



Facility Name & ID Number SHERWIN MANOR NURSING CENTER

# 0046102 Report Period Beginning: 01/01/04 Ending: 12/31/04

**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 \_\_\_\_\_

	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	219	Skilled (SNF)	219	80,154	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	219	TOTALS	219	80,154	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF			4,227	4,227	8
9	SNF/PED					9
10	ICF	27,219	2,070		29,289	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,219	2,070	4,227	33,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.81%

D. How many bed-hold days during this year were paid by Public Aid? \_\_\_\_\_ (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 05/01/79

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/79 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 31 and days of care provided 4,227

Medicare Intermediary ADMINISTAR

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/04 Fiscal Year: 12/31/04

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

## STATE OF ILLINOIS

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Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/04 Ending: 12/31/04**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	321,999	20,632	12,809	355,440		355,440		355,440		1
2	Food Purchase		286,783		286,783		286,783	(455)	286,328		2
3	Housekeeping	124,414	48,477		172,891		172,891		172,891		3
4	Laundry	101,285	18,314	8,519	128,118		128,118		128,118		4
5	Heat and Other Utilities			174,875	174,875		174,875		174,875		5
6	Maintenance		31,889	82,898	114,787		114,787	(8,333)	106,454		6
7	Other (specify):* Security	51,092			51,092		51,092		51,092		7
8	<b>TOTAL General Services</b>	598,790	406,095	279,101	1,283,986		1,283,986	(8,788)	1,275,198		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,123,070	108,028	20,107	1,251,205		1,251,205		1,251,205		10
10a	Therapy	75,325			75,325		75,325		75,325		10a
11	Activities	58,486	11,962	1,069	71,517		71,517		71,517		11
12	Social Services	20,568			20,568		20,568		20,568		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,277,449	119,990	31,976	1,429,415		1,429,415		1,429,415		16
	<b>C. General Administration</b>										
17	Administrative	573,464			573,464		573,464		573,464		17
18	Directors Fees										18
19	Professional Services			191,217	191,217		191,217		191,217		19
20	Dues, Fees, Subscriptions & Promotions			82,568	82,568		82,568	(32,600)	49,968		20
21	Clerical & General Office Expenses	381,919	55,154	36,045	473,118		473,118		473,118		21
22	Employee Benefits & Payroll Taxes			545,367	545,367		545,367		545,367		22
23	Inservice Training & Education			2,515	2,515		2,515		2,515		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			30,114	30,114		30,114		30,114		25
26	Insurance-Prop.Liab.Malpractice			213,796	213,796		213,796	(7,950)	205,846		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	955,383	55,154	1,101,622	2,112,159		2,112,159	(40,550)	2,071,609		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,831,622	581,239	1,412,699	4,825,560		4,825,560	(49,338)	4,776,222		29

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

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER #0046102 Report Period Beginning: 01/01/04 Ending: 12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation						159,947	159,947				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,338	9,338		9,338	172,954	182,292			32
33	Real Estate Taxes			211,750	211,750		211,750	211,750	211,750			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(361,520)	(1,520)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>STORAGE</b>			7,200	7,200		7,200		7,200			36
37	<b>TOTAL Ownership</b>			588,288	588,288		588,288	(28,619)	559,669			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			254	254		254		254			40
41	Coffee and Gift Shops			1,720	1,720		1,720		1,720			41
42	Provider Participation Fee			120,232	120,232		120,232		120,232			42
43	Other (specify):* <b>RENTAL</b>			3,200	3,200		3,200		3,200			43
44	<b>TOTAL Special Cost Centers</b>			125,406	125,406		125,406		125,406			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,831,622	581,239	2,126,393	5,539,254		5,539,254	(77,957)	5,461,297			45

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

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER**

# **0046102**

Report Period Beginning: **01/01/04**

Ending: **12/31/04**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,910	30		9
10	Interest and Other Investment Income	(662)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(455)	2		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	(9,207)	20		18
19	Entertainment				19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance	(7,950)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,812)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,582)	20		28
29	Other-Attach Schedule <b>PARKING</b>	(3,852)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,610)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(32,347)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (32,347)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (77,957)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SHERWIN MANOR NURSING CENTER

ID# 0046102

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	PARKING	\$ (1,520)	34	1
2	DEFERRED MAINTENANCE - CURRENT	(8,333)	6	2
3	DEFERRED MAINTENANCE - PRIOR YEARS	6,001	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,852)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SHERWIN MANOR NURSING CENTER

# 0046102 Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(455)	0	0	0	0	0	0	0	0	0	0	(455)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,333)	0	0	0	0	0	0	0	0	0	0	(8,333)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,788)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,788)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(32,600)	0	0	0	0	0	0	0	0	0	0	(32,600)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(7,950)	0	0	0	0	0	0	0	0	0	0	(7,950)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(40,550)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,550)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(49,338)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(49,338)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0046102

Report Period Beginning:

01/01/04

Ending:

12/31/04

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	5,910	154,037	0	0	0	0	0	0	0	0	0	159,947 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(662)	173,616	0	0	0	0	0	0	0	0	0	172,954 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(1,520)	(360,000)	0	0	0	0	0	0	0	0	0	(361,520) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>3,728</b>	<b>(32,347)</b>	<b>0</b>	<b>(28,619) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(45,610)</b>	<b>(32,347)</b>	<b>0</b>	<b>(77,957) 45</b>								

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER**

# **0046102**

Report Period Beginning:

01/01/04

Ending:

12/31/04

**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
SEE ATTACHED SCHEDULE						

**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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 RENT	\$ 360,000	SHERWIN MANOR REALTY, LLC		\$	\$(360,000)
2	V	30 DEPRECIATION				154,037	154,037
3	V	32 INTEREST				173,616	173,616
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 360,000			\$ 327,653	\$ * (32,347)

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

Facility Name & ID Number      SHERWIN MANOR NURSING CENTER      #      0046102      Report Period Beginning:      01/01/04      Ending:      12/31/04

## 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	JOSEPH OSINA	ADMINISTRATOR		27.35		40		SALARY	\$ 241,164	L17&C1	1
2	ABE OSINA	ASST. ADMIN.		28.68		73		SALARY	330,369	L17&C1	2
3	ROSANNE OSINA	FOOD SERV. SUP.				40		SALARY	63,540	L1&C1	3
4	SARAH OSINA	PURCHASING		1.33		40		SALARY	96,236	L21&C1	4
5	DEVORA OSINA	CLERICAL		4.00		45		SALARY	34,918	L21&C1	5
6	DEVORAH OSINA	DIETARY		4.00		5		SALARY	3,476	L1&C1	6
7	MORDECHAI OSINA	MAINTENANCE		4.00		40		SALARY	23,279	L6&C1	7
8	HANNA OSINA	CLERICAL		1.33		15		SALARY	6,622	L21&C1	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 799,604		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/04 Ending: 12/31/04

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

**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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1						\$	\$			\$	1									
2	BANK LEUMI	X	MORTGAGE	\$24,458.00	01/02	3,065,000	2,818,138	01/07	7.2700	173,616	2									
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6	BANK LEUMI	X					940,000			9,338	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>			\$24,458.00		\$ 3,065,000	\$ 3,758,138			\$ 182,954	9									
	<b>B. Non-Facility Related*</b>																			
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 3,065,000	\$ 3,758,138			\$ 182,954	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.    \$ \_\_\_\_\_    Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER**# **0046102** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2003 report.			\$	251,261	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.)			\$	237,816	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	(13,445)	3																			
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	225,195	4																			
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5																			
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	211,750	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1999	266,487	8	<table border="1"> <tr> <td colspan="3"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2003	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR OHF USE ONLY</b>																									
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2000	252,190	9																					
		2001	254,092	10																					
		2002	256,941	11																					
		2003	237,816	12																					

**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:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 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 Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SHERWIN MANOR NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046102

CONTACT PERSON REGARDING THIS REPORT EFFIE GALETZIS

TELEPHONE (630) 924-9800 FAX #: (630)-351-2466

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

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-314-028-0000</u>	<u>NURSING HOME</u>	\$ <u>111,452.56</u>	\$ <u>111,452.56</u>
2. <u>11-29-314-029-0000</u>	<u>NURSING HOME</u>	\$ <u>110,978.14</u>	\$ <u>110,978.14</u>
3. <u>11-29-314-027-0000</u>	<u>NURSING HOME</u>	\$ <u>7,044.01</u>	\$ <u>7,044.01</u>
4. <u>11-29-314-026-0000</u>	<u>NURSING HOME</u>	\$ <u>8,341.41</u>	\$ <u>8,341.41</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>237,816.12</u>	\$ <u>237,816.12</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 67,334 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facilities	47,313		\$ 123,000	1
2					2
3	TOTALS	47,313		\$ 123,000	3

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0046102

Report Period Beginning:

01/01/04

Ending:

12/31/04**XL 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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	219		1979	1979	\$ 2,919,751	\$ 88,477	33	\$ 88,477	\$	\$ 2,263,450	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LEASEHOLD IMPROVEMENTS		1984	9,000		15			9,000	9
10		LEASEHOLD IMPROVEMENTS		1991	28,119	893	31.5	893		12,094	10
11		LEASEHOLD IMPROVEMENTS		1992	23,487	746	31.5	746		9,076	11
12		LEASEHOLD IMPROVEMENTS		1993	11,285	358	31.5	358		4,208	12
13		LEASEHOLD IMPROVEMENTS		1993	5,825	149	39	149		1,711	13
14		LEASEHOLD IMPROVEMENTS		1994	34,686	890	39	889	(1)	9,077	14
15		ELECTRIC OUTLETS		1995	843	22	39	22		227	15
16		WHEELCHAIR RAMP		1995	4,800	123	39	123		1,222	16
17		VARIOUS ELECTRICAL WORK		1995	19,870	509	39	509		4,851	17
18		REPLACE STACK, VENT, CAST IRON DRAIN		1996	2,202	56	39	56		493	18
19		INSTALL NEW TOWER MOTOR, RAIN SHIELD, HEATER		1996	1,675	43	39	43		378	19
20		INSTALL CEILING FAN, NEW FIXTURE IN BATHROOM		1996	1,008	26	39	26		229	20
21		CONNECT GAS FOR KITCHEN COOKING EQUIPMENT		1996	1,200	31	39	31		272	21
22		INSTALL FLUORESCENT FIXTURES IN RESIDENT ROOMS		1996	56,385	1,446	39	1,446		12,734	22
23		REMODELING		1997	112,292	2,879	39	2,879		21,475	23
24		REPLACEMENT HOT WATER HEATERS		1998	25,065	643	39	643		4,153	24
25		FURNISH & INSTALL NEW FIRE SMOKE DUMPERS		1998	7,234	185	39	185		1,195	25
26		NEW SHOWER VALVE, SOIL PIPE		1998	1,739	45	39	45		290	26
27		REPAIR AIR CONDITIONING		1998	11,080	284	39	284		1,835	27
28		INSTALL NEW RECESSED CANS, FIXTURES ILLUMINATING EXT		1998	7,249	186	39	186		1,201	28
29		REPLACEMENT COOLING TOWER		1999	25,622	657	39	657		3,587	29
30		ELECTRICAL WORK FRONT OF BUILDING, OFFICE AREA		1999	17,362	445	39	445		2,429	30
31		CORRIDOR SYSTEM		1999	3,311	85	39	85		464	31
32		WATER COOLER		1999	2,414	62	39	62		338	32
33		LAUNDRY DOMESTIC HOT WATER HEATER		2000	11,789	302	39	302		1,347	33
34		INSTALL NEW FENCE		2000	7,840	201	15	523	322	2,293	34
35		FLUORESCENT LIGHTING		2000	13,041	335	39	335		1,494	35
36		INSTALLED SMOKERS EXHAUST SYSTEM		2000	6,748	173	39	173		771	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

STATE OF ILLINOIS

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

# 0046102

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	ELECTRIC WORK	2001	\$ 86,952	\$ 2,229	39	\$ 2,229	\$	\$ 7,144	37
38	SWITCH GEAR FOR AIR CONDITIONING	2002	10,000	364	27.5	364		895	38
39	VARIOUS ELECTRICAL WORK	2002	71,684	2,607	27.5	2,607		6,409	39
40	WATER HEATER, CHILLER VALAVES, RE-KEY ALL LOCKS	2002	8,928	324	27.5	324		797	40
41	PLUMBING & HEATING	2003	4,822	381	27.5	164	(217)	463	41
42	RETUBE BOILER	2003	11,242	400	27.5	376	(24)	588	42
43	FIRE ALARM SYSTEM	2003	19,953	700	27.5	666	(34)	1,033	43
44	AIR CONDITION SYSTEM	2003	55,100	1,832	27.5	1,832		2,748	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,641,603	\$ 109,088		\$ 109,134	\$ 46	\$ 2,391,971	70

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

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	\$ 408,813	\$ 39,674	\$ 49,934	\$ 10,260	10 YS	\$ 293,833	71
72	Current Year Purchases	8,791	5,275	879	(4,396)	5 YRS	5,275	72
73	Fully Depreciated Assets	611,980					611,980	73
74								74
75	TOTALS	\$ 1,029,584	\$ 44,949	\$ 50,813	\$ 5,864		\$ 911,088	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,794,187	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,037	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,947	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,910	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,303,059	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A - RELATED PARTY  
 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	Storage				3,200			5
6								6
7	TOTAL				\$ 3,200			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ N/A Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits		N/A			#VALUE!		6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$	#VALUE!	\$	14

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

STATE OF ILLINOIS

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER** # **0046102** Report Period Beginning: **01/01/04** Ending: **12/31/04**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/04** (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 137,031	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,592,285	3
4	Supply Inventory (priced at )	1,609,608	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	93,859	7
8	Accounts Receivable (owners or related parties)	188,727	8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,874,871	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	123,000	13
14	Buildings, at Historical Cost	2,919,751	14
15	Leasehold Improvements, at Historical Cost	721,852	15
16	Equipment, at Historical Cost	1,181,970	16
17	Accumulated Depreciation (book methods)	(3,434,404)	17
18	Deferred Charges	31,990	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): <b>AMORT DEFF LOAN COSTS</b>	(19,202)	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,524,957	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,874,871	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 301,659	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	940,000	29
30	Accrued Salaries Payable	43,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,586	31
32	Accrued Real Estate Taxes(Sch.IX-B)	225,195	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	<b>Accrued expenses</b>	967,156	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,511,734	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,818,138	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,818,138	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,490,147	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (636,863)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,874,871	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (296,554)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>	\$ (296,554)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(340,309)	<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>	\$ (340,309)	<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>	\$ (636,863)	<b>24</b> *

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

# 0046102

Report Period Beginning: 01/01/04

Ending:

12/31/04

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,192,855	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,192,855	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,160	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,160	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	662	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 662	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		1,748	28
28a	Parking	1,520	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,268	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,198,945	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,283,986	31
32	Health Care	1,429,415	32
33	General Administration	2,112,159	33
<b>B. Capital Expense</b>			
34	Ownership	588,288	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,174	35
36	Provider Participation Fee	120,232	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,539,254	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(340,309)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (340,309)	43

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

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

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

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

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER**

# **0046102**

Report Period Beginning: **01/01/04**

Ending:

**12/31/04**

**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	2,003	2,091	\$ 68,925	\$ 32.96	1
2	Assistant Director of Nursing	1,430	1,663	49,845	29.97	2
3	Registered Nurses	5,803	6,143	153,867	25.05	3
4	Licensed Practical Nurses	17,753	19,353	403,561	20.85	4
5	Nurse Aides & Orderlies	50,153	51,534	446,872	8.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,932	3,195	75,325	23.58	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,845	1,845	37,690	20.43	9
10	Activity Assistants	2,672	2,707	20,796	7.68	10
11	Social Service Workers	1,751	1,976	20,568	10.41	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,091	72,230	34.54	13
14	Head Cook	1,951	2,168	31,818	14.68	14
15	Cook Helpers/Assistants	21,690	23,449	217,951	9.29	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,026	14,188	124,414	8.77	18
19	Laundry	8,552	9,091	101,285	11.14	19
20	Administrator	2,091	2,091	243,823	116.61	20
21	Assistant Administrator	2,091	2,091	329,641	157.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,076	26,418	381,919	14.46	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	4,023	5,056	51,092	10.11	33
34	TOTAL (lines 1 - 33)	166,933	177,150	\$ 2,831,622 *	\$ 15.98	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	132	\$ 9,465	L1&C3	35
36	Medical Director	48	10,800	L9&C3	36
37	Medical Records Consultant	96	3,784	L10&C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,051	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	18	1,069	L11&C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	414	\$ 26,169		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	112	\$ 6,408	L10&C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	96	3,157	L10&C3	52
53	TOTAL (lines 50 - 52)	208	\$ 9,565		53



**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	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATING	1999	\$ 8,000	3 YRS	\$ 2,667	\$ 1,333	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	2000	10,000	3 YRS	3,333	3,333	1,667					
3	PAINTING/DECORATING	2001	5,000	3 YRS	835	1,665	1,665	835				
4	PAINTING/DECORATING	2002	11,500	3 YRS		1,917	3,833	3,833	1,917			
5	PAINTING/DECORATING	2003	4,000	3 YRS			667	1,333	1,333	667		
6	PAINTING/DECORATING	2004	10,000	3 YRS			1,667	3,333	3,333	1,667		
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>		\$ 48,500		\$ 6,835	\$ 8,248	\$ 7,832	\$ 7,668	\$ 6,583	\$ 4,000	\$ 1,667	\$

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM \$7776
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line \_\_\_\_\_
- (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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 120,232  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

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
Sherwin Manor Holdings	100%	Sherwin Manor Nursing Center, LLC	Chicago			
Abe Osina	28.66%			Sherwin Manor Holdings	Chicago	
Joseph Osina	27.33%			Sherwin Manor Holdings	Chicago	
Pesach Osina Revocable Trust	4.00%			Sherwin Manor Holdings	Chicago	
Devora Osina Gift Trust	4.00%			Sherwin Manor Holdings	Chicago	
Shaindel Osina Gift Trust	4.00%			Sherwin Manor Holdings	Chicago	
Mordecai Osina Gift Trust	4.00%			Sherwin Manor Holdings	Chicago	
Eliczer Moshe Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Hannah Miriam Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Rshke Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Chaim Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Yehuda Leib Osina Gift Trust	4.00%			Sherwin Manor Holdings	Chicago	
Devorah Osina Gift Trust	4.00%			Sherwin Manor Holdings	Chicago	
Chaya Rivka Osina Revocable Trust	4.00%			Sherwin Manor Holdings	Chicago	
Hinda Rachel Osina Revocable Trust	4.00%			Sherwin Manor Holdings	Chicago	
Sarah Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Chaim Yaacov Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Raphael Pesach Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Hannah Miriam Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	
Meir Osina Gift Trust	1.33%			Sherwin Manor Holdings	Chicago	

## STATE OF ILLINOIS

Facility Name &amp; ID Number

SHERWIN MANOR NURSING CENTER

# 0046102

Report Period Beginning:

01/01/04

Ending: 12/31/04

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## Detailed schedule of training and education

Date	Amount	Description	Employees attending
2/4/2005	\$ 300.00	Subpart S rules	Abe Osina, Roseanne Osina, Jill Peelo, Joseph Osina
4/4/2005	\$ 370.00	LTC Documentation	Abe Osina, Jill Peelo
4/4/2005	\$ 1,050.00	Alzheimers Rules	Abe Osina, Jill Peelo
10/4/2005	\$ 390.00	OIG Updates	Abe Osina, Jill Peelo
11/4/2005	\$ 380.00	Survey Preperation	Abe Osina, Roseanne Osina, Jill Peelo, Joseph Osina
12/4/2005	\$ 85.00	Food Servcie	Roseanne Osina