box & Filter	2013	6,692		15	446	446	1,412	25
26	Install Cornice Boards in Resident Rooms	2012	11,917		15	794	794	2,515	26
27	Install Cabinets in S, N & SW Nurses' Station & Dining Rm.	2012	43,528		15	2,902	2,902	9,190	27
28	Install Cabinets & Counters in Activity Room	2012	10,630		15	708	708	2,243	28
29									29
30	Patient Room & Bath Flooring-Vinyl (rooms 103,107,204,206,	2014	46,175	4,618	10	4,618		5,388	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		10,994	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,879,613	$ 149,880		$ 143,394	$ (6,486)	$ 4,041,697	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: 01/01/2015 Ending: 12/31/2015

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 12B, Carried Forward		$ 5,879,613	$ 149,880		$ 143,394	$ (6,486)	$ 4,041,697	1
2									2
3	Aluminum Panels- Monument Sign	2015	5,516	230	10	276	46	276	3
4									4
5	Installation, wiring, purchase of overbed lights for 73 beds	2015	28,386		10	1,419	1,419	1,419	5
6									6
7	Allocated from Advocate Health Care					17,990	17,990		7
8									8
9	To reconcile to financial statements			34,414			(34,414)		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,913,515	$ 184,524		$ 163,079	$ (21,445)	$ 4,043,392	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: 01/01/2015 Ending: 12/31/2015

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	$ 60,495	$ 13,176	$ 13,176	$	5-20	$ 33,930	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,518,427					1,518,427	73
74	Allocated from Advocate Health Care			73,782	73,782			74
75	TOTALS	$ 1,578,922	$ 13,176	$ 86,958	$ 73,782		$ 1,552,357	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	Resident Recreational	2001 Glaval Bus	2013	$ 9,677	$ 3,056	$ 3,056	$	3	$ 7,894	76
77										77
78										78
79										79
80	TOTALS			$ 9,677	$ 3,056	$ 3,056	$		$ 7,894	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)	$ 8,006,293	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 200,756	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 253,093	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,337	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,603,643	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 49,417 Description: 10,105 Admin-Copiers / 30,912 Nursing-Beds&Mattresses / 8,100 PT-Equip / 300 Water Cooler
    (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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	39(1),(3)	8229 hrs	$ 326,927	1,609	$ 106,986	$	9,838	$ 433,913	1
2	Licensed Speech and Language Development Therapist	39(1),(3)	3091 hrs	130,524				3,091	130,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(1),(3)	15643 hrs	684,756	469	30,954		16,112	715,710	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				995,663		995,663	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): OxygenGases	39(2)					69,084		69,084	12
13	Other (specify): Reference Lab				681	49,022		681	49,022	13
14	TOTAL			$ 1,142,207	2,759	$ 186,962	$ 1,064,747	29,722	$ 2,393,916	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.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,137,482	$ 1,137,482	1
2	Cash-Patient Deposits	155	155	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 884,560)	2,451,553	2,451,553	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	71,927	71,927	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,661,117	$ 3,661,117	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	770,000	504,179	13
14	Buildings, at Historical Cost	2,561,956	2,486,860	14
15	Leasehold Improvements, at Historical Cost	393,632	3,426,655	15
16	Equipment, at Historical Cost	70,172	1,588,599	16
17	Accumulated Depreciation (book methods)	(508,399)	(5,603,643)	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 (spe CIP Clearing	10,500	10,500	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,297,861	$ 2,413,150	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,958,978	$ 6,074,267	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 215,709	$ 215,709	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	154	154	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	543,595	543,595	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	548,684	548,684	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,308,142	$ 1,308,142	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,867,494	3,867,494	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,867,494	$ 3,867,494	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,175,636	$ 5,175,636	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,783,342	$ 898,631	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,958,978	$ 6,074,267	48

*(See instructions.)

Facility Name: **Sherman West Court**
IDPH License ID Number: **0037507**
Fiscal Year End: **12/31/2015**

Schedule 17A

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

	Description	Operating	After Consolidation
030-90000-21720-00	Accrued Audit And Legal Fees	15,000	15,000
030-90000-21751-00	Local and Other Tax Accrual	37,855	37,855
030-90000-21810-00	Deferred Revenue-Advance Fees	150,830	150,830
030-90000-23754-00	Interco Due To Co 30	41,194	41,194
030-90000-23756-00	Interco Due To Co 40	210	210
030-90000-23758-00	Interco Due To Co 25	157,970	157,970
030-90000-23772-00	Interco Due To Co 60	145,625	145,625
	Total - Line 36	**548,684**	**548,684**

Facility Name & ID Number Sherman West Court **#** 0037507 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,452,947	1	
2	Restatements (describe):		2	
3	**Reconciling Item - prior period adj**	(201)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,452,746	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	330,596	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)**	$ 330,596	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)**	$ 1,783,342	24	*

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 17,739,872	1
2	Discounts and Allowances for all Levels	(7,030,360)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,709,512	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	3,781	13
14	Non-Patient Meals	13,401	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	528,531	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 545,713	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,407	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activities & Outings	(3,562)	28
28a	See Schedule 19A	80,912	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,350	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,337,982	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,265,560	31
32	Health Care	3,351,637	32
33	General Administration	2,851,242	33
	B. Capital Expense		
34	Ownership	330,821	34
	C. Ancillary Expense		
35	Special Cost Centers	3,056,356	35
36	Provider Participation Fee	151,770	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,007,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	330,596	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 330,596	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 307,576	44
45	Private Pay - Net Inpatient Revenue	4,177,428	45
46	Medicare - Net Inpatient Revenue	6,296,335	46
47	Other-(specify) Bad Debt & Charity	(71,826)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,709,512	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.**

Facility Name: **Sherman West Court**
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Schedule 19A

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

	Description	Amount
030-11300-44611-00	Medical Records	(11,411)
030-11300-96388-00	I/C Purchase Services	81,978
030-19000-49000-00	Other Misc Revenues	5,134
030-19040-44742-00	Wheelchair Revenue	2,364
030-19040-49000-00	Other Misc Revenues	2,847
	Total - Line 28	**80,912**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2,037	2,037	$ 95,815	$ 47.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	53,805	53,805	1,829,324	34.00	3
4	Licensed Practical Nurses	1,470	1,470	36,579	24.88	4
5	CNAs & Orderlies	55,322	55,322	771,851	13.95	5
6	CNA Trainees					6
7	Licensed Therapist	26,361	26,361	1,142,207	43.33	7
8	Rehab/Therapy Aides	1,146	1,146	27,882	24.33	8
9	Activity Director	2,072	2,072	44,161	21.31	9
10	Activity Assistants	4,641	4,641	51,662	11.13	10
11	Social Service Workers					11
12	Dietician	1,572	1,572	31,402	19.98	12
13	Food Service Supervisor	2,623	2,623	80,362	30.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,364	21,364	262,522	12.29	15
16	Dishwashers					16
17	Maintenance Workers	4,126	4,126	90,970	22.05	17
18	Housekeepers	14,722	14,722	186,800	12.69	18
19	Laundry					19
20	Administrator	2,078	2,078	121,237	58.35	20
21	Assistant Administrator	2,078	2,078	92,013	44.29	21
22	Other Administrative					22
23	Office Manager	1,591	1,591	34,113	21.44	23
24	Clerical	21,203	21,203	348,747	16.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	129	129	15,477	120.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,031	2,031	29,144	14.35	31
32	Other Health Ca					32
33	Other(specify) See Sched 20A	7,438	7,438	172,368	23.18	33
34	TOTAL (lines 1 - 33)	227,809	227,809	$ 5,464,636 *	$ 23.99	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	Monthly	3,459	10(3)	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	Monthly	894	10(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 4,353		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,586	$ 77,087	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,998	72,473	10(3)	52
53	TOTAL (lines 50 - 52)	4,584	$ 149,560		53

Facility Name: **Sherman West Court**
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Schedule 20A

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Sales Representative	4,646	4,646	101,814	$ 21.91
Marketing Specialist	2,709	2,709	69,148	$ 25.53
Pastoral Care Associate	82	82	1,406	$ 17.15
Total - Line 33 Other (specify):	**7,437**	**7,437**	**172,368**	**$ 23.18**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph McManus	Administrator	0	$ 121,237
Angela Lackowski	Asst. Adimimistrator	0	92,013
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 213,250

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 216,528
Board of Director Meeting Fees	4,750
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 221,278

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	See Schedule 21C	$ 44,791
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 44,791

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,114
Unemployment Compensation Insurance	
FICA Taxes	395,386
Employee Health Insurance	608,247
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Employer Contributions/ Plan Admin Fees	99,813
Prescription Drug Plan	141,729
Dental / Vision	16,750
Life Insurance	5,659
Disability Insurance	36,421
Tuition Reimbursement / Other	17,641
Home Office Allocation	84,651
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,420,411

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,833
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 760	19,760
Miscellaneous Licenses & Fees	2,218
Miscellaneous Dues & Subscriptions	7,305
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,655
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,655

**See instructions.

Facility Name: **Sherman West Court**
IDPH License ID Number: **0037507**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Scheflow & Rydell	Collections	5,327
Ernst & Young	Audit Fees	2,869
Frost, Ruttenberg & Rothblatt	Healthcare Billing Consulting	2,000
Med Assets	Clinical Consulting	34,595
	Total (agree to Schedule V, line 19, column 3)	44,791
Less: Non-Allowable Legal Fees		(5,327)
	Total (agree to Schedule V, line 19, column 8)	39,464

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **No**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,447** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **151,770**
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? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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? 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.