



Facility Name & ID Number Sherman West Court

# 0037507 Report Period Beginning: 05/01/08 Ending: 04/30/09

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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		1,874	13,029	14,903	8
9	SNF/PED					9
10	ICF	3,733	13,636	0	17,369	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,733	15,510	13,029	32,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.68%

#REF!

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 2/18/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/18/91 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 58 and days of care provided 13,029

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 4/30/09 Fiscal Year: 4/30/09

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

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**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
	<b>A. General Services</b>										
1	Dietary		106,548		106,548		106,548	284,196	390,744		1
2	Food Purchase		172,690		172,690		172,690	(2,941)	169,749		2
3	Housekeeping		21,862		21,862		21,862	113,966	135,828		3
4	Laundry		6,547		6,547		6,547	37,736	44,283		4
5	Heat and Other Utilities			203,834	203,834		203,834		203,834		5
6	Maintenance			120,001	120,001		120,001	119,015	239,016		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>		307,647	323,835	631,482		631,482	551,972	1,183,454		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			33,600	33,600		33,600		33,600		9
10	Nursing and Medical Records	1,244,374	304,353	2,251,116	3,799,843		3,799,843	(389,839)	3,410,004		10
10a	Therapy							1,407,153	1,407,153		10a
11	Activities							98,454	98,454		11
12	Social Services							89,000	89,000		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,244,374	304,353	2,284,716	3,833,443		3,833,443	1,204,768	5,038,211		16
	<b>C. General Administration</b>										
17	Administrative			308,947	308,947		308,947	(141,705)	167,242		17
18	Directors Fees										18
19	Professional Services			148,800	148,800		148,800	10,790	159,590		19
20	Dues, Fees, Subscriptions & Promotions			31,105	31,105		31,105	(8,025)	23,080		20
21	Clerical & General Office Expenses	2,420,128	7,714	76,710	2,504,552		2,504,552	(1,654,184)	850,368		21
22	Employee Benefits & Payroll Taxes			614,380	614,380		614,380		614,380		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,447	5,447		5,447	(65)	5,382		24
25	Other Admin. Staff Transportation			1,666	1,666		1,666		1,666		25
26	Insurance-Prop.Liab.Malpractice			331,091	331,091		331,091		331,091		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	2,420,128	7,714	1,518,146	3,945,988		3,945,988	(1,793,189)	2,152,799		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,664,502	619,714	4,126,697	8,410,913		8,410,913	(36,449)	8,374,464		29

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

#REF!

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

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#0037507

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## 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	
	<b>D. Ownership</b>											
30	Depreciation			202,211	202,211		202,211	118,904	321,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			283,388	283,388		283,388		283,388			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,245	36,245		36,245		36,245			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			521,844	521,844		521,844	118,904	640,748			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			4,094	4,094		4,094		4,094			38
39	Ancillary Service Centers		788,448		788,448		788,448		788,448			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* <b>Non-allowable cost</b>			152,046	152,046		152,046	(152,046)				43
44	<b>TOTAL Special Cost Centers</b>		788,448	221,840	1,010,288		1,010,288	(152,046)	858,242			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,664,502	1,408,162	4,870,381	9,943,045		9,943,045	(69,591)	9,873,454			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.

#REF!

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**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	(2,941)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,341)	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	41,179	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	(16,000)	43		18
19	Entertainment	(1,464)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,512)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,566)	43		24
25	Fund Raising, Advertising and Promotional	(16,555)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(321)	21		28
29	Other-Attach Schedule See PG5A	(49,606)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (147,127)		\$	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)	77,536		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 77,536		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (69,591)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Reference Lab Expense	\$ (46,741)	43	1
2	Disallow Residents Clothing Expense	(320)	43	2
3	Offset Other Inc Against Misc Expense	146	21	3
4	Offset Code Alert Income against Related Exp	(1,275)	10	4
5	Disallow Travel & Seminar	(65)	24	5
6	Offset Misc Inc against Misc Exp	(1,351)	21	6
7	Reclass salaries to correct cost center	278,187	1	7
8	Reclass salaries to correct cost center	113,966	3	8
9	Reclass salaries to correct cost center	37,736	4	9
10	Reclass salaries to correct cost center	110,443	6	10
11	Reclass salaries to correct cost center	1,085,787	10	11
12	Reclass salaries to correct cost center	92,504	11	12
13	Reclass salaries to correct cost center	89,000	12	13
14	Reclass salaries to correct cost center	167,242	17	14
15	Reclass salaries to correct cost center	(1,974,865)	21	15
16	Reclass purchased services to correct cost centers	6,009	1	16
17	Reclass purchased services to correct cost centers	9,847	6	17
18	Reclass purchased services to correct cost centers	(1,475,626)	10	18
19	Reclass purchased services to correct cost centers	5,950	11	19
20	Reclass purchased services to correct cost centers	1,407,153	10A	20
21	Reclass purchased services to correct cost centers	19,302	19	21
22	Reclass purchased services to correct cost centers	27,365	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	<b>Total</b>	(49,606)		49

**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 System	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	\$ 308,947	Sherman Health Systems	100.00%	\$	(308,947)	1
2	V	21 Administrative Expense		Sherman Health Systems	100.00%	308,758	308,758	2
3	V	30 Depreciation Expense		Sherman Health Systems	100.00%	77,725	77,725	3
4	V	22 Fringe Benefits	5,598	Sherman Hospital		5,598		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		\$ 314,545			\$ 392,081	\$ * 77,536	14

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

Sherman West Court  
Facility #0037507  
4/30/2009

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
Michael Kenyon	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Lois Oberst	No	N/A	N/A	N/A
Ronald Pavlik	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Michael Grassi	No	N/A	N/A	N/A
George Gonnella	No	N/A	N/A	N/A
Tom Nitz	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

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# 0037507

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05/01/08

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## 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	Michael Kenyon	Chairman	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fee	\$ 750	L18, C3	1
2	Earl W. Lamp	Treasurer	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	500	L18, C3	2
3	Al Pagorski	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L18, C3	3
4	Ronald Pavlik	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	500	L18, C3	4
5	Richard Floyd	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L18, C3	5
6	Dr. Michael Grassi	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L18, C3	6
7	Dr. George Gonnella	Medical Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L18, C3	7
8	Tom Nitz	Director	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	0	L18, C3	8
9	Lois Oberst	Elgin Women's Club Representative	Board Member	None	None	Less than 1	Less than 1	Board Mtg Fees	750	L18, C3	9
10											10
11											11
12											12
13								TOTAL	\$ 2,500		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

#REF!

Facility Name & ID Number Sherman West Court

# 0037507

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VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	234,873,247	3	\$ 7,362,779	\$ 9,849,443	\$ 308,758	1
2	30	Depreciation Expense	Accumulated Costs	234,873,247	3	1,853,462	9,849,443	77,725	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					\$ 9,216,241	\$	\$ 386,483	25

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Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/08

Ending:

04/30/09

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	<b>TOTALS</b>	<b>115,500</b>		<b>\$ 504,179</b>	<b>3</b>

#REF!

**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	\$	\$ 1,132,038
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Building Improvements	1991		99,031		5			99,031
10	Building Improvements	1991		219,089		10			219,089
11	Building Improvements	1991		205,843		15			205,843
12	Building Improvements	1991		826,676	41,334	20	41,334		752,622
13	Building Improvements	1991		91,155	3,646	25	3,646		66,389
14	Building Improvements	1991		21,960		10			21,960
15	Building Improvements	1991		3,398		15			3,398
16	Building Improvements	1992		22,980		10			22,980
17	Building Improvements	1992		2,000		15			2,000
18	Building Improvements	1993		962		5			962
19	Building Improvements	1993		13,219		10			13,219
20	Building Improvements	1993		3,750	125	15	125		3,750
21	Building Improvements	1993		14,525	50	20	726	676	11,254
22	Building Improvements	1994		6,951	348	20	348		5,043
23	Carpet Tiles	1995		1,500		10			1,500
24	Sliding Doors	1996		3,345		10			3,345
25	Resurface Parking Lot	1996		4,800		5			4,800
26	Carpeting	1997		3,930		5			3,930
27	Carpet/tile Base	1997		12,580		5			12,580
28	Kickplates	1997		4,165		5			4,165
29	Carpet Living Room	1998		4,340	217	10	217		4,334
30	Cement Board & Ceramic Tile	1999		4,475	224	10	224		4,480
31	Wallpaper	1999		1,819		5			1,819
32	Landscaping	1999		893		5			893
33	Construction contract for new entrance & nursing station	1999		938,914	23,473	40	23,473		232,289
34	Kitchen Wall Boards	2000		1,365		5			1,365
35	Parking Lot Improvements	2000		52,250	3,483	30	1,742	(1,741)	15,678
36	Purchasing Department Ceiling Light Fixtures	2000		1,967	197	10	197		1,773

\*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 #REF!

Facility Name &amp; ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/08

Ending:

04/30/09

## 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		1,050	39
40	<u>Door</u>	2001	1,125	75	15	75		563	40
41	<u>Carpeting</u>	2003	5,732		5			5,732	41
42	<u>Carpeting</u>	2003	1,855		5	185	185	2,040	42
43	<u>Wiring for therapy rooms</u>	2003	4,431	443	10	443		2,880	43
44	<u>HVAC upgrade and testing</u>	2003	52,902	3,527	15	3,527		22,926	44
45	<u>Fire sprinklers</u>	2003	12,149	607	20	607		3,946	45
46	<u>HVAC upgrade and testing</u>	2003	51,875	4,589	10	5,188	599	36,328	46
47	<u>Light fixtures and wiring for cafeteria</u>	2004	3,967	397	10	397		2,183	47
48	<u>Wallpaper</u>	2004	6,868	687	5	1,374	687	7,557	48
49	<u>Vent pipe</u>	2004	1,068	107	5	105	(2)	1,068	49
50	<u>Vinyl base</u>	2004	900	90	5	90		900	50
51	<u>HVAC upgrade and testing</u>	2004	8,909		15	594	594	3,267	51
52	<u>Door holder</u>	2004	1,046	71	15	70	(1)	385	52
53	<u>Circuit breaker</u>	2004	2,250		15	150	150	825	53
54	<u>Door plate</u>	2004	2,053		15	137	137	753	54
55	<u>Sewer line and trap</u>	2004	2,940		15	196	196	1,080	55
56	<u>Drapes</u>	2005	5,817	1,162	5	1,163	1	5,235	56
57	<u>Carpeting</u>	2005	11,175	2,235	5	2,235		10,056	57
58	<u>Carpeting</u>	2005	9,400	940	10	940		4,230	58
59	<u>Light fixtures and wiring</u>	2005	8,667	867	10	867		3,900	59
60	<u>Sign for dining room</u>	2005	2,039	204	10	204		918	60
61	<u>Fire system</u>	2005	12,230	815	15	815		3,261	61
62	<u>Sewer line</u>	2005	2,950	118	25	118		531	62
63									63
64	<u>Fire Doors - 4</u>	2006	5,670	378	15	378		1,323	64
65	<u>Dining room doors/closures</u>	2006	1,785	119	15	119		417	65
66	<u>Cement sidewalk ramp</u>	2006	1,950	130	15	130		455	66
67	<u>Exit lights - 4</u>	2006	3,600	240	15	240		840	67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,321,173	\$ 153,209		\$ 154,689	\$ 1,480	\$ 3,016,856	70

#REF!

\*\*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:

05/01/08

Ending:

04/30/09

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,321,173	\$ 153,209		\$ 154,689	\$ 1,480	\$ 3,016,856	1
2	Upgrade firedoors per IDPH specification	2006	6,020	401	15	401	0	1,403	2
3	Sprinkler installation in attic	2006	4,414	294	15	294	0	1,029	3
4	Generator - 150 amp circuit breaker	2006	1,103	55	20	55	0	193	4
5	Installation of handrails	2006	6,400	320	20	320		1,120	5
6	Sprinkler system air compressor	2007	3,020	302	10	302		906	6
7	5 PTAC units & connections	2007	3,326	222	15	111	(111)	333	7
8	Roof shingles	2007	92,083	6,139	15	3,069	(3,070)	9,206	8
9	14 Smoke detectors and bases	2007	1,036	69	15	35	(34)	105	9
10									10
11	Wallpaper for resident rooms	2007	7,146	1,429	5	1,430	1	2,145	11
12	Repair dry pipe sprinkler system	2007	3,905	260	15	260		390	12
13	Hot Water Boiler	2008	17,742	1,183	15	1,182	(1)	1,773	13
14	PTAC Zoneline Heater/Air Conditioners for Resident Rooms	2008	26,069	2,607	10	2,606	(1)	3,909	14
15									15
16	Replace 3, 4 & 6" Sprinkler Main	2008	59,719	1,991	15	1,991		1,991	16
17	Ductwork-Sprinkler System Install	2008	2,952	98	15	98		98	17
18	Carrier-5 Ton A/C Condensing Unit	2008	3,310	166	10	166		166	18
19	Replace Nurse Station Cabinets	2009	4,484	149	15	149		149	19
20	Shower Rehab-plumbing, tile, hardware	2009	44,000	1,467	15	1,467		1,467	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,607,902	\$ 170,361		\$ 168,625	\$ (1,736)	\$ 3,043,239	34

#REF!

\*\*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:

05/01/08

Ending:

04/30/09

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	\$ 707,911	\$ 28,364	\$ 71,279	\$ 42,915	5-20	\$ 525,817	71
72	Current Year Purchases	47,821	3,486	3,486	(0)	5-10	3,486	72
73	Fully Depreciated Assets	687,935					687,935	73
74	Allocated from Sherman Health Systems			77,725	77,725			74
75	TOTALS	\$ 1,443,667	\$ 31,850	\$ 152,490	\$ 120,640		\$ 1,217,238	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)	\$ 7,555,748	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,211	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,115	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 118,904	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,260,477	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.

#REF!

**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: \$ 36,245 Description: \$22,471-Copiers, \$596-Postage Meter, \$360-Water Softener, \$450-Knife & Sharpening, \$12,368-Therapy Equi

(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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	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		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		19,702	1,407,153		19,702	1,407,153	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				713,615		713,615	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)					74,833		74,833	13
14	TOTAL			\$	19,702	\$ 1,407,153	\$ 788,448	19,702	\$ 2,195,601	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.

#REF!

Sherman West Court  
Facility #0037507  
4/30/2009

Schedule 16A

XIV. Special Services  
Line 13 Other (specify):

Service	Line Ref	Outside Units	Practitioner Cost	Supplies
Specialized Beds & Equipment	39(2)			30,307
Oxygen	39(2)			44,526
				<u>74,833</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court# 0037507Report Period Beginning: 05/01/08

Ending:

04/30/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 04/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 631,671	\$ 631,671	1
2	Cash-Patient Deposits	245	245	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(214,500)</u> )	1,465,894	1,465,894	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,683	73,683	6
7	Other Prepaid Expenses	9,648	9,648	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,181,141	\$ 2,181,141	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	194,592	194,592	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	2,179,547	3,121,042	15
16	Equipment, at Historical Cost	1,446,252	1,443,667	16
17	Accumulated Depreciation (book methods)	(4,205,415)	(4,260,477)	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>	71,854	71,854	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,616,778	\$ 3,561,717	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,797,919	\$ 5,742,858	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 313,840	\$ 313,840	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	245	245	28
29	Short-Term Notes Payable	166,646	166,646	29
30	Accrued Salaries Payable	380,885	380,885	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	69,536	69,536	33
34	Deferred Compensation	222,601	222,601	34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37	<u>See Schedule 17A</u>	161,047	161,047	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,314,800	\$ 1,314,800	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,943,415	4,943,415	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Accrued Liability-Malpractice</u>	313,447	313,447	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,256,862	\$ 5,256,862	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,571,662	\$ 6,571,662	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (773,743)	\$ (828,804)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,797,919	\$ 5,742,858	48

#REF!

\*(See instructions.)

Sherman West Court  
Facility #0037507  
4/30/2009

Schedule 17A

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

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
A/R - Medicare Settlements	72,757	72,757
Liability due to Blue Cross	22,507	22,507
Accrued Liability - Nursing Home Provi	4,567	4,567
Accrued Liability - Workmen's Comp	13,377	13,377
Accrued Liability - Health & Dental	24,889	24,889
Accrued Liability - Long Term Disability	898	898
Accrued Liability - Other	1,222	1,222
Accrued Liability - Other	20,830	20,830
	<u>161,047</u>	<u>161,047</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,325,851)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Audit Adjustments</b>	<b>936,910</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(388,941)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(384,802)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(384,802)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(773,743)</b>	<b>24</b> *

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

#REF!

Facility Name &amp; ID Number Sherman West Court

# 0037507

Report Period Beginning: 05/01/08

Ending: 04/30/09

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,722,642	1
2	Discounts and Allowances for all Levels	(3,616,343)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,106,299	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	153,324	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 153,324	8
<b>C. Other Operating Revenue</b>			
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	4,728	13
14	Non-Patient Meals	2,941	14
15	Telephone, Television and Radio	5,941	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	280,027	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 293,637	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	165	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 165	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Schedule 19A	4,818	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,818	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,558,243	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	631,482	31
32	Health Care	3,833,443	32
33	General Administration	3,945,988	33
<b>B. Capital Expense</b>			
34	Ownership	521,844	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	944,588	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,943,045	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(384,802)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (384,802)	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. #REF!

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

Sherman West Court  
Facility #0037507  
4/30/2009

Schedule 19A

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

<u>Description</u>	<u>Operating</u>
Miscellaneous Income	1,207
Other Inc-Code Alert Security System	1,275
Other Inc-Wheelchair Revenue	2,145
Activities & Outings Income	191
	<u>4,818</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court

# 0037507

Report Period Beginning:

05/01/08

Ending:

04/30/09

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	2,150	2,181	\$ 142,407	\$ 65.29	1
2	Assistant Director of Nursing	1,986	2,206	79,518	36.05	2
3	Registered Nurses	34,628	35,256	1,117,954	31.71	3
4	Licensed Practical Nurses	6,290	6,893	126,420	18.34	4
5	CNAs & Orderlies	51,075	54,490	655,336	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,958	2,086	41,555	19.92	9
10	Activity Assistants	3,970	4,163	50,949	12.24	10
11	Social Service Workers	3,157	3,398	89,000	26.19	11
12	Dietician	1,512	1,662	39,358	23.68	12
13	Food Service Supervisor	2,015	2,083	42,743	20.52	13
14	Head Cook	6,651	6,851	95,724	13.97	14
15	Cook Helpers/Assistants	10,750	11,402	100,362	8.80	15
16	Dishwashers					16
17	Maintenance Workers	3,984	4,239	110,443	26.05	17
18	Housekeepers	12,698	13,841	113,966	8.23	18
19	Laundry	4,043	4,371	37,736	8.63	19
20	Administrator	1,997	2,086	97,183	46.59	20
21	Assistant Administrator	2,007	2,086	70,059	33.59	21
22	Other Administrative	12,100	13,398	168,787	12.60	22
23	Office Manager	1,900	2,086	73,311	35.14	23
24	Clerical	8,938	8,938	95,812	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	2,325	2,533	37,849	14.94	31
32	Other Health C: See Sch 20A	8,840	9,543	170,677	17.89	32
33	Other(specify) <u>Admissions Coord</u>	3,750	4,176	107,353	25.71	33
34	TOTAL (lines 1 - 33)	188,724	199,968	\$ 3,664,502 *	\$ 18.33	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	97	\$ 6,009	L1 C3	35
36	Medical Director	120	33,600	L9 C3	36
37	Medical Records Consultant	16	1,080	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	204	13,248	L10 C3	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	5,950	L11 C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	453	\$ 59,887		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,912	\$ 441,651	L10 C3	50
51	Licensed Practical Nurses	1,698	63,673	L10 C3	51
52	Certified Nurse Assistants/Aides	9,599	65,196	L10 C3	52
53	TOTAL (lines 50 - 52)	18,209	\$ 570,520		53

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Sherman West Court  
IDPH Facility ID # 0037507  
4/30/2009

Schedule 20A

Schedule XVIII  
**Line 32, Other**

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	2,050	2,283	81,013	35.49
Unit Clerk	3,847	4,121	52,568	12.76
Resident Assistants	2,943	3,139	37,096	11.82
Total	<b>8,840</b>	<b>9,543</b>	<b>170,677</b>	<b>17.89</b>

**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	\$ 97,183	Workers' Compensation Insurance	\$ 83,946	IDPH License Fee	\$ 16,995	
Angela Lackowski	Asst Administrator	0	70,059	Unemployment Compensation Insurance	22,149	Advertising: Employee Recruitment		
				FICA Taxes	272,939	Health Care Worker Background Check		
				Employee Health Insurance	161,695	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	319 7,975	
				Illinois Municipal Retirement Fund (IMRF)*		Life Service Netowrk of IL	5,547	
				LT Disability	2,261	JCAHO	1,655	
				Employee Recognition	2,799	Miscellaneous Dues	1,951	
				Other Employee Benefits	13,576	Miscellaneous Subscriptions	4,957	
				Pension Contributions	48,228	Less: Disallow IDPH Survey Fine	(16,000)	
				Employee Dental Benefits	6,787	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 167,242				\$ 614,380			\$ 23,080	
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)	\$ 308,947			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)				TOTAL			Seminar Expense	
\$ 308,947				\$			5,382	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type	Amount					( )	
Duane Morris, LLP	Legal	\$ 128,730					TOTAL (agree to Sch. V, line 24, col. 8)	
Accumed Services	Data Processing	7,940					\$ 5,382	
IVAN's	Data Processing	1,507						
McKesson Medical	Data Processing	450						
Neopost	Data Processing	180						
Cbord Group Inc	Data Processing	1,500						
McGladrey & Pullen, LLP	Accounting	7,390						
Schelflow & Rydell	Collection	1,103						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 148,800								

\* Attach copy of IMRF notifications

\*\*See instructions.

Sherman West Court

Facility #0037507

4/30/2009

Schedule 21A

**Schedule XIX(C) Professional Services**

Total (from Page 21C) agrees to Schedule V, Line 19, Column 3	148,800
Add: Sherman Hospital Medicare Billing	19,302
Less: Non-allowable legal	(7,409)
Less: Non-allowable collection fees	<u>(1,103)</u>
Total (agrees to Schedule V, Line 19, Column 8)	159,590

**Schedule XIX(G) Travel and Seminar**

Total agrees to Schedule V, Line 24, Column 3	5,447
Less: Disallow Travel & Seminar	<u>(65)</u>
Total (agrees to Schedule V, Line 24, Column 8)	5,382

**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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

#REF!

Facility Name & ID Number Sherman West Court# 0037507Report Period Beginning: 05/01/08Ending: 04/30/09**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 Service Network of Illinois-\$5,547
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,406 Line L10 C2
- (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. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,941
- (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
- (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.

#REF!