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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0037507

Facility Name: Sherman West Court

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

County: Kane

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

HFS ID Number:

Date of Initial License for Current Owners: 02/18/1991

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Jennifer Hanes **Telephone Number:** (630) 929-5767
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 01/01/2017 to 12/31/2017 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) Michael Volante
(Title) Corporate Reimbursement Director

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: 01/01/2017 Ending: 12/31/2017

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	1,161	6,756	16,540	24,457	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,161	6,756	16,540	24,457	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.83%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 74 and days of care provided 10,702

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	489,451	8,685	26,303	524,439		524,439	(10,578)	513,861			1
2	Food Purchase		181,159		181,159		181,159		181,159			2
3	Housekeeping	244,604		26,087	270,691		270,691		270,691			3
4	Laundry		10,333		10,333		10,333		10,333			4
5	Heat and Other Utilities			133,393	133,393		133,393		133,393			5
6	Maintenance	73,034	7,179	120,772	200,985		200,985		200,985			6
7	Other (specify):*											7
8	**TOTAL General Services**	807,089	207,356	306,555	1,321,000		1,321,000	(10,578)	1,310,422			8
	B. Health Care and Programs											
9	Medical Director	15,922			15,922		15,922		15,922			9
10	Nursing and Medical Records	2,882,489	252,435	576,829	3,711,753		3,711,753	(35,734)	3,676,019			10
10a	Therapy											10a
11	Activities	100,518	232	2,017	102,767		102,767		102,767			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,998,929	252,667	578,846	3,830,442		3,830,442	(35,734)	3,794,708			16
	C. General Administration											
17	Administrative	236,428		220,528	456,956		456,956	63,253	520,209			17
18	Directors Fees											18
19	Professional Services			68,420	68,420		68,420	(60,729)	7,691			19
20	Dues, Fees, Subscriptions & Promotions			55,213	55,213		55,213		55,213			20
21	Clerical & General Office Expenses	600,969		279,717	880,686		880,686	(150,174)	730,512			21
22	Employee Benefits & Payroll Taxes			1,420,265	1,420,265		1,420,265	160,591	1,580,856			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,844	2,844		2,844		2,844			24
25	Other Admin. Staff Transportation			1,805	1,805		1,805		1,805			25
26	Insurance-Prop.Liab.Malpractice			54,262	54,262		54,262		54,262			26
27	Other (specify):*											27
28	**TOTAL General Administration**	837,397		2,103,054	2,940,451		2,940,451	12,941	2,953,392			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,643,415	460,023	2,988,455	8,091,893		8,091,893	(33,371)	8,058,522			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: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			222,489	222,489		222,489	60,980	283,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			81,194	81,194		81,194	(2,092)	79,102			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			48,606	48,606		48,606		48,606			35
36	Other (specify):*											36
37	**TOTAL Ownership**			352,289	352,289		352,289	58,888	411,177			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,231,298	1,112,450	76,693	2,420,441		2,420,441		2,420,441			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,851	109,851		109,851		109,851			42
43	Other (specify):* **Non-allowable Costs**			1,690,145	1,690,145		1,690,145	(1,690,145)				43
44	**TOTAL Special Cost Centers**	1,231,298	1,112,450	1,876,689	4,220,437		4,220,437	(1,690,145)	2,530,292			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,874,713	1,572,473	5,217,433	12,664,619		12,664,619	(1,664,628)	10,999,991			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: 01/01/2017 Ending: 12/31/2017

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	(10,578)	1		4
5	Telephone, TV & Radio in Resident Rooms	(7,708)	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	(23,499)	30		9
10	Interest and Other Investment Income	(2,092)	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	(3,825)	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	(1,654,842)	43		24
25	Fund Raising, Advertising and Promotional	(9,046)	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	(263,127)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,974,717)		$	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)	310,089		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 310,089		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,664,628)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Alcoholic beverages	$ (96)	43	1
2	State sales taxes	0	43	2
3	bank service charges	0	21	3
4	credit card service charges	(12,984)	43	4
5			10	5
6	Sales representative	(101,341)	21	6
7	Marketing	(47,833)	21	7
8	Misc Rev	(35,734)	10	8
9	Non-allowable legal & consulting	(60,729)	19	9
10	Depreciation on patient TVs	(1,766)	30	10
11	lobbying	(1,644)	43	11
12	Community support	(1,000)	21	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**	(263,127)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(10,578)	0	0	0	0	0	0	0	0	0	0	(10,578)	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**	(10,578)	0	0	0	0	0	0	0	0	0	0	(10,578)	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	(35,734)	0	0	0	0	0	0	0	0	0	0	(35,734)	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**	(35,734)	0	0	0	0	0	0	0	0	0	0	(35,734)	16
	C. General Administration													
17	Administrative	0	63,253	0	0	0	0	0	0	0	0	0	63,253	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,729)	0	0	0	0	0	0	0	0	0	0	(60,729)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(150,174)	0	0	0	0	0	0	0	0	0	0	(150,174)	21
22	Employee Benefits & Payroll Taxes	0	160,591	0	0	0	0	0	0	0	0	0	160,591	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**	(210,903)	223,844	0	0	0	0	0	0	0	0	0	12,941	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(257,215)	223,844	0	0	0	0	0	0	0	0	0	(33,371)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(25,265)	86,245	0	0	0	0	0	0	0	0	0	60,980	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,092)	0	0	0	0	0	0	0	0	0	0	(2,092)	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**	(27,357)	86,245	0	0	0	0	0	0	0	0	0	58,888	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):*	(1,690,145)	0	0	0	0	0	0	0	0	0	0	(1,690,145)	43
44	**TOTAL Special Cost Centers**	(1,690,145)	0	0	0	0	0	0	0	0	0	0	(1,690,145)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,974,717)	310,089	0	0	0	0	0	0	0	0	0	(1,664,628)	45

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	vaious	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%	$ 279,781	$ 63,253	1
2	V	22	Employee Benefits	138,538	Advocate Health Care	100.00%	299,129	160,591	2
3	V	30	Depreciation Expense - Bldg		Advocate Health Care	100.00%	21,916	21,916	3
4	V	30	Depreciation Expense - Equip		Advocate Health Care	100.00%	64,329	64,329	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			$ 355,066			$ 665,155	$ * 310,089	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: 01/01/2017 Ending: 12/31/2017

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
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25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	17(3)	1
2	Audrey Reed	Secretary	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	17(3)	2
3	Pat Crawford	Treasure	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	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	Dr. Michael Berkson	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	1,000	17(3)	6
7	Denise Keefe	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	7
8	Linda Deering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	8
9	Mary Martini	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee		17(3)	9
10	Patricia Gering	Director	Board Member	None	None	Less than 1	Less than 1	Brd Mtg Fee	0	17(3)	10
11											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: 01/01/2017 Ending: 2/31/2017

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: Advocate 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	5,597,213,293	18	$ 102,223,550	$	11,041,077	$ 201,646	1
2	17	Management Fees-IS	Revenue	###########	18	78,697,562		16,032,223	78,135	2
3	1	Employee Benefits	Salaries	2,282,667,082	18	104,736,340		6,519,350	299,129	3
4	30	Depreciation Expense-Bldg	Total Cost	5,597,213,293	18	11,110,085		11,041,077	21,916	4
5	30	Depreciation Expense-Equip	Total Cost	5,597,213,293	18	32,611,305		11,041,077	64,329	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					$ 329,378,842	$		$ 665,155	25

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Advocate Sherman Hospital	X		Working Capital	Demand	8/1/13	4,427,360	3,579,135	8/1/27	0.0200	71,583	6
7	Advocate Sherman Hospital	X		Working Capital	Demand	7/12/17	500,000	500,000	8/1/22	0.0400	9,611	7
8												8
9	TOTAL Facility Related						$ 4,927,360	$ 4,079,135			$ 81,194	9
	B. Non-Facility Related*											
10								Interest Income Offset			(2,092)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,092)	14
15	TOTALS (line 9+line14)						$ 4,927,360	$ 4,079,135			$ 79,102	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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

Facility is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Jennifer Hanes

TELEPHONE (630) 929-5767 FAX #: (630) 929-9908

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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. [ ] (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: 01/01/2017 Ending: 12/31/2017

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	$ 59,441	$ (80,325)	$ 1,684,406	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements 293105-06			1991	118,269		5			118,269	9
10	Building Improvements 293099			1991	219,089		10			219,089	10
11	Building Improvements 293100			1991	205,843		15			205,843	11
12	Building Improvements 293102			1991	826,676		20			826,676	12
13	Building Improvements 293103			1991	91,155		25			91,155	13
14	Building Improvements 293107-09			1991	21,960		10			21,960	14
15	Building Improvements 293101, 293110			1991	4,444		15			4,444	15
16	Building Improvements 293111			1992	22,980		10			22,980	16
17	Building Improvements 293112			1992	2,000		15			2,000	17
18	Building Improvements 293114			1993	962		5			962	18
19	Building Improvements 293115-117			1993	13,219		10			13,219	19
20	Building Improvements 293118			1993	3,750		15			3,750	20
21	Building Improvements 293113			1993	1,006		20			1,006	21
22	Building Improvements 293119			1994	6,951		20			6,951	22
23	Carpet Tiles 293124			1995	1,500		10			1,500	23
24	Sliding Doors 293123			1996	3,345		10			3,345	24
25	Resurface Parking Lot 293125			1996	4,800		5			4,800	25
26	Carpeting 293126			1997	3,690		5			3,690	26
27	Carpet/tile Base 293126			1997	12,580		5			12,580	27
28	Kickplates 293127			1997	4,165		5			4,165	28
29	Carpet Living Room 293132			1998	4,340		10			4,340	29
30	Cement Board & Ceramic Tile 293131			1999	4,475		10			4,475	30
31	Wallpaper 293130			1999	1,819		5			1,819	31
32	Landscaping 293130			1999	893		5			893	32
33	Construction contract for new entrance & nursing station 292984, 293133			1999	938,914		40	23,530	23,530	431,891	33
34	Kitchen Wall Boards 292982-83			2000	1,365		5			1,365	34
35	Parking Lot Improvements 292986			2000	52,250		15			52,250	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 292987	2002	$ 19,943	$	5	$	$	$ 19,943	37
38	Wallpaper 292988	2002	19,893		5			19,893	38
39	Roofing 292990	2001	1,400		10			1,400	39
40	Door 292991	2001	1,125		15			1,125	40
41	Carpeting 293013	2003	5,732		5			5,732	41
42	Painting 293014	2003	1,855		5			1,855	42
43	Wiring for therapy rooms 293015	2003	4,431		10			4,431	43
44	HVAC upgrade and testing 293016	2003	52,902		15	3,035	3,035	51,384	44
45	Fire sprinklers 293017-18	2003	12,149		20	563	563	9,085	45
46	HVAC upgrade and testing 293027	2003	51,875		15	2,976	2,976	50,387	46
47	Light fixtures and wiring for cafeteria 293023	2004	3,967		10			3,967	47
48	Wallpaper 293022	2004	6,868		5			6,868	48
49	Vent pipe293021	2004	1,068		5			1,068	49
50	Vinyl base 293020	2004	900		5			900	50
51	HVAC upgrade and testing 293028	2004	8,909		15	617	617	8,601	51
52	Door holder 293026	2004	1,071		15	74	74	1,034	52
53	Circuit breaker 293025	2004	2,250		15	156	156	2,172	53
54	Door plate 293024	2004	2,133		15	148	148	2,059	54
55	sewerline and trap 293052	2005	2,940		15	200	200	2,439	55
56	Drapes 293051	2005	5,027		5			5,027	56
57	Carpeting 293047	2005	11,448		5			11,448	57
58	Carpeting 293039-40	2005	9,400		10			9,400	58
59	Light fixtures and wiring 293041	2005	8,667		10			8,667	59
60	Sign for dining room 293042	2005	2,034		10			2,034	60
61	Fire system 293043	2005	11,075		15	658	658	9,429	61
62	Sewer line 293044	2005	2,950		25	119	119	1,701	62
63	Light Fixtures 293007	2001	18,540		10			18,540	63
64	Fire Doors - 4 293053	2006	5,670		15	386	386	4,704	64
65	Dining room doors/closures 293054	2006	1,785		15	122	122	1,481	65
66	Cement sidewalk ramp 293057	2006	1,950		15	133	133	1,618	66
67	Exit lights - 4 293056	2006	3,600		15	245	245	2,987	67
68	signage 293038	2004	3,674		15	215	215	3,351	68
69	sprinkler system +293029-30	2004	2,855		15	190	190	2,716	69
70	TOTAL (lines 4 thru 69)		$ 5,349,386	$ 139,766		$ 92,808	$ (46,958)	$ 4,027,269	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: 01/01/2017 Ending: 12/31/2017

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		$ 5,349,386	$ 139,766		$ 92,808	$ (46,958)	$ 4,027,269	1
2	Upgrade firedoors per IDPH specification 293055	2006	6,016		15	410	410	4,991	2
3	Sprinkler installation in attic 293058	2006	4,414		15	265	265	3,485	3
4	Generator - 150 amp circuit breaker 293059	2006	1,103		20	56	56	685	4
5	Installation of handrails 293060	2006	6,400		20	323	323	3,658	5
6	Sprinkler system air compressor 293067	2007	3,020		10	125	125	3,020	6
7	5 PTAC units & connections 293068	2007	3,326		15	226	226	2,537	7
8	Roof shingles 293069	2007	92,083		15	6,243	6,243	70,232	8
9	14 Smoke detectors and bases 293070	2007	1,036		15	70	70	790	9
10	Wallpaper for resident rooms 293078	2007	7,146		5			7,146	10
11	Repair dry pipe sprinkler system 293080	2007	3,905		15	264	264	2,718	11
12	Hot Water Boiler 292951	2008	17,742		15	1,084	1,084	11,780	12
13	PTAC Zoneline Heater/Air Conditioners for Resident Rooms 2929	2008	26,069		10	2,220	2,220	24,959	13
14	Replace 3, 4 &6" Sprinkler Main 292955-56	2008	59,719		15	4,019	4,019	37,614	14
15	Ductwork-Sprinkler System Install 292957-60	2008	2,952		15	199	199	1,859	15
16	Carrier-5 Ton A/C Condensing Unit 292962	2008	3,310		10	340	340	3,140	16
17	smoke detectors 292978	2010	4,826		10	426	426	3,762	17
18	Shower Rehab-plumbing, tile, hardware 292969	2009	44,000		15	2,961	2,961	27,713	18
19	code alert security system 293048	2005	9,296		5			9,296	19
20	Furnish & Install New Doors 293089	2007	4,720		10	246	246	4,720	20
21	Replace Trane HT Exchanger 293137	2011	5,620		10	568	568	4,199	21
22	Install Plank Flooring 293142-45	2011	91,661		10	9,220	9,220	59,391	22
23	Parking Lot: Remove & Replace Concrete Curbs & Walkway 293	2011	2,500		15	167	167	1,080	23
24	Installation of Water Lines 293140	2011	4,436		15	286	286	2,007	24
25	Install Kitchen Damper Box & Filter 293163	2013	6,692		15	432	432	2,160	25
26	Install Cornice Boards in Resident Rooms 293150	2012	11,917		15	795	795	4,364	26
27	Install Cabinets in S, N & SW Nurses' Station & Dining Rm. 2931	2012	43,528		15	2,806	2,806	16,869	27
28	Install Cabinets & Counters in Activity Room 293162	2012	10,630		15	709	709	3,893	28
29	zoneline heaters 293063	2005	3,251		10			3,251	29
30	Patient Room & Bath Flooring-Vinyl (rooms 103,107,204,206, 303	2014	46,175	4,618	10	4,618		14,622	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 299796	2014	43,977	5,497	8	5,497		21,989	32
33	furnace replacement 292970-71	2009	41,175		15	2,764	2,764	23,212	33
34	TOTAL (lines 1 thru 33)		$ 5,962,031	$ 149,881		$ 140,145	$ (9,735)	$ 4,408,411	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: 01/01/2017 Ending: 12/31/2017

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		$ 5,962,031	$ 149,881		$ 140,145	$ (9,735)	$ 4,408,411	1
2	doors 292975-76	2009	4,234		10	431	431	3,587	2
3	Aluminum Panels- Monument Sign 310087	2015	5,516	552	10	552		1,333	3
4	zoneline heating 293075	2007	3,018		10	125	125	3,018	4
5	Installation, wiring, purchase of overbed lights for 73 beds -cap re	2015	28,386		10	2,839	2,839	7,097	5
6	furnish & install 293097	2008	2,780		10	237	237	2,662	6
7	electrical room work	2010	4,575		10	458	458	3,414	7
8	Air conditioning/condensing 292973	2009	2,522		5			2,522	8
9	Doors 316093 - North east and north west entrance doors	2016	12,864	643	20	643		1,179	9
10	190 Larkin land improvements 293167	2013		34,414			(34,414)		10
11	Flooring 324321 - patient rooms 300-311, 400-415, and 100-117	2016	91,980	9,198	10	9,198		12,264	11
12									12
13	Fire Alarm 325402	2016	11,915	1,197	10	1,197		1,341	13
14									14
15	Concrete Sidewalk-improvements 314694-replace SW entrance	2016	10,500	700	15	700		1,400	15
16									16
17	Paving - improvements 315378 - shed entrance sidewalk	2016	10,391	1,299	8	1,299		2,489	17
18									18
19	Capitalize repair fire system	2016	15,910		20	796	796	1,194	19
20									20
21	capitalize repair painting - outside window trim all patient rooms	2016	12,040		5	2,408	2,408	3,612	21
22									22
23	allocated from Advocate Healthcare Home Office					21,916	21,916		23
24	Fire Alarm horn/strobe lights 341205	2017	5,485	457	10	457		457	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)		$ 6,184,147	$ 198,340		$ 183,400	$ (14,940)	$ 4,455,980	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: 01/01/2017 Ending: 12/31/2017

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	$ 114,502	$ 17,436	$ 25,172	$ 7,736	5-20	$ 70,903	71
72	Current Year Purchases	15,865	2,646	2,646		5-7	2,646	72
73	Fully Depreciated Assets	1,545,965	4,067	9,418	5,351		1,522,494	73
74	Allocated from Advocate Health Care			64,329	64,329			74
75	TOTALS	$ 1,676,332	$ 24,149	$ 101,565	$ 77,416		$ 1,596,043	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	Residential Recreational	2001 Glaval Bus	2013	$ 9,677	$	$	$	3	$ 9,677	76
77										77
78										78
79										79
80	TOTALS			$ 9,677	$	$	$		$ 9,677	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)	$ 8,374,334	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,489	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 284,965	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,476	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,061,700	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 48,582 Description: 38,971-beds and mattresses, 9311-copiers, and 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: 01/01/2017 Ending: 12/31/2017

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.

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(3)	7008	hrs	$ 298,755	208	$ 13,728	$	7,216	$ 312,483	1
2	Licensed Speech and Language Development Therapist	39(3)	2930	hrs	133,103				2,930	133,103	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(3)	11672	hrs	568,875				11,672	568,875	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				1,051,508		1,051,508	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): oxygen gases	39(2)						60,434		60,434	12
13	Other (specify): reference lab	39(3)				753	54,219		753	54,219	13
14	TOTAL				$ 1,000,733	961	$ 67,947	$ 1,111,942	22,571	$ 2,180,622	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:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 75,140	$ 75,140	1
2	Cash-Patient Deposits	429	429	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,246,900)	2,275,686	2,275,686	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	107,695	107,695	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,458,950	$ 2,458,950	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	2,684,200	2,675,682	14
15	Leasehold Improvements, at Historical Cost	414,523	3,508,465	15
16	Equipment, at Historical Cost	167,582	1,686,009	16
17	Accumulated Depreciation (book methods)	(942,690)	(6,054,445)	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)**	$ 3,093,615	$ 2,319,890	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,552,565	$ 4,778,840	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 268,922	$ 268,922	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	235	235	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	485,223	485,223	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	Other Current	2,460,338	2,460,338	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,214,718	$ 3,214,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,079,135	4,079,135	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)**	$ 4,079,135	$ 4,079,135	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,293,853	$ 7,293,853	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,741,288)	$ (2,515,013)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,552,565	$ 4,778,840	48

***(See instructions.)**

Facility Name: Sherman West Court
IDPH License ID 0037507
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XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Account	Description	Operating	After Consolidation
030-90000-21720-0	Accrued Audit And Legal Fees	13,500	13,500
030-90000-21751-0	Local and Other Tax Accrual	21,295	21,295
030-90000-21810-0	Deferred Revenue-Advance Fees	-	-
030-90000-23752-0	Interco Due To Co 31	-	-
030-90000-23754-0	Interco Due To Co 30	51,187	51,187
030-90000-23756-0	Interco Due To Co 40	51	51
030-90000-23758-0	Interco Due To Co 25	1,871,544	1,871,544
030-90000-23772-0	Interco Due To Co 60	502,759	502,759
	Total Line 36	2,460,338	2,460,338

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 999,287	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 999,287	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,740,580)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **rounding**	5	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,740,575)	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)**	$ (1,741,288)	24 *

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,531,188	1
2	Discounts and Allowances for all Levels	(6,164,626)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,366,562	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	4,172	13
14	Non-Patient Meals	10,578	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	501,035	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 515,785	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,092	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,092	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activities and Outings	(4,074)	28
28a	See Schedule 19A	43,674	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,600	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,924,039	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,317,800	31
32	Health Care	3,830,442	32
33	General Administration	2,947,251	33
	B. Capital Expense		
34	Ownership	352,289	34
	C. Ancillary Expense		
35	Special Cost Centers	4,106,986	35
36	Provider Participation Fee	109,851	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,664,619	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,740,580)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,740,580)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 342,239	44
45	Private Pay - Net Inpatient Revenue	4,413,759	45
46	Medicare - Net Inpatient Revenue	4,610,565	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,366,563	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.**

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

Account	Description	Amount
030-11300-44611-0	Medical Records	7,619
030-19040-44742-0	Wheelchair Revenue	322
030-19000-49000-0	Other Misc Revenue	1,069
030-19040-49000-0	Other Misc Revenue	34,664
	Total Line 28	43,674

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,796	1,996	$ 114,935	$ 57.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,338	56,728	2,152,840	37.95	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	42,036	44,476	649,432	14.60	5
6	CNA Trainees					6
7	Licensed Therapist	21,997	23,688	1,126,984	47.58	7
8	Rehab/Therapy Aides	4,332	4,666	119,049	25.51	8
9	Activity Director	1,555	1,662	39,786	23.94	9
10	Activity Assistants	4,218	4,717	61,384	13.01	10
11	Social Service Workers					11
12	Dietician	2,491	2,619	40,654	15.52	12
13	Food Service Supervisor	5,516	6,008	175,299	29.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,997	20,357	281,850	13.85	15
16	Dishwashers					16
17	Maintenance Workers	3,943	4,227	99,060	23.44	17
18	Housekeepers	14,704	15,694	244,604	15.59	18
19	Laundry					19
20	Administrator	1,496	1,616	123,596	76.48	20
21	Assistant Administrator	1,611	1,672	112,832	67.48	21
22	Other Administrative					22
23	Office Manager	2,145	2,270	46,364	20.42	23
24	Clerical	14,760	16,108	283,570	17.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	130	130	15,799	121.53	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,951	2,207	36,201	16.40	31
32	Other Health Care(specify)					32
33	Other(specify) See PG 20A	5,676	6,236	150,474	24.13	33
34	TOTAL (lines 1 - 33)	201,692	217,077	$ 5,874,713 *	$ 27.06	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	31	2,116	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	880	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	31	$ 2,996		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,058	$ 168,336	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	11,293	291,291	10(3)	52
53	TOTAL (lines 50 - 52)	14,351	$ 459,627		53

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid & Accrued	Total Salaries	Average Hourly Wage
Sales Representative	3,734	4,145	101,341	24.45
Marketing Specialist	1,871	2,021	47,833	23.67
Pastoral Care Associate	70	70	1,300	18.57
Total - Line 33 Other	5,675	6,236	150,474	24.13

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph McManus	Administrator	0	$ 123,596
Angela Lackowski	Asst. Administrator	0	112,832
		0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 236,428

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 216,528
Board of Directors Meeting Fees	4,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 220,528
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C on tab PG 21A	See Schedule 21C	$ 68,420
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 68,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,000
Unemployment Compensation Insurance	(4,779)
FICA Taxes	427,802
Employee Health Insurance	465,650
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Employer Contributions/Plan Admin Fees	94,987
Prescription Drug Plan	150,054
Dental/Vision	20,510
Life Insurance	6,109
Disability Insurance	47,646
Tuition Reimbursement/Other	43,748
Home Office Allocation	299,129
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,580,856

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 800	20,985
Miscellaneous Licenses & Fees	
Miscellaneous Dues & Subscriptions	30,248
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,213

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,844
- no individual item greater than $2,500	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,844

* Attach copy of IMRF notifications

**See instructions.

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XIX. Support Schedules
Section C: Professional Services

Vendor	Type	Amount	Allowable
Ernst & Young	Consulting	15,150	-
Ziegler	Legal Retainer	45,507	-
Duane Morris	Legal - Facility related	4,051	4,051
Law Office of Douglas Scheflow	Legal - collections & complaint	812	740
Accrual	Consulting	2,900	2,900
	Total	68,420	7,691

Less Non-allowable legal fees	45,579
Less Non-allowable consulting fees	15,150
Total (agrees to Schedule V, line 19, column 8)	7,691

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

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

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(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. $ **30,324** 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. $ **109,851**
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