

Facility Name & ID Number Sherman West Court

0037507 Report Period Beginning: 05/01/05 Ending: 04/30/06

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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	2,252	15,015	12,164	29,431	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,146		3,146	12
13	DD 16 OR LESS					13
14	TOTALS	2,252	18,161	12,164	32,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.38%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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 34 and days of care provided 11,508

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 4/30/06 Fiscal Year: 4/30/06

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/05 Ending: 04/30/06

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
	A. General Services										
1	Dietary	279,337	10,701	3,141	293,179		293,179		293,179		1
2	Food Purchase		152,450		152,450		152,450	(3,131)	149,319		2
3	Housekeeping	83,492		15,846	99,338		99,338		99,338		3
4	Laundry	28,757	7,460		36,217		36,217		36,217		4
5	Heat and Other Utilities			143,600	143,600		143,600		143,600		5
6	Maintenance	77,393	2,187	52,391	131,971		131,971		131,971		6
7	Other (specify):*										7
8	TOTAL General Services	468,979	172,798	214,978	856,755		856,755	(3,131)	853,624		8
	B. Health Care and Programs										
9	Medical Director			42,300	42,300		42,300		42,300		9
10	Nursing and Medical Records	2,147,832	103,580	6,748	2,258,160		2,258,160	(452)	2,257,708		10
10a	Therapy	161,925	217	256,036	418,178		418,178		418,178		10a
11	Activities	68,142	3,297	2,619	74,058		74,058		74,058		11
12	Social Services	54,648			54,648		54,648		54,648		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,432,547	107,094	307,703	2,847,344		2,847,344	(452)	2,846,892		16
	C. General Administration										
17	Administrative	82,344		216,533	298,877		298,877	(216,533)	82,344		17
18	Directors Fees			3,250	3,250		3,250		3,250		18
19	Professional Services			48,051	48,051		48,051	(4,539)	43,512		19
20	Dues, Fees, Subscriptions & Promotions			34,572	34,572		34,572		34,572		20
21	Clerical & General Office Expenses	358,438	8,005	40,064	406,507		406,507	171,111	577,618		21
22	Employee Benefits & Payroll Taxes			688,818	688,818		688,818		688,818		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,636	10,636		10,636		10,636		24
25	Other Admin. Staff Transportation			1,434	1,434		1,434		1,434		25
26	Insurance-Prop.Liab.Malpractice			382,788	382,788		382,788		382,788		26
27	Other (specify):*										27
28	TOTAL General Administration	440,782	8,005	1,426,146	1,874,933		1,874,933	(49,961)	1,824,972		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,342,308	287,897	1,948,827	5,579,032		5,579,032	(53,544)	5,525,488		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.

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			230,139	230,139		230,139	13,978	244,117		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			312,267	312,267		312,267	(31,940)	280,327		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			11,359	11,359		11,359		11,359		35
36	Other (specify):*										36
37	TOTAL Ownership			553,765	553,765		553,765	(17,962)	535,803		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			1,022	1,022		1,022		1,022		38
39	Ancillary Service Centers		675,491		675,491		675,491		675,491		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			61,320	61,320		61,320		61,320		42
43	Other (specify):* Nonallowable Cost			507,258	507,258		507,258	(507,258)			43
44	TOTAL Special Cost Centers		675,491	569,600	1,245,091		1,245,091	(507,258)	737,833		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,342,308	963,388	3,072,192	7,377,888		7,377,888	(578,764)	6,799,124		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.

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	(3,131)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(802)	30		9
10	Interest and Other Investment Income	(31,940)	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	(1,506)	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	(460,030)	43		24
25	Fund Raising, Advertising and Promotional	(12,522)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(298)	21		28
29	Other-Attach Schedule See PG5A	(40,016)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (550,245)		\$	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	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)	(28,519)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,519)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (578,764)		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	TOTAL (C): (sum of lines 38-46)			\$	47

Sherman West Court

ID# 0037507

Report Period Beginning: 05/01/05

Ending: 04/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow non-allowable legal fees	\$ (4,539)	19	1
2	Disallow Resident clothing expense	(1,246)	43	2
3	Disallow reference lab expense	(30,399)	43	3
4	Disallow non-allowable purchased service fees	(1,555)	43	4
5	Offset supplies revenue against related expense	(1,825)	21	5
6	Offset code alert income against related expense	(452)	10	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	Total	(40,016)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court# 0037507

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,131)	0	0	0	0	0	0	0	0	0	0	(3,131)	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	(3,131)	0	0	0	0	0	0	0	0	0	0	(3,131)	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	(452)	0	0	0	0	0	0	0	0	0	0	(452)	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	(452)	0	0	0	0	0	0	0	0	0	0	(452)	16
	C. General Administration													
17	Administrative	0	(216,533)	0	0	0	0	0	0	0	0	0	(216,533)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,539)	0	0	0	0	0	0	0	0	0	0	(4,539)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,123)	173,234	0	0	0	0	0	0	0	0	0	171,111	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	TOTAL General Administration	(6,662)	(43,299)	0	(49,961)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,245)	(43,299)	0	(53,544)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/05 Ending: 04/30/06

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	(802)	14,780	0	0	0	0	0	0	0	0	0	13,978	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,940)	0	0	0	0	0	0	0	0	0	0	(31,940)	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	(32,742)	14,780	0	(17,962)	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):*	(507,258)	0	0	0	0	0	0	0	0	0	0	(507,258)	43
44	TOTAL Special Cost Centers	(507,258)	0	0	0	0	0	0	0	0	0	0	(507,258)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(550,245)	(28,519)	0	(578,764)	45								

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	N/A		Sherman Hospital	Elgin	Hospital
				Sherman Home		Home Health
				Care Partners	Elgin	Agency
				Sherman Health Systems	Elgin	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	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	\$ 216,533	Sherman Health Systems	100.00%	\$	(216,533)	1
2	V	21 Administrative Expenses		Sherman Health Systems	100.00%	173,234	173,234	2
3	V	30 Depreciation Expense		Sherman Health Systems	100.00%	14,780	14,780	3
4	V	10 Nursing Cost	17,343	Sherman Hospital		17,343		4
5	V	22 Fringe Benefits	(42,321)	Sherman Hospital		(42,321)		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		\$ 191,555			\$ 163,036	\$ * (28,519)	14

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

Schedule 6A

List of Board of Directors

Page 6: VII - Schedule A - Non-Profit required attachment:				
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. Linstrom	No	N/A	N/A	N/A
Richard S.Scheflow	No	N/A	Scheflow & Rydell	Legal
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Toni Geister	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Kyung W. Koo, M.D.	Yes	Medicare Medical Director	N/A	N/A
Sue Spears	No	N/A	N/A	N/A
Michael Kenyon	No	N/A	N/A	N/A

Facility Name & ID Number

Sherman West Court

0037507

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	Toni Geister	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fe	\$ 750	L 18, C 3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	250	L 18, C 3	2
3	Richard S. Scheflow	Secretary	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L 18, C 3	3
4	Michael Kenyon	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L 18, C 3	4
5	Reverend Dr. Robert Linstrom	Chairman	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	750	L 18, C 3	5
6	Kyung W. Koo, M.D.	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L 18, C 3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,250		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:

05/01/05

Ending: 04/30/06

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

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

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

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 Expense	Accumulated Costs	213,673,149	3	\$ 5,378,371	\$ 6,882,280	\$ 173,234	1
2	30	Depreciation Expense	Accumulated Costs	213,673,149	3	458,862	6,882,280	14,780	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					\$ 5,837,233	\$	\$ 188,014	25

Facility Name & ID Number

Sherman West Court

0037507

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	Illinois Health Facilities		X	Refinance construction bond	\$24,326.00	10/15/97	\$ 4,736,121	\$ 5,422,083	8/2027	Various	\$ 312,267	1								
2	Authority											2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$24,326.00		\$ 4,736,121	\$ 5,422,083			\$ 312,267	9								
B. Non-Facility Related*																				
10										Less: Interest income offset	(31,940)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (31,940)	14								
15	TOTALS (line 9+line14)						\$ 4,736,121	\$ 5,422,083			\$ 280,327	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	<u>1</u>
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.)		\$	<u>N/A</u>
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>3</u>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>4</u>
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.)		\$	<u>5</u>
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.)		\$	<u>6</u>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>7</u>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	<u>8</u>	
	2002	<u>9</u>	
	2003	<u>10</u>	
	2004	<u>11</u>	
	2005	<u>N/A</u>	<u>12</u>
No real estate tax paid as facility has been granted real estate tax exempt status.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	<u>13</u>
	14	PLUS APPEAL COST FROM LINE 5 \$	<u>14</u>
	15	LESS REFUND FROM LINE 6 \$	<u>15</u>
	16	AMOUNT TO USE FOR RATE CALCULATION \$	<u>16</u>

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Carolyn Ceval

TELEPHONE (847) 742-7070 FAX #: (847) 742-7248

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. <u>N/A</u>	<u></u>	<u>\$</u>	<u>\$</u>
2. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
3. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
4. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
5. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10. <u></u>	<u></u>	<u>\$</u>	<u>\$</u>
TOTALS		<u>\$</u>	<u>\$</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

05/01/05

Ending:

04/30/06

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? (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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

(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	<u>Resident Care</u>	<u>115,500</u>	<u>1991</u>	<u>\$ 504,179</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	115,500		\$ 504,179	3

Facility Name & ID Number Sherman West Court

0037507

Report Period Beginning:

05/01/05

Ending:

04/30/06

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		
Beds*	FOR BHF 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		\$ 945,523	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements		1991	99,031		5			99,031	9
10	Building Improvements		1991	219,089		10			219,089	10
11	Building Improvements		1991	205,843	10,863	15	10,863		205,843	11
12	Building Improvements		1991	826,676	41,334	20	41,334		628,620	12
13	Building Improvements		1991	91,155	3,646	25	3,646		55,451	13
14	Building Improvements		1991	21,960		10			21,960	14
15	Building Improvements		1991	3,398	227	15	227		3,287	15
16	Building Improvements		1992	22,980		10			22,980	16
17	Building Improvements		1992	2,000	133	15	133		1,798	17
18	Building Improvements		1993	962		5			962	18
19	Building Improvements		1993	13,219		10			13,219	19
20	Building Improvements		1993	3,750	250	15	250		3,125	20
21	Building Improvements		1993	14,525		20	726	726	9,076	21
22	Building Improvements		1994	6,951	348	20	348		3,999	22
23	Carpet Tiles		1995	1,500	150	10	150		1,575	23
24	Sliding Doors		1996	3,345	334	10	334		3,510	24
25	Resurface Parking Lot		1996	4,800		5			4,800	25
26	Carpeting		1997	3,930		5			3,930	26
27	Carpet/tile Base		1997	12,580		5			12,580	27
28	Kickplates		1997	4,165		5			4,165	28
29	Carpet Living Room		1998	4,340	433	10	433		3,249	29
30	Cement Board & Ceramic Tile		1999	4,475	448	10	448		3,360	30
31	Wallpaper		1999	1,819		5			1,819	31
32	Landscaping		1999	893		5			893	32
33	Construction contract for new entrance & nursing station		1999	938,914	23,473	40	23,473		161,870	33
34	Kitchen Wall Boards		2000	1,365		5			1,365	34
35	Parking Lot Improvements		2000	52,250	1,742	30	1,742		10,452	35
36	Purchasing Department Ceiling Light Fixtures		2000	1,967	197	10	197		1,182	36

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

See Page 12A, Line 70 for total

**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:

05/01/05

Ending:

04/30/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting</u>	2002	\$ 19,785	\$ 3,957	5	\$ 3,957	\$	\$ 15,994	37
38	<u>Wallpaper</u>	2002	19,893	3,979	5	3,979		16,082	38
39	<u>Roofing</u>	2001	1,400	140	10	140		630	39
40	<u>Door</u>	2001	1,125	75	15	75		338	40
41	<u>Carpeting</u>	2003	5,732	1,146	5	1,146		4,011	41
42	<u>Carpeting</u>	2003	1,855	371	5	371		1,299	42
43	<u>Wiring for therapy rooms</u>	2003	4,431	443	10	443		1,551	43
44	<u>HVAC upgrade and testing</u>	2003	52,902	3,527	15	3,527		12,345	44
45	<u>Fire sprinklers</u>	2003	12,149	607	20	607		2,125	45
46	<u>HVAC upgrade and testing</u>	2003	51,875	5,188	10	5,188		20,752	46
47	<u>Light fixtures and wiring for cafeteria</u>	2004	3,967	397	10	397		992	47
48	<u>Wallpaper</u>	2004	6,868	1,374	5	1,374		3,435	48
49	<u>Vent pipe</u>	2004	1,068	214	5	214		535	49
50	<u>Vinyl base</u>	2004	900	180	5	180		450	50
51	<u>HVAC upgrade and testing</u>	2004	8,909	594	15	594		1,485	51
52	<u>Door holder</u>	2004	1,056	70	15	70		175	52
53	<u>Circuit breaker</u>	2004	2,250	150	15	150		375	53
54	<u>Door plate</u>	2004	2,053	137	15	137		342	54
55	<u>Sewer line and trap</u>	2004	2,950	197	15	197		492	55
56	<u>Drapes</u>	2005	5,817	1,164	5	1,164		1,746	56
57	<u>Carpeting</u>	2005	11,175	2,234	5	2,234		3,351	57
58	<u>Carpeting</u>	2005	9,400	940	10	940		1,410	58
59	<u>Light fixtures and wiring</u>	2005	8,667	866	10	866		1,299	59
60	<u>Sign for dining room</u>	2005	2,039	204	10	204		306	60
61	<u>Fire system</u>	2005	12,230	816	15	816		816	61
62	<u>Sewer line</u>	2005	2,950	118	25	118		177	62
63									63
64	<u>Fire Doors - 4</u>	2006	5,670	189	15	189		189	64
65	<u>Dining room doors/closures</u>	2006	1,785	60	15	60		60	65
66	<u>Cement sidewalk ramp</u>	2006	1,950	65	15	65		65	66
67	<u>Exit lights - 4</u>	2006	3,600	120	15	120		120	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,321,193	\$ 175,271		\$ 175,997	\$ 726	\$ 2,541,660	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:

05/01/05

Ending:

04/30/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,321,193	\$ 175,271		\$ 175,997	\$ 726	\$ 2,541,660	1
2	Upgrade firedoors per IDPH specification	2006	6,000	200	15	200		200	2
3	Sprinkler installation in attic	2006	4,414	1,835	15	147	(1,688)	147	3
4	Generator - 150 amp circuit breaker	2006	1,103	28	20	28		28	4
5	Installation of handrails	2006	6,400		20	160	160	160	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	TOTAL (lines 1 thru 33)		\$ 5,339,109	\$ 177,334		\$ 176,532	\$ (802)	\$ 2,542,195	34

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

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	\$ 623,849	\$ 49,396	\$ 49,396	\$	5-20	\$ 422,892	71
72	Current Year Purchases	24,195	3,409	3,409		5-15	3,409	72
73	Fully Depreciated Assets	596,135					596,135	73
74	Allocated from Sherman Health Systems			14,780	14,780			74
75	TOTALS	\$ 1,244,179	\$ 52,805	\$ 67,585	\$ 14,780		\$ 1,022,436	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,087,467	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 230,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 244,117	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,978	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,564,631	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

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: _____ *

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: \$ 11,359 Description: Copy machines - 10544; TDD phone - 315; Water softner - 360; Therapy equipment - 140

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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 CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1),(3)	29	hrs	\$ 1,258	1,910	\$ 96,370	\$	1,939	\$ 97,628	1
2	Licensed Speech and Language Development Therapist	10A(1)	299	hrs	10,914	46	5,770		345	16,684	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1),(2),(3)	4277	hrs	149,753	2,637	153,896	217	6,914	303,866	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 prescripts				628,316		628,316	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): <u>See attached Schedule 16A</u>							47,175		47,175	13
14	TOTAL				\$ 161,925	4,593	\$ 256,036	\$ 675,708	9,198	\$ 1,093,669	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Sherman West Court
Provider #: 0037507
05/01/05 to 04/30/06

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner</u>	<u>Supplies</u>
		<u>Units</u>	<u>Cost</u>
Specialized beds & equipment	39(2)		20,392
Oxygen	39(2)		26,783
			<u>47,175</u>

Facility Name & ID Number Sherman West Court

0037507

Report Period Beginning: 05/01/05

Ending:

04/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 04/30/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,512,584	\$ 1,512,584	1
2	Cash-Patient Deposits	218	218	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 338,080)	1,230,573	1,230,573	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,445	69,445	6
7	Other Prepaid Expenses	9,648	9,648	7
8	Accounts Receivable (owners or related parties)	72,148	72,148	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,894,616	\$ 2,894,616	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	5,339,109	5,339,109	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,244,179	1,244,179	16
17	Accumulated Depreciation (book methods)	(3,554,489)	(3,564,631)	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>Deferred financing charges</u>	83,665	83,665	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,616,643	\$ 3,606,501	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,511,259	\$ 6,501,117	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 118,890	\$ 118,890	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	218	218	28
29	Short-Term Notes Payable	141,950	141,950	29
30	Accrued Salaries Payable	313,848	313,848	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	75,716	75,716	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Related Party Liabilities (See Sch 17A)</u>	802,644	802,644	36
37	<u>Other Current Liab. (See Sch 17A)</u>	644,752	644,752	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,098,018	\$ 2,098,018	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,422,083	5,422,083	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)	\$ 5,422,083	\$ 5,422,083	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,520,101	\$ 7,520,101	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,008,842)	\$ (1,018,984)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,511,259	\$ 6,501,117	48

*(See instructions.)

Sherman West Court
Provider # 0037507
05/01/2005 - 04/30/2006

Schedule 17A

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

Description	Operating	After Consolidation
Advances from Operating Fund	(72,148)	(72,148)
Due to Sherman Hospital	(712,452)	(712,452)
Due to Sherman Health Systems	(18,044)	(18,044)
	<u>(802,644)</u>	<u>(802,644)</u>

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

Description	Operating	After Consolidation
Liability due to Blue Cross	(87,696)	(87,696)
Deferred Income	(208,405)	(208,405)
Accrued Expenses	(33,493)	(33,493)
Accrued Liability - Workmen's Comp	(13,377)	(13,377)
Accrued Liability - Health & Dental	(29,100)	(29,100)
Accrued Liability - Disability	(6,101)	(6,101)
Accrued Liability - Nursing Home Provider Tax	(4,267)	(4,267)
Malpractice Tail Insurance	(262,313)	(262,313)
	<u>(644,752)</u>	<u>(644,752)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,029,029)	1
2	Restatements (describe):		2
3			3
4	Prior Period Audit Adjustments	59,013	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (970,016)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(38,826)	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)	\$ (38,826)	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)	\$ (1,008,842)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,526,820	1
2	Discounts and Allowances for all Levels	(1,567,766)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,959,054	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,090,566	6
7	Oxygen	112,395	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,202,961	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,641	13
14	Non-Patient Meals	7,096	14
15	Telephone, Television and Radio	6,325	15
16	Rental of Facility Space		16
17	Sale of Drugs	883,216	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,560	19
20	Radiology and X-Ray	687	20
21	Other Medical Services	208,038	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,138,563	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,940	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,940	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous revenue (See Sch 19A)</u>	6,544	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,544	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,339,062	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	856,755	31
32	Health Care	2,847,344	32
33	General Administration	1,874,933	33
	B. Capital Expense		
34	Ownership	553,765	34
	C. Ancillary Expense		
35	Special Cost Centers	1,183,771	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,377,888	40
41	Income before Income Taxes (line 30 minus line 40)**	(38,826)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (38,826)	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.

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

Sherman West Court
Provider # 0037507
05/01/2005 - 04/30/2006

Schedule 19A

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

<u>Description</u>	<u>Operating</u>
Activities Income	447
Code Alert Security Revenue	4,272
Miscellaneous	1,825
	<u>6,544</u>

Facility Name & ID Number **Sherman West Court**

0037507

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	3,958	4,288	\$ 166,481	\$ 38.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,576	35,632	971,730	27.27	3
4	Licensed Practical Nurses	5,644	5,918	118,858	20.08	4
5	CNAs & Orderlies	59,500	62,855	795,917	12.66	5
6	CNA Trainees					6
7	Licensed Therapist	4,605	4,810	161,925	33.66	7
8	Rehab/Therapy Aides	4,162	4,519	53,784	11.90	8
9	Activity Director	1,902	2,086	38,451	18.43	9
10	Activity Assistants	2,772	3,011	29,691	9.86	10
11	Social Service Workers	1,960	2,024	54,648	27.00	11
12	Dietician	1,174	1,218	27,137	22.28	12
13	Food Service Supervisor	4,011	4,172	105,791	25.36	13
14	Head Cook	5,075	5,164	53,706	10.40	14
15	Cook Helpers/Assistants					15
16	Dishwashers	10,605	11,828	92,703	7.84	16
17	Maintenance Workers	4,020	4,404	77,393	17.57	17
18	Housekeepers	9,890	10,374	83,492	8.05	18
19	Laundry	2,799	3,065	28,757	9.38	19
20	Administrator	1,792	1,984	82,344	41.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,930	2,086	68,838	33.00	23
24	Clerical	17,423	18,948	289,600	15.28	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	1,968	2,205	27,629	12.53	31
32	Other Health C: (MDS Coord)	391	391	13,433	34.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,157	190,982	\$ 3,342,308 *	\$ 17.50	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	16	42,300	9(3) 36
37	Medical Records Consultant	20	1,040	10(3) 37
38	Nurse Consultant			38
39	Pharmacist Consultant	48	1,440	10(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	16	784	11(3) 44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	100	\$ 45,564	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	72	\$ 3,870	10(3) 50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	14	398	10(3) 52
53	TOTAL (lines 50 - 52)	86	\$ 4,268	53

Facility Name & ID Number Sherman West Court

0037507

Report Period Beginning: 05/01/05

Ending: 04/30/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Anne Huang	Administrator	0	\$ 82,344	Workers' Compensation Insurance	\$ 96,882	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	20,722	Advertising: Employee Recruitment	13,814	
				FICA Taxes	255,352	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	144,388	Patient Background Checks		
				Employee Meals		Life Services Network of Illinois dues	4,381	
				Illinois Municipal Retirement Fund (IMRF)*		JCAHO dues	1,575	
				Employee Benefits - PTO	103,308	See Schedule 21A	12,812	
				Other Employee Benefits	12,701			
				Pension Contributions	45,121			
				Employee Dental Benefits	6,350	Less: Public Relations Expense (
				Employee Recognition & Morale	3,994	Non-allowable advertising (
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,344	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 688,818		\$ 34,572		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management fees (eliminated in column 7)			\$ 216,533				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 216,533				Seminar Expense	
							See attached schedule	10,636
							Entertainment Expense (
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,051	TOTAL		\$	TOTAL	\$ 10,636

* Attach copy of IMRF notifications

**See instructions.

Sherman West Court
Provider #: 0037507
05/01/05 to 04/30/06

Schedule 21A

Schedule XIX(C) Professional Services

Total (agrees to Schedule V, line 19, column 3)	48,051
Less: Non-allowable collection fees	<u>(4,539)</u>
Total (agrees to Schedule V, line 19, column 8)	<u><u>43,512</u></u>

Schedule XIX(F) Dues, Fees, Subscription, & Promotion

Miscellaneous Books & Subscriptions	3,894
JCAHO Survey Fees	7,101
Miscellaneous Dues	515
Miscellaneous Licenses & Fees	<u>1,302</u>
Total	<u><u>12,812</u></u>

Facility Name & ID Number Sherman West Court# 0037507Report Period Beginning: 05/01/05Ending: 04/30/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of Illinois - 4,381
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,401 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. \$ 61,320
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,131
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen 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