

Facility Name & ID Number Sherman West Court

0037507 Report Period Beginning: 05/01/2007 Ending: 04/30/2008

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)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	8	Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		1,781	12,844	14,625	8
9	SNF/PED					9
10	ICF	3,584	17,092		20,676	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,584	18,873	12,844	35,301	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.38%

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

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 54 and days of care provided 12,844

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 04/30/2008 Fiscal Year: 04/30/2008

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

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2007 Ending: 04/30/2008

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		102,644		102,644		102,644	290,284	392,928	1	
2	Food Purchase		179,140		179,140		179,140	(3,389)	175,751	2	
3	Housekeeping		21,612		21,612		21,612	111,381	132,993	3	
4	Laundry		11,303		11,303		11,303	40,437	51,740	4	
5	Heat and Other Utilities			165,631	165,631		165,631		165,631	5	
6	Maintenance			96,579	96,579		96,579	92,547	189,126	6	
7	Other (specify):*									7	
8	TOTAL General Services		314,699	262,210	576,909		576,909	531,260	1,108,169	8	
	B. Health Care and Programs										
9	Medical Director			33,575	33,575		33,575		33,575	9	
10	Nursing and Medical Records	1,378,350	352,838	1,858,836	3,590,024		3,590,024	(283,583)	3,306,441	10	
10a	Therapy							1,383,944	1,383,944	10a	
11	Activities							95,530	95,530	11	
12	Social Services							91,082	91,082	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,378,350	352,838	1,892,411	3,623,599		3,623,599	1,286,973	4,910,572	16	
	C. General Administration										
17	Administrative			216,533	216,533		216,533	(45,948)	170,585	17	
18	Directors Fees									18	
19	Professional Services			33,542	33,542		33,542	(468)	33,074	19	
20	Dues, Fees, Subscriptions & Promotions			17,715	17,715		17,715		17,715	20	
21	Clerical & General Office Expenses	2,353,656	8,358	51,227	2,413,241		2,413,241	(1,744,938)	668,303	21	
22	Employee Benefits & Payroll Taxes			677,801	677,801		677,801		677,801	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			6,071	6,071		6,071		6,071	24	
25	Other Admin. Staff Transportation			1,516	1,516		1,516		1,516	25	
26	Insurance-Prop.Liab.Malpractice			316,304	316,304		316,304		316,304	26	
27	Other (specify):*									27	
28	TOTAL General Administration	2,353,656	8,358	1,320,709	3,682,723		3,682,723	(1,791,354)	1,891,369	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,732,006	675,895	3,475,330	7,883,231		7,883,231	26,879	7,910,110	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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			218,576	218,576		218,576	85,295	303,871			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			299,163	299,163		299,163		299,163			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,979	21,979		21,979		21,979			35
36	Other (specify):*											36
37	TOTAL Ownership			539,718	539,718		539,718	85,295	625,013			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,779	3,779		3,779		3,779			38
39	Ancillary Service Centers		783,475		783,475		783,475		783,475			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,776	64,776		64,776		64,776			42
43	Other (specify):* Non-allowable cost			151,229	151,229		151,229	(151,229)				43
44	TOTAL Special Cost Centers		783,475	219,784	1,003,259		1,003,259	(151,229)	852,030			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,732,006	1,459,370	4,234,832	9,426,208		9,426,208	(39,055)	9,387,153			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,389)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,493)	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	9,314	30		9
10	Interest and Other Investment Income				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	(2,309)	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	(84,999)	43		24
25	Fund Raising, Advertising and Promotional	(20,105)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(404)	21		28
29	Other-Attach Schedule <u>See Pg 5A</u>	(46,567)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,952)		\$	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)	116,897		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 116,897		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (39,055)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court

ID# 0037507
 Report Period Beginning: 05/01/2007
 Ending: 04/30/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Reference Lab Expense	\$ (39,365)	43	1
2	Disallow Residents Clothing Expense	(4,451)	43	2
3	Disallow Non-Allowable Legal Fees	(468)	19	3
4	Offset code alert income against related expense	(2,489)	6	4
5	Offset Misc Inc against Misc Expense	206	21	5
6	Reclass salaries to correct cost centers	285,883	1	6
7	Reclass salaries to correct cost centers	111,381	3	7
8	Reclass salaries to correct cost centers	40,437	4	8
9	Reclass salaries to correct cost centers	94,049	6	9
10	Reclass salaries to correct cost centers	1,119,055	10	10
11	Reclass salaries to correct cost centers	91,332	11	11
12	Reclass salaries to correct cost centers	91,082	12	12
13	Reclass salaries to correct cost centers	170,585	17	13
14	Reclass salaries to correct cost centers	4,313	10A	14
15	Reclass salaries to correct cost centers	(2,008,117)	21	15
16	Reclass purchased services to correct cost centers	4,401	1	16
17	Reclass purchased services to correct cost centers	987	6	17
18	Reclass purchased services to correct cost centers	(1,402,638)	10	18
19	Reclass purchased services to correct cost centers	4,198	11	19
20	Reclass purchased services to correct cost centers	1,379,631	10A	20
21	Reclass purchased services to correct cost centers	18,648	21	21
22	Reclass purchased services to correct cost centers	(5,227)	21	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	(46,567)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court# 0037507

Report Period Beginning:

05/01/2007

Ending:

04/30/2008

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	290,284	0	0	0	0	0	0	0	0	0	0	290,284	1
2	Food Purchase	(3,389)	0	0	0	0	0	0	0	0	0	0	(3,389)	2
3	Housekeeping	111,381	0	0	0	0	0	0	0	0	0	0	111,381	3
4	Laundry	40,437	0	0	0	0	0	0	0	0	0	0	40,437	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	92,547	0	0	0	0	0	0	0	0	0	0	92,547	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	531,260	0	0	0	0	0	0	0	0	0	0	531,260	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	(283,583)	0	0	0	0	0	0	0	0	0	0	(283,583)	10
10a	Therapy	1,383,944	0	0	0	0	0	0	0	0	0	0	1,383,944	10a
11	Activities	95,530	0	0	0	0	0	0	0	0	0	0	95,530	11
12	Social Services	91,082	0	0	0	0	0	0	0	0	0	0	91,082	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	1,286,973	0	0	0	0	0	0	0	0	0	0	1,286,973	16
	C. General Administration													
17	Administrative	170,585	(216,533)	0	0	0	0	0	0	0	0	0	(45,948)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(468)	0	0	0	0	0	0	0	0	0	0	(468)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,002,387)	257,449	0	0	0	0	0	0	0	0	0	(1,744,938)	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	(1,832,270)	40,916	0	(1,791,354)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,037)	40,916	0	26,879	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court# 0037507

Report Period Beginning:

05/01/2007 Ending:04/30/2008

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	9,314	75,981	0	0	0	0	0	0	0	0	0	85,295	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	9,314	75,981	0	85,295	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):*	(151,229)	0	0	0	0	0	0	0	0	0	0	(151,229)	43
44	TOTAL Special Cost Centers	(151,229)	0	0	0	0	0	0	0	0	0	0	(151,229)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(155,952)	116,897	0	(39,055)	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	Elgin	Home Health
				Care Partners		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%	257,449	257,449	2
3	V	30 Depreciation Expense		Sherman Health Systems	100.00%	75,981	75,981	3
4	V	22 Fringe Benefits	5,463	Sherman Hospital		5,463		4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 221,996			\$ 338,893	\$ * 116,897	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
 Facility #0037507
 4/30/2008

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
Michael Kenyon	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sherman West Court

0037507

Report Period Beginning:

05/01/2007

Ending:

04/30/2008

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	\$ 1,250	L18, C3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	1,000	L18, C3	2
3	Richard S. Scheflow	Secretary	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	1,000	L18, C3	3
4	Michael Kenyon	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	1,500	L18, C3	4
5	Reverend Dr. Robert Linstrom	Chairman	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	1,250	L18, C3	5
6	Kyung W. Koo, M.D.	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	1,000	L18, C3	6
7	Dr. Michael Grassi	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L18, C3	7
8	Dr. George Gonnella	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L18, C3	8
9	Lois Oberst	Elgin Women's Club Representative	Board Member	None	None	Less than 1	Less than 1	Board Mtg. Fees	500	L18, C3	9
10											10
11											11
12											12
13								TOTAL	\$ 8,500		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: 05/01/2007

Ending: 4/30/2008

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 Expense	Accumulated Costs	226,010,565	3	\$ 6,240,834	\$ 9,323,438	\$ 257,448	1
2	30	Depreciation Expense	Accumulated Costs	226,010,565	3	1,841,849	9,323,438	75,980	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					\$ 8,082,683	\$	\$ 333,428	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sherman West Court

0037507

Report Period Beginning:

05/01/2007

Ending:

04/30/2008

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	\$ 5,267,363	08/20/27	Various	\$ 299,163	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	\$ 5,267,363			\$ 299,163	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,736,121	\$ 5,267,363			\$ 299,163	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2007 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.)		\$	N/A
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	N/A	12
No real estate taxes paid as facility has been granted real estate tax exempt status.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Carolyn Cekal

TELEPHONE (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 2007 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 2007.

(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. <u>No real estate taxes paid as facility has been granted real estate tax exempt status.</u>	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

05/01/2007 Ending:

04/30/2008

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: N/A

(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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

0037507

Report Period Beginning:

05/01/2007 Ending: 04/30/2008

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	\$	\$ 1,069,867	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	10,864	15		(10,864)	205,843	11
12	Building Improvements		1991	826,676	41,334	20	41,334		711,288	12
13	Building Improvements		1991	91,155	3,646	25	3,646		62,743	13
14	Building Improvements		1991	21,960		10			21,960	14
15	Building Improvements		1991	3,398		15	(2)	(2)	3,398	15
16	Building Improvements		1992	22,980		10			22,980	16
17	Building Improvements		1992	2,000	69	15	69		2,000	17
18	Building Improvements		1993	962		5			962	18
19	Building Improvements		1993	13,219		10			13,219	19
20	Building Improvements		1993	3,750	250	15	250		3,625	20
21	Building Improvements		1993	14,525	50	20	726	676	10,528	21
22	Building Improvements		1994	6,951	348	20	348		4,695	22
23	Carpet Tiles		1995	1,500		10	(225)	(225)	1,500	23
24	Sliding Doors		1996	3,345		10			3,345	24
25	Resurface Parking Lot		1996	4,800		5			4,800	25
26	Carpeting		1997	3,930		5			3,930	26
27	Carpet/tile Base		1997	12,580		5			12,580	27
28	Kickplates		1997	4,165		5			4,165	28
29	Carpet Living Room		1998	4,340	434	10	434		4,117	29
30	Cement Board & Ceramic Tile		1999	4,475	448	10	448		4,256	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		208,816	33
34	Kitchen Wall Boards		2000	1,365		5			1,365	34
35	Parking Lot Improvements		2000	52,250	3,483	30	1,742	(1,741)	13,936	35
36	Purchasing Department Ceiling Light Fixtures		2000	1,967	197	10	197		1,576	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:

05/01/2007 Ending: 04/30/2008

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	\$	5	\$	\$	\$ 19,785	37
38	<u>Wallpaper</u>	2002	19,893		5			19,893	38
39	<u>Roofing</u>	2001	1,400	140	10	140		910	39
40	<u>Door</u>	2001	1,125	75	15	75		488	40
41	<u>Carpeting</u>	2003	5,732	575	5	575		5,732	41
42	<u>Carpeting</u>	2003	1,855	185	5	185		1,855	42
43	<u>Wiring for therapy rooms</u>	2003	4,431	443	10	443		2,437	43
44	<u>HVAC upgrade and testing</u>	2003	52,902	3,527	15	3,527		19,399	44
45	<u>Fire sprinklers</u>	2003	12,149	607	20	607		3,339	45
46	<u>HVAC upgrade and testing</u>	2003	51,875	4,589	10	5,188	599	31,140	46
47	<u>Light fixtures and wiring for cafeteria</u>	2004	3,967	397	10	397		1,786	47
48	<u>Wallpaper</u>	2004	6,868	1,373	5	1,374	1	6,183	48
49	<u>Vent pipe</u>	2004	1,068	214	5	214		963	49
50	<u>Vinyl base</u>	2004	900	180	5	180		810	50
51	<u>HVAC upgrade and testing</u>	2004	8,909		15	594	594	2,673	51
52	<u>Door holder</u>	2004	1,046	70	15	70		315	52
53	<u>Circuit breaker</u>	2004	2,250		15	150	150	675	53
54	<u>Door plate</u>	2004	2,053		15	137	137	616	54
55	<u>Sewer line and trap</u>	2004	2,940		15	196	196	884	55
56	<u>Drapes</u>	2005	5,817	1,162	5	1,163	1	4,072	56
57	<u>Carpeting</u>	2005	11,175	2,235	5	2,235		7,821	57
58	<u>Carpeting</u>	2005	9,400	940	10	940		3,290	58
59	<u>Light fixtures and wiring</u>	2005	8,667	867	10	867		3,033	59
60	<u>Sign for dining room</u>	2005	2,039	204	10	204		714	60
61	<u>Fire system</u>	2005	12,230	815	15	815		2,446	61
62	<u>Sewer line</u>	2005	2,950	59	25	118	59	413	62
63									63
64	<u>Fire Doors - 4</u>	2006	5,670	189	15	378	189	945	64
65	<u>Dining room doors/closures</u>	2006	1,785	60	15	119	59	298	65
66	<u>Cement sidewalk ramp</u>	2006	1,950	65	15	130	65	325	66
67	<u>Exit lights - 4</u>	2006	3,600	120	15	240	120	600	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,321,173	\$ 165,858		\$ 155,871	\$ (9,987)	\$ 2,862,166	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,321,173	\$ 165,858		\$ 155,871	\$ (9,987)	\$ 2,862,166	1
2	Upgrade firedoors per IDPH specification	2006	6,020	200	15	401	201	1,002	2
3	Sprinkler installation in attic	2006	4,414	1,835	15	294	(1,541)	735	3
4	Generator - 150 amp circuit breaker	2006	1,103		20	55	55	138	4
5	Installation of handrails	2006	6,400		20	320	320	800	5
6	Sprinkler system air compressor	2007	3,020	(1,005)	5	302	1,307	604	6
7	5 PTAC units & connections	2007	3,326		15	111	111	222	7
8	Roof shingles	2007	92,083		15	3,069	3,069	6,137	8
9	14 Smoke detectors and bases	2007	1,036		15	35	35	70	9
10									10
11	Wallpaper for resident rooms	2007	7,146	5,818	5	715	(5,103)	715	11
12	Repair dry pipe sprinkler system	2007	3,905	130	15	130		130	12
13	Hot Water Boiler	2008	17,742		15	591	591	591	13
14	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069		10	1,303	1,303	1,303	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)		\$ 5,493,437	\$ 172,836		\$ 163,197	\$ (9,639)	\$ 2,874,613	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 589,394	\$ 38,490	\$ 58,107	\$ 19,617	5-20	\$ 447,953	71
72	Current Year Purchases	118,517	7,250	6,586	(664)	5-10	6,586	72
73	Fully Depreciated Assets	687,935					687,935	73
74	Allocated from Sherman Health Systems			75,981	75,981			74
75	TOTALS	\$ 1,395,846	\$ 45,740	\$ 140,674	\$ 94,934		\$ 1,142,474	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)	\$ 7,393,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,576	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 303,871	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 85,295	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,017,087	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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: \$ 21,979 Description: Copiers - \$13,036; Water Softener - \$360; Knives - \$436; Therapy Eqpt. - \$8,147

(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			N/A		18
19					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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.
- 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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	10A(1)	163 hrs	4,313				163	4,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		19,290	1,379,631		19,290	1,379,631	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				725,714		725,714	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See attached Schedule</u>	39(2)					57,761		57,761	13
14	TOTAL			\$ 4,313	19,290	\$ 1,379,631	\$ 783,475	19,453	\$ 2,167,419	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
4/30/2008

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Ref	Outside Units	Practitioner Cost	Supplies
Specialized Beds & Equipment	39(2)			19,650
Oxygen	39(2)			38,111
				<u>57,761</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

0037507

Report Period Beginning: 05/01/2007

Ending:

04/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 04/30/2008

(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	\$ 859,922	\$ 859,922	1
2	Cash-Patient Deposits	145	145	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>156,945</u>)	1,337,435	1,337,435	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	82,315	82,315	5
6	Prepaid Insurance	71,236	71,236	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)	\$ 2,432,849	\$ 2,432,849	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	191,565	191,565	12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	3,425,769	2,486,860	14
15	Leasehold Improvements, at Historical Cost	2,069,566	3,006,577	15
16	Equipment, at Historical Cost	1,393,946	1,395,846	16
17	Accumulated Depreciation (book methods)	(4,003,203)	(4,017,087)	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 Finance Charges</u>	75,791	75,791	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,657,613	\$ 3,643,731	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,090,462	\$ 6,076,580	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 497,784	\$ 497,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	145	145	28
29	Short-Term Notes Payable	157,841	157,841	29
30	Accrued Salaries Payable	366,494	366,494	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	71,706	71,706	33
34	Deferred Compensation	218,713	218,713	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Related Party Liab (See Sch 17A)</u>	615,271	615,271	36
37	<u>Other Current Liab (See Sch 17A)</u>	88,071	88,071	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,016,025	\$ 2,016,025	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,109,522	5,109,522	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Accrued Liab. - Malpractice Ins.</u>	290,766	290,766	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,400,288	\$ 5,400,288	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,416,313	\$ 7,416,313	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,325,851)	\$ (1,339,733)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,090,462	\$ 6,076,580	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Sherman West Court
Facility #0037507
4/30/2008

Schedule 17A

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

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Advances from Operating Fund	72,148	72,148
Due to Sherman Hospital	512,484	512,484
Due to Sherman Health Systems	30,639	30,639
	<u>615,271</u>	<u>615,271</u>

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

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
A/R - Medicare Settlements	12,793	12,793
Liability due to Blue Cross	26,644	26,644
Accrued Liability - Workmen's Comp	13,377	13,377
Accrued Liability - Health & Dental	30,389	30,389
Accrued Liability - Disability	301	301
Accrued Liability - Nursing Home Provider Tax	4,567	4,567
	<u>88,071</u>	<u>88,071</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,008,353)	1
2	Restatements (describe):		2
3	Prior period audit adjustments	249,765	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,758,588)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	432,735	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) Rounding	2	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 432,737	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)	\$ (1,325,851)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 12,192,517	1
2	Discounts and Allowances for all Levels	(2,652,878)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,539,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	95,623	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 95,623	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,436	13
14	Non-Patient Meals	3,389	14
15	Telephone, Television and Radio	7,493	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	200,323	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 215,641	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	8,040	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,040	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,858,943	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	576,909	31
32	Health Care	3,623,599	32
33	General Administration	3,682,723	33
	B. Capital Expense		
34	Ownership	539,718	34
	C. Ancillary Expense		
35	Special Cost Centers	938,483	35
36	Provider Participation Fee	64,776	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,426,208	40
41	Income before Income Taxes (line 30 minus line 40)**	432,735	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 432,735	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.

Sherman West Court
Facility #0037507
4/30/2008

Schedule 19A

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

<u>Description</u>	<u>Operating</u>
Miscellaneous Income	636
Other Inc-Pt	189
Other Inc-Code Alert Security System	2,489
Other Inc-Wheelchair Revenue	5,121
Activities & Outings Income	(395)
	<u>8,040</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

0037507

Report Period Beginning:

05/01/2007

Ending:

04/30/2008

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	3,462	3,719	\$ 128,486	\$ 34.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,651	39,253	1,228,855	31.31	3
4	Licensed Practical Nurses	6,865	7,327	149,495	20.40	4
5	CNAs & Orderlies	56,797	60,929	809,260	13.28	5
6	CNA Trainees					6
7	Licensed Therapist	163	163	4,313	26.46	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,867	2,091	40,688	19.46	9
10	Activity Assistants	3,963	4,186	50,644	12.10	10
11	Social Service Workers	3,211	3,567	91,082	25.53	11
12	Dietician	1,915	2,161	51,261	23.72	12
13	Food Service Supervisor	1,979	2,091	38,566	18.44	13
14	Head Cook	6,295	6,500	87,017	13.39	14
15	Cook Helpers/Assistants	11,829	12,262	109,039	8.89	15
16	Dishwashers					16
17	Maintenance Workers	4,690	4,878	94,049	19.28	17
18	Housekeepers	10,859	11,417	111,381	9.76	18
19	Laundry	5,320	5,512	40,437	7.34	19
20	Administrator	1,893	2,200	100,977	45.90	20
21	Assistant Administrator	2,019	2,091	69,608	33.29	21
22	Other Administrative	3,418	3,710	68,553	18.48	22
23	Office Manager	1,885	2,091	74,127	35.45	23
24	Clerical	8,584	8,978	96,251	10.72	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	2,132	2,343	33,080	14.12	31
32	Other Health C: See Sch 20A	7,801	8,406	148,229	17.63	32
33	Other(specify) Admissions Coord	3,830	4,167	106,608	25.58	33
34	TOTAL (lines 1 - 33)	187,428	200,042	\$ 3,732,006 *	\$ 18.66	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	80	\$ 4,401	1(3)	35
36	Medical Director	Monthly	33,575	9(3)	36
37	Medical Records Consultant	8	540	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	4,687	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	83	4,198	11(3)	44
45	Social Service Consultant			12(3)	45
46	Other(specify) Other Med Services	Monthly	25,608	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	243	\$ 73,009		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,349	\$ 210,292	10(3)	50
51	Licensed Practical Nurses	1,138	41,179	10(3)	51
52	Certified Nurse Assistants/Aides	6,766	173,892	10(3)	52
53	TOTAL (lines 50 - 52)	12,253	\$ 425,363		53

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
IDPH Facility ID # 0037507
4/30/2008

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	1,927	2,102	73,889	35.15
Unit Clerk	3,155	3,481	41,684	11.97
Resident Assistants	2,719	2,823	32,656	11.57
Total	7,801	8,406	148,229	17.63

SEE ACCOUNTANTS' COMPILATION REPORT

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		
Joseph McManus	Administrator	0	\$ 100,977	Workers' Compensation Insurance	\$ 119,516	IDPH License Fee	\$ 995		
Angela Lackowski	Assistant Administrator	0	69,608	Unemployment Compensation Insurance	23,431	Advertising: Employee Recruitment			
				FICA Taxes	288,736	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	163,265	Patient Background Checks			
				Employee Meals		Life Service Network of IL	5,800		
				Illinois Municipal Retirement Fund (IMRF)*		JCAHO	6,065		
				LT Disability	5,357	Miscellaneous Dues	625		
				Employee Recognition	4,935	Miscellaneous Subscriptions	4,230		
				Other Employee Benefits	14,361				
				Pension Contributions	51,020	Less: Public Relations Expense (_____)			
				Employee Dental Benefits	7,180	Non-allowable advertising (_____)			
						Yellow page advertising (_____)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 170,585	TOTAL (agree to Schedule V, line 22, col.8)		\$ 677,801	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,715
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	N/A			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	_____	
C. Professional Services				TOTAL			See Attached Schedule		
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount	
Duane Morris, LLP	Legal	\$ 18,224							
Accumed Services	Data Processing	7,580							
IVAN's	Data Processing	1,096							
National Government Services	Data Processing	546							
McKesson Medical	Data Processing	1,825							
Neopost	Data Processing	175							
Cbord Group Inc	Data Processing	752							
McGladrey & Pullen, LLP	Accounting	2,876							
Schelflow & Rydell	Collection	468							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 33,542	TOTAL		\$ _____	Entertainment Expense (_____)		
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,071	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Sherman West Court

Facility #0037507

4/30/2008

Schedule 21A

Schedule XIX(C) Professional Services

Total (from Page 21C) agrees to Schedule V, Line 19, Column 3	33,542
Less: Non-allowable collection fees	<u>(468)</u>
Total (agrees to Schedule V, Line 19, Column 8)	33,074

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court# 0037507Report Period Beginning: 05/01/2007Ending: 04/30/2008**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 - \$5,800
- (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? 7.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,069 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. \$ 64,776
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,389
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees