



Facility Name & ID Number Sherman West Court

# 0037507 Report Period Beginning: 05/01/2000 Ending: 04/30/2001

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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	8	Sheltered Care (SC)	8	2,920	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	4,677	18,654	7,728	31,059	8
9	SNF/PED					9
10	ICF	0	3,378		3,378	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,677	22,032	7,728	34,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.62%

D. How many bed-hold days during this year were paid by Public Aid?

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  NO  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

I. On what date did you start providing long term care at this location?

Date started 02/18/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 02/18/91 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 26 and days of care provided 6,961

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 04/30/2001 Fiscal Year: 04/30/2001

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

STATE OF ILLINOIS

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2000 Ending: 04/30/2001

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	231,574	8,545	2,620	242,739	242,739		242,739		1	
2	Food Purchase		148,174		148,174	148,174	(2,549)	145,625		2	
3	Housekeeping	131,681		15,785	147,466	147,466		147,466		3	
4	Laundry	34,169	14,879		49,048	49,048		49,048		4	
5	Heat and Other Utilities			131,826	131,826	131,826		131,826		5	
6	Maintenance	73,616	4,076	56,346	134,038	134,038		134,038		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	471,040	175,674	206,577	853,291	853,291	(2,549)	850,742		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			43,800	43,800	43,800		43,800		9	
10	Nursing and Medical Records	2,042,313	131,170	1,896	2,175,379	2,175,379		2,175,379		10	
10a	Therapy	279,117	782		279,899	279,899		279,899		10a	
11	Activities	61,691	3,889	4,413	69,993	69,993	(1,096)	68,897		11	
12	Social Services	42,099			42,099	42,099		42,099		12	
13	Nurse Aide Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	2,425,220	135,841	50,109	2,611,170	2,611,170	(1,096)	2,610,074		16	
	<b>C. General Administration</b>										
17	Administrative	72,579		256,468	329,047	329,047	(256,468)	72,579		17	
18	Directors Fees									18	
19	Professional Services			43,213	43,213	43,213		43,213		19	
20	Dues, Fees, Subscriptions & Promotions			27,202	27,202	27,202		27,202		20	
21	Clerical & General Office Expenses	266,241	7,198	48,853	322,292	322,292	261,908	584,200		21	
22	Employee Benefits & Payroll Taxes			615,207	615,207	615,207		615,207		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			11,334	11,334	11,334		11,334		24	
25	Other Admin. Staff Transportation			159	159	159		159		25	
26	Insurance-Prop.Liab.Malpractice			39,452	39,452	39,452		39,452		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	338,820	7,198	1,041,888	1,387,906	1,387,906	5,440	1,393,346		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,235,080	318,713	1,298,574	4,852,367	4,852,367	1,795	4,854,162		29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			236,927	236,927		236,927	23,730	260,657			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			242,283	242,283		242,283	(72,236)	170,047			32
33	Real Estate Taxes			(206,756)	(206,756)		(206,756)		(206,756)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,316	7,316		7,316		7,316			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			279,770	279,770		279,770	(48,506)	231,264			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			740	740		740		740			38
39	Ancillary Service Centers		455,710		455,710		455,710		455,710			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,152	61,152		61,152		61,152			42
43	Other (specify):* <b>Nonallowable costs</b>			209,345	209,345		209,345	(209,345)				43
44	<b>TOTAL Special Cost Centers</b>		455,710	271,237	726,947		726,947	(209,345)	517,602			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,235,080	774,423	1,849,581	5,859,084		5,859,084	(256,056)	5,603,028			45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/2000

Ending:

04/30/2001

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,273)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,864)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	676	30		9
10	Interest and Other Investment Income	(72,236)	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	(1,361)	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	(184,811)	43		24
25	Fund Raising, Advertising and Promotional	(11,567)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,301)	21		28
29	Other-Attach Schedule <u>See Schedule 5A</u>	(16,443)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (294,180)		\$	30

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	2	
		Amount	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)	38,124		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 38,124		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (256,056)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court

ID# 0037507

Report Period Beginning 05/01/2000

Ending: 04/30/2001

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Printing & Forms	\$ (1,746)	43	1
2	Lab Expense	(9,860)	43	2
3	Income Offset	(2,465)	21	3
4	Activity Income Offset	(1,096)	11	4
5	Vending Income Offset	(1,276)	2	5
6				6
7	Total	(16,443)		7

See Accountants' Compilation Report

Sherman West Court

ID# 0037507

Report Period Beginning: 05/01/2000

Ending: 04/30/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/2000

Ending:

04/30/2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,273)	0	0	0	0	0	0	0	0	0	0	(1,273)	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	<b>TOTAL General Services</b>	<b>(1,273)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,273)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(256,468)	0	0	0	0	0	0	0	0	0	(256,468)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,165)	271,538	0	0	0	0	0	0	0	0	0	264,373	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(7,165)</b>	<b>15,070</b>	<b>0</b>	<b>7,905</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(8,438)</b>	<b>15,070</b>	<b>0</b>	<b>6,632</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Sherman West Court# 0037507

Report Period Beginning:

05/01/2000 Ending:

Summary B

04/30/2001

## 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	676	23,054	0	0	0	0	0	0	0	0	0	23,730	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72,236)	0	0	0	0	0	0	0	0	0	0	(72,236)	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	<b>TOTAL Ownership</b>	<b>(71,560)</b>	<b>23,054</b>	<b>0</b>	<b>(48,506)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(197,739)	0	0	0	0	0	0	0	0	0	0	(197,739)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(197,739)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(197,739)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(277,737)</b>	<b>38,124</b>	<b>0</b>	<b>(239,613)</b>	<b>45</b>								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sherman Health Systems	100%			Sherman Hospital	Elgin, IL	Hospital
				Sherman Home		Home Health
				Care Partners	Elgin, IL	Agency
				Sherman Health Systems	Elgin, IL	Management Co.
See Schedule 6A for Board of Directors						

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 256,468	Sherman Health Systems	100.00%	\$	\$ (256,468)	1
2	V	21 Administrative Expenses		Sherman Health Systems	100.00%	271,538	271,538	2
3	V	30 Depreciation Expense		Sherman Health Systems	100.00%	23,054	23,054	3
4	V	6 Maintenance Cost	1,417	Sherman Hospital		1,417		4
5	V	10 Nursing Cost	25,153	Sherman Hospital		25,153		5
6	V	21 Office Supplies	10,427	Sherman Hospital		10,427		6
7	V	22 Fringe Benefits	30,878	Sherman Hospital		30,878		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 324,343			\$ 362,467	\$ * 38,124	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court  
 Facility #0037507  
 04/30/2001

Medicaid Cost Report  
 Schedule 6A

Page 6: VII - Schedule A - Non-Profit required attachment: List of Board of Directors				
Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Reverend Dr. Robert D. Lir	No	N/A	N/A	N/A
Richard S. Schefflow	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Terry Dunning	No	N/A	N/A	N/A
Mary Flodin	No	N/A	N/A	N/A
John A. Graham	No	N/A	N/A	N/A
Kyung W. Koo, M.D.	Yes	Medicare Medical Director	N/A	N/A
Elaine Hastings	No	N/A	N/A	N/A
D. Ray Wilson	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2000 Ending: 04/30/2001

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

# 0037507 Report Period Beginning: 05/01/2000 Ending: 4/30/2001

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  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Administrative Expenses	Accumulated Costs	164,771,418	3	\$ 8,258,161	\$ 5,417,880	\$ 271,538	1
2	30	Depreciation Expense	Accumulated Costs	164,771,418	3	701,125	5,417,880	23,054	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 8,959,286	\$	\$ 294,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sherman West Court

# 0037507

Report Period Beginning:

05/01/2000

Ending:

04/30/2001

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		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
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Illinois Health Facilities		x	Refinance construction bond	\$24,326.00	10/15/97	\$ 4,736,121	\$ 4,443,071	8/2027	Various	\$ 241,071	1								
2	Authority											2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	First Chicago NBD		x	Working Capital	15000+interest	12/95	1,550,000		4/2004	0.0763	1,212	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$24,326.00		\$ 6,286,121	\$ 4,443,071			\$ 242,283	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income Offset										(72,236)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (72,236)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,286,121	\$ 4,443,071			\$ 170,047	15								

\* 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: 05/01/2000 Ending: 04/30/2001

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		<b>Important</b> , 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 2001 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$ 20,000	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. <b>TOTAL REFUND \$ 226,756 For 19 96,97 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b> & 98			\$ (226,756)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ (206,756)	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
1996		8		
1997		9		
1998		10		
1999		11		
2000		12		
<b>No real estate taxes to be paid in 2000 or 2001 due to real estate tax exempt status being granted.</b>				
			<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2000	\$		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:

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Sherman West Court

# 0037507 Report Period Beginning:

05/01/2000 Ending:

04/30/2001

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 40,260 B. General Construction Type: Exterior Brick Frame Wood/Masonry Number of Stories 1

C. Does the Operating Entity?  (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?  (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>	<u>115,500</u>	<u>1991</u>	<u>\$ 504,179</u>	1
2					2
3	<b>TOTALS</b>	<b>115,500</b>		<b>\$ 504,179</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/2000

Ending:

04/30/2001

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	1991	1991	\$ 2,486,860	\$ 62,171	40	\$ 62,171	\$	\$ 634,668	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Building Improvements		1991	99,031		5			99,031	9
10	Building Improvements		1991	219,089	16,432	10	16,432		218,176	10
11	Building Improvements		1991	205,843	13,723	15	13,723		140,088	11
12	Building Improvements		1991	826,676	41,334	20	41,334		421,950	12
13	Building Improvements		1991	91,155	3,646	25	3,646		37,221	13
14	Building Improvements		1991	21,960	2,196	10	2,196		20,862	14
15	Building Improvements		1991	3,398	227	15	227		2,152	15
16	Building Improvements		1992	22,980	2,298	10	2,298		19,533	16
17	Building Improvements		1992	2,000	183	15	133	(50)	1,133	17
18	Building Improvements		1993	962		5			962	18
19	Building Improvements		1993	13,219	1,322	10	1,322		9,914	19
20	Building Improvements		1993	3,750	250	15	250		1,875	20
21	Building Improvements		1993	14,525		20	726	726	5,446	21
22	Building Improvements		1994	6,951	348	20	348		2,259	22
23	Carpet Tiles		1995	1,500	150	10	150		825	23
24	Sliding Doors		1996	3,345	334	10	334		1,840	24
25	Resurface Parking Lot		1996	4,800	960	5	960		4,320	25
26	Carpeting		1997	3,930	786	5	786		3,537	26
27	Carpet/file Base		1997	12,580	2,468	5	2,468		11,106	27
28	Kickplates		1997	4,165	833	5	833		2,915	28
29	Carpet Living Room		1998	4,340	433	10	433		1,084	29
30	Cement Board & Ceramic Tile		1999	4,475	448	10	448		1,120	30
31	Wallpaper		1999	1,819	363	5	363		909	31
32	Landscaping		1999	893	179	5	179		447	32
33	Construction contract for new entrance & nursing station		1999	938,914	23,473	40	23,473		44,505	33
34	Kitchen Wall Boards		2000	1,365	273	5	273		409	34
35	Parking Lot Improvements		2000	52,250	1,742	30	1,742		1,742	35
36	Purchasing Department Ceiling Light Fixtures		2000	1,967	197	10	197		197	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/2000 Ending: 04/30/2001

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,054,742	\$ 176,769		\$ 177,445	\$ 676	\$ 1,690,226	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2000 Ending: 04/30/2001

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 548,904	\$ 59,594	\$ 59,594	\$	5-20	\$ 310,690	71
72	Current Year Purchases	120,037	564	564		5-15	564	72
73	Fully Depreciated Assets	417,502				5	417,502	73
74	Allocated from Sherman Health Systems			23,054	23,054			74
75	TOTALS	\$ 1,086,443	\$ 60,158	\$ 83,212	\$ 23,054		\$ 728,756	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,645,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,657	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,730	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,418,982	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: 05/01/2000

Ending: 04/30/2001

**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 Date of Lease	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	<b>TOTAL</b>				\$			7

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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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: N/A \*

**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: \$ 7,316 Description: Copy Machines \$7,316

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19		<u>N/A</u>			19
20					20
21	<b>TOTAL</b>		\$	\$	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.

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

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L 10A, C 1&2	656 hrs	\$ 17,463		\$	\$ 62	656	\$ 17,525	1
2	Licensed Speech and Language Development Therapist	L10A, C 1&2	1487 hrs	44,521			20	1,487	44,541	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C 1&2	4116 hrs	121,571			700	4,116	122,271	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C 2	# of prescripts				425,396		425,396	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Specialized Beds Other (specify): <u>Oxygen</u>	L39, C 2 L39, C 2					7,647 22,667		7,647 22,667	13
14	TOTAL			\$ 183,555		\$	\$ 456,492	6,259	\$ 640,047	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court# 0037507Report Period Beginning: 05/01/2000

Ending:

04/30/2001

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 04/30/2001 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 840,226	\$ 840,226	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>92,046</u> )	1,301,868	1,301,868	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,611	25,611	6
7	Other Prepaid Expenses	10,555	10,555	7
8	Accounts Receivable (owners or related parties)	92,437	92,437	8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,270,697	\$ 2,270,697	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	5,042,943	5,054,742	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,086,443	1,086,443	16
17	Accumulated Depreciation (book methods)	(2,413,964)	(2,418,982)	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): <u>Bond Issue Cost</u>	87,415	87,415	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,307,016	\$ 4,313,797	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,577,713	\$ 6,584,494	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 177,283	\$ 177,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	73,244	73,244	29
30	Accrued Salaries Payable	200,989	200,989	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	58,433	58,433	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Parties</u>	3,325,334	3,325,334	36
37	<u>Deferred Income, Accrued Expenses</u>	216,828	216,828	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,052,111	\$ 4,052,111	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,369,827	4,369,827	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,369,827	\$ 4,369,827	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,421,938	\$ 8,421,938	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,844,225)	\$ (1,837,444)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,577,713	\$ 6,584,494	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,901,309)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,901,309)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	2,072	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)	\$ 2,072	17
<b>B. Transfers (Itemize):</b>			
18	Endowment Fund	55,012	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 55,012	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,844,225)	24 *

Operating entity only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning: 05/01/2000

Ending: 04/30/2001

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,462,233	1
2	Discounts and Allowances for all Levels	(1,301,857)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,160,376	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	732,846	6
7	Oxygen	49,759	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 782,605	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,276	13
14	Non-Patient Meals	1,273	14
15	Telephone, Television and Radio	2,864	15
16	Rental of Facility Space		16
17	Sale of Drugs	608,523	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,287	19
20	Radiology and X-Ray		20
21	Other Medical Services	206,061	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 831,284	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	72,236	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 72,236	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous, Vending, & Activities Income	4,837	28
28a	Endowment Income	9,818	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,655	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,861,156	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	853,291	31
32	Health Care	2,611,170	32
33	General Administration	1,387,906	33
<b>B. Capital Expense</b>			
34	Ownership	279,770	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	665,795	35
36	Provider Participation Fee	61,152	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,859,084	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,072	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,072	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning: 05/01/2000

Ending:

04/30/2001

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	4,880	5,359	\$ 139,184	\$ 25.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,534	40,176	967,838	24.09	3
4	Licensed Practical Nurses	6,179	6,969	97,617	14.01	4
5	Nurse Aides & Orderlies	54,323	57,887	693,130	11.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,051	6,259	183,555	29.33	7
8	Rehab/Therapy Aides	5,763	5,888	95,562	16.23	8
9	Activity Director	1,766	1,798	25,927	14.42	9
10	Activity Assistants	3,664	3,943	35,764	9.07	10
11	Social Service Workers	1,934	2,086	42,099	20.18	11
12	Dietician	104	104	2,149	20.66	12
13	Food Service Supervisor	1,849	2,086	40,998	19.65	13
14	Head Cook	7,637	8,250	95,838	11.62	14
15	Cook Helpers/Assistants					15
16	Dishwashers	11,236	11,653	92,589	7.95	16
17	Maintenance Workers	4,267	4,568	73,616	16.12	17
18	Housekeepers	15,291	16,306	131,681	8.08	18
19	Laundry	3,910	4,375	34,169	7.81	19
20	Administrator	1,926	2,086	72,579	34.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,858	2,086	52,989	25.40	23
24	Clerical	14,097	15,122	213,252	14.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,934	2,130	29,580	13.89	31
32	Other Health Ca <u>See Sch. 20A</u>	6,970	7,451	114,964	15.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,173	206,582	\$ 3,235,080 *	\$ 15.66	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	43,800	L. 9, C. 3	36
37	Medical Records Consultant	Quarterly	996	L. 10, C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	728	L. 11, C. 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 46,424		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court  
Schedule XVIII Attachment  
April 30, 2001

# 0037507

Schedule 20A

Line 32, Other

Description	Hours Worked	Hours Paid	Salaries / Wages	Average
MDS Coordinator	3,558	3,808	80,130	21.04
Nursing Secretary	3,412	3,643	34,834	9.56
Total	6,970	7,451	114,964	15.43

SEE ACCOUNTANTS' COMPILATION REPORT



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$ 5,368
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 12.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,788 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 61,152  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,273
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: Hutton Nelson & McDonald LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	231,574	8,545	2,620	242,739	0	242,739	0	242,739
2. Food Purchase	0	148,174	0	148,174	0	148,174	-2,549	145,625
3. Housekeeping	131,681	0	15,785	147,466	0	147,466	0	147,466
4. Laundry	34,169	14,879	0	49,048	0	49,048	0	49,048
5. Heat and Other Utilities	0	0	131,826	131,826	0	131,826	0	131,826
6. Maintenance	73,616	4,076	56,346	134,038	0	134,038	0	134,038
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	471,040	175,674	206,577	853,291	0	853,291	-2,549	850,742
9. Medical Director	0	0	43,800	43,800	0	43,800	0	43,800
10. Nursing & Medical Records	2,042,313	131,170	1,896	2,175,379	0	2,175,379	0	2,175,379
10a. Therapy	279,117	782	0	279,899	0	279,899	0	279,899
11. Activities	61,691	3,889	4,413	69,993	0	69,993	-1,096	68,897
12. Social Services	42,099	0	0	42,099	0	42,099	0	42,099
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,425,220	135,841	50,109	2,611,170	0	2,611,170	-1,096	2,610,074
17. Administrative	72,579	0	256,468	329,047	0	329,047	-256,468	72,579
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	43,213	43,213	0	43,213	0	43,213
20. Fees, Subscriptions & Promotion	0	0	27,202	27,202	0	27,202	0	27,202
21. Clerical & General Office	266,241	7,198	48,853	322,292	0	322,292	261,908	584,200
22. Employee Benefits & Payroll	0	0	615,207	615,207	0	615,207	0	615,207
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	11,334	11,334	0	11,334	0	11,334
25. Other Admin. Staff Trans	0	0	159	159	0	159	0	159
26. Insurance-Prop.Liab.Malpractice	0	0	39,452	39,452	0	39,452	0	39,452
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	338,820	7,198	1,041,888	1,387,906	0	1,387,906	5,440	1,393,346
29. Total General Administrative	3,235,080	318,713	1,298,574	4,852,367	0	4,852,367	1,795	4,854,162
30. Depreciation	0	0	236,927	236,927	0	236,927	23,730	260,657
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	242,283	242,283	0	242,283	-72,236	170,047
33. Real Estate	0	0	-206,756	-206,756	0	-206,756	0	-206,756
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	7,316	7,316	0	7,316	0	7,316
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	279,770	279,770	0	279,770	-48,506	231,264
38. Medically Necessary T	0	0	740	740	0	740	0	740
39. Ancillary Service Cent	0	455,710	0	455,710	0	455,710	0	455,710
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	61,152	61,152	0	61,152	0	61,152
43. Other (specify):*	0	0	209,345	209,345	0	209,345	-209,345	0
44. Total Special Cost Ce	0	455,710	271,237	726,947	0	726,947	-209,345	517,602
45. Grand Total	3,235,080	774,423	1,849,581	5,859,084	0	5,859,084	-256,056	5,603,028

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	840,226	840,226
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,301,868	1,301,868
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	25,611	25,611
7. Other Prepaid Expenses	10,555	10,555
8. Accounts Receivable-Owner/Related Party	92,437	92,437
9. Other (specify):	0	0
10. Total current assets	2,270,697	2,270,697
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	504,179	504,179
14. Buildings, at Historical Cost	5,042,943	5,054,742
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,086,443	1,086,443
17. Accumulated Depreciation (book methods)	-2,413,964	-2,418,982
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	87,415	87,415
24. Total Long-Term Assets	4,307,016	4,313,797
25. Total Assets	6,577,713	6,584,494
CURRENT LIABILITIES		
26. Accounts Payable	177,283	177,283
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	73,244	73,244
30. Accrued Salaries Payable	200,989	200,989
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	58,433	58,433
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	3,325,334	3,325,334
37. Other Current Liabilities (specify):	216,828	216,828
38. Total Current Liabilities	4,052,111	4,052,111
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	4,369,827	4,369,827
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	4,369,827	4,369,827
46. Total Liabilities	8,421,938	8,421,938
47. Total Equity	-1,844,225	-1,837,444
48. Total Liabilities and Equity	6,577,713	6,584,494

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,462,233
2. Discounts and Allowances for all Levels	-1,301,857
Subtotal - Inpatient Care	4,160,376
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	732,846
7. Oxygen	49,759
Subtotal - Ancillary Revenue	782,605
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	2,276
14. Non-Patient Meals	1,273
15. Telephone, Television, and Radio	2,864
16. Rental of Facility Space	0
17. Sale of Drugs	608,523
18. Sale of Supplies to Non-Patients	0
19. Laboratory	10,287
20. Radiology and X-Ray	0
21. Other Medical Services	206,061
22. Laundry	0
Subtotal - Other Operating Revenue	831,284
24. Contributions	0
25. Interest and Other Investments Income	72,236
Subtotal - Non-Operating Revenue	72,236
27. Other Revenue (specify):	4,837
28. Other Revenue (specify):	9,818
Subtotal - Other Revenue	14,655
30. Total Revenue	5,861,156
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	3,111,540
42. Income Taxes	0
43. Net Income or Loss for the Year	3,111,540
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	3,111,540
42. Income Taxes	0
43. Net Income or Loss for the Year	3,111,540

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under \*\*, you must write in any comments

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RECONCILIATION REPORT

Sherman West Court

04:09 PM 11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-256,056	equal to	-256,056	0	O.K.	Pg5 222	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	170,047	equal to	170,047	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	-206,756	equal to	-206,756	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	260,657	equal to	260,657	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,316	equal to	7,316	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	183,555	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	184,337	equal to	279,899	-95,562	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	456,492	equal to	456,492	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	853,291	equal to	853,291	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,611,170	equal to	2,611,170	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	1,387,906	equal to	1,387,906	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	279,770	equal to	279,770	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	665,795	equal to	665,795	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	61,152	equal to	61,152	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff - Nursing	1,927,349	equal to	2,042,313	-114,964	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	183,555	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	61,691	equal to	61,691	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	42,099	equal to	42,099	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	231,574	equal to	231,574	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	73,616	equal to	73,616	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	131,681	equal to	131,681	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,169	equal to	34,169	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	72,579	equal to	72,579	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	266,241	equal to	266,241	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,235,080	equal to	3,235,080	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	2,620	-2,620	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	43,800	< or = to	43,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,896	< or = to	1,896	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	728	< or = to	4,413	-3,685	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched. - Admin. Salar.	72,579	equal to	72,579	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched. - Admin. Other	256,468	equal to	256,468	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched. - Prof. Serv.	43,213	equal to	43,213	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched. - Benefit/Taxes	615,207	equal to	615,207	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched. - Sched of dues..	27,202	equal to	27,202	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched. - Sched. of trav	11,334	equal to	11,334	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	61,152	equal to	61,152	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,961	equal to	7,728	-767	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	38,124	equal to	38,124	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4C	B.	14	8
Total loan balance	4,443,071	equal to	4,443,071	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	504,179	equal to	504,179	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,054,742	equal to	5,054,742	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,086,443	equal to	1,086,443	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,418,982	equal to	2,418,982	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,844,225	equal to	-1,844,225	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,072	equal to	2,072	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	6,577,713	equal to	6,577,713	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1