

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0046102</u></p> <p>Facility Name: <u>SHERWIN MANOR NURSING CENTER</u></p> <p>Address: <u>7350 NORTH SHERIDAN ROAD</u> <u>CHICAGO</u> <u>60626</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 274-1000</u> Fax # <u>(773) 274-2353</u></p> <p>HFS ID Number: <u>36-3090453</u></p> <p>Date of Initial License for Current Owners: <u>05/01/79</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>EFFIE GALETSIS</u> Telephone Number: <u>(630) 924-9800</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>JOSEPH OSINA</u></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>EFFIE GALETSIS, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>GALETSIS & ASSOCIATES, INC.</u> <u>124 WEST LAKE STREET, BLOOMINGDALE, IL. 60108</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 924-9800</u> Fax # <u>(630) 351-2466</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>JOSEPH OSINA</u>		(Title) <u>ADMINISTRATOR</u>		(Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) <u>EFFIE GALETSIS, C.P.A.</u>		(Firm Name & Address) <u>GALETSIS & ASSOCIATES, INC.</u> <u>124 WEST LAKE STREET, BLOOMINGDALE, IL. 60108</u>		(Telephone) <u>(630) 924-9800</u> Fax # <u>(630) 351-2466</u>
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Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	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	79,935	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	79,935	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 Medicaid Recipient	4 Private Pay	Other		
8	SNF			2,314	2,314	8
9	SNF/PED					9
10	ICF	27,947	1,566		29,513	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,947	1,566	2,314	31,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.82%

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 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 _____ and days of care provided _____

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER** # **0046102** Report Period Beginning: **01/01/06** Ending: **12/31/06**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	306,931	34,215	9,108	350,254		350,254		350,254		1
2	Food Purchase		285,001		285,001		285,001	(6,381)	278,620		2
3	Housekeeping	132,759	46,528		179,287		179,287		179,287		3
4	Laundry	88,615	16,491	2,442	107,548		107,548		107,548		4
5	Heat and Other Utilities			210,215	210,215		210,215		210,215		5
6	Maintenance		108,434	21,938	130,372		130,372	6,125	136,497		6
7	Other (specify):* Security	49,284			49,284		49,284		49,284		7
8	TOTAL General Services	577,589	490,669	243,703	1,311,961		1,311,961	(256)	1,311,705		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,000,938	87,403	33,680	1,122,021		1,122,021		1,122,021		10
10a	Therapy	73,775			73,775		73,775		73,775		10a
11	Activities	8,557	12,367		20,924		20,924		20,924		11
12	Social Services	2,884			2,884		2,884		2,884		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,086,154	99,770	44,480	1,230,404		1,230,404		1,230,404		16
	C. General Administration										
17	Administrative	393,798			393,798		393,798	(154,198)	239,600		17
18	Directors Fees										18
19	Professional Services			73,999	73,999		73,999		73,999		19
20	Dues, Fees, Subscriptions & Promotions			75,760	75,760		75,760	(44,695)	31,065		20
21	Clerical & General Office Expenses	381,320		106,202	487,522		487,522	(396)	487,126		21
22	Employee Benefits & Payroll Taxes			587,357	587,357		587,357	(1,932)	585,425		22
23	Inservice Training & Education			4,444	4,444		4,444		4,444		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			65,294	65,294		65,294		65,294		25
26	Insurance-Prop.Liab.Malpractice			199,886	199,886		199,886	(10,582)	189,304		26
27	Other (specify):*										27
28	TOTAL General Administration	775,118		1,112,942	1,888,060		1,888,060	(211,803)	1,676,257		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,438,861	590,439	1,401,125	4,430,425		4,430,425	(212,059)	4,218,366		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: 01/01/06 Ending: 12/31/06

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
	D. Ownership										
30	Depreciation						126,781	126,781			30
31	Amortization of Pre-Op. & Org.						6,390	6,390			31
32	Interest			307,353	307,353		307,102	614,455			32
33	Real Estate Taxes			239,791	239,791		239,791	239,791			33
34	Rent-Facility & Grounds			369,600	369,600		369,600	(362,780)	6,820		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			916,744	916,744		916,744	77,493	994,237		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			119,903	119,903		119,903	119,903			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			119,903	119,903		119,903	119,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,438,861	590,439	2,437,772	5,467,072		5,467,072	(134,566)	5,332,506		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: **01/01/06**

Ending: **12/31/06**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,725)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,825)	20		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(171)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,656)	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	(1,932)	22		18
19	Entertainment				19
20	Contributions	(2,250)	20		20
21	Owner or Key-Man Insurance	(10,582)	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	(23,695)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,925)	20		28
29	Other-Attach Schedule See attached	(151,249)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,010)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	80,444		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 80,444		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (134,566)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SHERWIN MANOR NURSING CENTER

ID# 0046102

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Parking Income	\$ (2,780)	34	1
2	Barber and Beauty Income	(396)	21	2
3	Owners Compensation Cap	(154,198)	17	3
4	(see support for owners comp. Cap)			4
5	Deferred Maintenance - Prior Years	15,625	6	5
6	Deferred Maintenance - Current Year	(9,500)	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	Total	(151,249)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102 Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,381)	0	0	0	0	0	0	0	0	0	0	(6,381)	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	6,125	0	0	0	0	0	0	0	0	0	0	6,125	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(256)	0	0	0	0	0	0	0	0	0	0	(256)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(154,198)	0	0	0	0	0	0	0	0	0	0	(154,198)	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	(44,695)	0	0	0	0	0	0	0	0	0	0	(44,695)	20
21	Clerical & General Office Expenses	(396)	0	0	0	0	0	0	0	0	0	0	(396)	21
22	Employee Benefits & Payroll Taxes	(1,932)	0	0	0	0	0	0	0	0	0	0	(1,932)	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	(10,582)	0	0	0	0	0	0	0	0	0	0	(10,582)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(211,803)	0	0	0	0	0	0	0	0	0	0	(211,803)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(212,059)	0	0	0	0	0	0	0	0	0	0	(212,059)	29

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

0046102

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 OWNERSHIP 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		\$			\$	\$	1
2	V	34 RENT	360,000	SHERWIN MANOR REALTY LLC			(360,000)	2
3	V	30 DEPRECIATION				126,781	126,781	3
4	V	31 AMORTIZATION				6,390	6,390	4
5	V	32 INTEREST				307,273	307,273	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		\$ 360,000			\$ 440,444	\$ * 80,444	14

* 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: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOSEPH OSINA	ADMINISTRATOR		27.35		40		SALARY	\$ 128,713	L17 C1	1
2	ABE OSINA	ASST. ADMIN		28.68		73		SALARY	229,532	L17 C1	2
3	ROSEANNE OSINA	FOOD SER. SUPER		0.00		40		SALARY	22,274	L1 C1	3
4	SARAH OSINA	PURCHASING		1.33		40		SALARY	79,910	L21 C1	4
5	DEVORA OSINA	CLERICAL		4.00		45		SALARY	32,333	L21 C1	5
6	DEVORAH OSINA	DIETARY		4.00		5		SALARY	17,956	L1 C1	6
7	HANNA OSINA	CLERICAL		1.33		15		SALARY	55	L21 C1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 510,773		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: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 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	TOTALS				\$	\$		\$	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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	BANK LEUMI		X	MORTGAGE	\$25,606.00	01/06	\$ 4,400,000	\$ 4,400,000	01/11	7.0000	\$ 307,273	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	BANK LEUMI		X					1,806,968			307,273	6							
7												7							
8												8							
9	TOTAL Facility Related				\$25,606.00		\$ 4,400,000	\$ 6,206,968			\$ 614,546	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 4,400,000	\$ 6,206,968			\$ 614,546	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: **01/01/06** Ending: **12/31/06****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2005 report.				\$	243,099	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.)				\$	245,573	2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,474	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	237,317	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	239,791	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2001	254,092	8			
	2002	256,941	9			
	2003	237,816	10			
	2004	243,099	11			
	2005	245,573	12			
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERWIN MANOR NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046102

CONTACT PERSON REGARDING THIS REPORT EFFIE GALETSIS

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 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-314-028-0000</u>	<u>NURSING HOME</u>	\$ <u>115,088.00</u>	\$ _____
2. <u>11-29-314-029-0000</u>	<u>NURSING HOME</u>	\$ <u>114,598.00</u>	\$ _____
3. <u>11-29-314-027-0000</u>	<u>NURSING HOME</u>	\$ <u>7,274.00</u>	\$ _____
4. <u>11-29-314-026-0000</u>	<u>NURSING HOME</u>	\$ <u>8,613.00</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>245,573.00</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

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

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	1979	\$ 123,000	1
2					2
3	TOTALS	47,313		\$ 123,000	3

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0046102

Report Period Beginning:

01/01/06

Ending:

12/31/06**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 BHF 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	\$	\$ 2,440,404	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1984	9,000		15			9,000	9
10	LEASEHOLD IMPROVEMENTS		1991	28,119	893	31.5	893		13,880	10
11	LEASEHOLD IMPROVEMENTS		1992	23,487	746	31.5	746		10,568	11
12	LEASEHOLD IMPROVEMENTS		1993	11,285	358	31.5	358		4,924	12
13	LEASEHOLD IMPROVEMENTS		1993	5,825	149	39	149		2,009	13
14	LEASEHOLD IMPROVEMENTS		1994	34,686	890	39	890		10,856	14
15	ELECTRIC OUTLETS		1995	843	22	39	22		271	15
16	WHEELCHAIR RAMP		1995	4,800	123	39	123		1,468	16
17	VARIOUS ELECTRICAL WORK		1995	19,870	509	39	509		5,869	17
18	REPLACE STACK, VENT, CAST IRON DRAIN		1996	2,202	56	39	56		605	18
19	INSTALL NEW TOWER MOTOR, RAIN SHIELD, HEATER		1996	1,675	43	39	43		464	19
20	INSTALL CEILING FAN, NEW FIXTURE IN BATHROOM		1996	1,008	26	39	26		281	20
21	CONNECT GAS FOR KITCHEN COOKING EQUIPMENT		1996	1,200	31	39	31		334	21
22	INSTALL FLUORESCENT FIXTURES IN RESIDENT ROOMS		1996	56,385	1,446	39	1,446		15,626	22
23	REMODELING		1997	112,292	2,879	39	2,879		27,233	23
24	REPLACEMENT HOT WATER HEATERS		1998	25,065	643	39	643		5,439	24
25	FURNISH & INSTALL NEW FIRE SMOKE DUMPERS		1998	7,234	185	39	185		1,565	25
26	NEW SHOWER VALVE, SOIL PIPE		1998	1,739	45	39	45		380	26
27	REPAIR AIR CONDITIONING		1998	11,080	284	39	284		2,403	27
28	INSTALL NEW RECESSED CANS, FIXTURES ILLUMINATING EXT		1998	7,249	186	39	186		1,573	28
29	REPLACEMENT COOLING TOWER		1999	25,622	657	39	657		4,901	29
30	ELECTRICAL WORK FRONT OF BUILDING, OFFICE AREA		1999	17,362	445	39	445		3,319	30
31	CORRIDOR SYSTEM		1999	3,311	85	39	85		634	31
32	WATER COOLER		1999	2,414	62	39	62		462	32
33	LAUNDRY DOMESTIC HOT WATER HEATER		2000	11,789	302	39	302		1,951	33
34	INSTALL NEW FENCE		2000	7,840	523	15	523		3,339	34
35	FLUORESCENT LIGHTING		2000	13,041	335	39	335		2,164	35
36	INSTALLED SMOKERS EXHAUST SYSTEM		2000	6,748	173	39	173		1,117	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	ELECTRIC WORK	2001	\$ 86,952	\$ 2,229	39	\$ 2,229	\$	\$ 11,602	37
38	SWITCH GEAR FOR AIR CONDITIONING	2002	10,000	364	27.5	364		1,623	38
39	VARIOUS ELECTRICAL WORK	2002	71,684	2,607	27.5	2,607		11,623	39
40	WATER HEATER, CHILLER VALAVES, RE-KEY ALL LOCKS	2002	8,928	324	27.5	324		1,445	40
41	PLUMBING & HEATING	2003	4,822	381	27.5	381		1,008	41
42	RETUBE BOILER	2003	11,242	400	27.5	400		1,364	42
43	FIRE ALARM SYSTEM	2003	19,953	700	27.5	700		2,399	43
44	AIR CONDITION SYSTEM	2003	55,100	1,832	27.5	1,832		6,412	44
45	ELECTRIC WORK	2005	9,028	464	27.5	464		696	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)		\$ 3,650,631	\$ 109,874		\$ 109,874	\$	\$ 2,611,211	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	\$ 392,242	\$ 16,907	\$ 16,907	\$		\$ 362,597	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	644,731					644,731	73
74								74
75	TOTALS	\$ 1,036,973	\$ 16,907	\$ 16,907	\$		\$ 1,007,328	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,810,604	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,781	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,781	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,618,539	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								5
6	STORAGE				9,600			6
7	TOTAL				\$ 9,600			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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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: \$ _____ 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 CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		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	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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		N/A			#VALUE!		5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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	TOTAL			\$		\$	\$	#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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$	\$ 8,048	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,848,509	1,848,509	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	202,782	202,782	7
8 Accounts Receivable (owners or related parties)	120,208	120,208	8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,171,499	\$ 2,179,547	10
B. Long-Term Assets			
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		730,880	15
16 Equipment, at Historical Cost		1,036,973	16
17 Accumulated Depreciation (book methods)		(3,618,539)	17
18 Deferred Charges		31,990	18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(31,990)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):		2,968,281	22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 4,160,346	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,171,499	\$ 6,339,893	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 593,870	\$ 593,870	26
27 Officer's Accounts Payable	771,585	771,585	27
28 Accounts Payable-Patient Deposits	4,753	4,753	28
29 Short-Term Notes Payable	981,958	981,958	29
30 Accrued Salaries Payable	55,945	55,945	30
31 Accrued Taxes Payable (excluding real estate taxes)	115,429	115,429	31
32 Accrued Real Estate Taxes(Sch.IX-B)	237,525	237,525	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 LINE OF CREDIT	1,806,968	1,806,968	36
37 OTHER	164,357	164,357	37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,732,390	\$ 4,732,390	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		4,400,000	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,400,000	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,732,390	\$ 9,132,390	46
47 TOTAL EQUITY (page 18, line 24)	\$ (2,560,891)	\$ (2,792,497)	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,171,499	\$ 6,339,893	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,013,433)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,013,433)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,547,456)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ROUNDING	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,547,458)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,560,891)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,912,544	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,912,544	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,725	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,725	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 171	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PARKING	2,780	28
28a	BARBER AND BEAUTY	396	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,176	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,919,616	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,311,961	31
32	Health Care	1,230,404	32
33	General Administration	1,888,060	33
B. Capital Expense			
34	Ownership	916,744	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	119,903	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,467,072	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,547,456)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,547,456)	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: 01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,086	2,986	\$ 77,400	\$ 25.92	1
2	Assistant Director of Nursing	1,129	1,341	41,599	31.02	2
3	Registered Nurses	2,675	2,902	74,462	25.66	3
4	Licensed Practical Nurses	1,641	18,686	408,830	21.88	4
5	CNAs & Orderlies	42,952	44,781	398,647	8.90	5
6	CNA Trainees					6
7	Licensed Therapist	2,858	2,999	73,775	24.60	7
8	Rehab/Therapy Aides					8
9	Activity Director	86	86	1,114	12.95	9
10	Activity Assistants	758	810	7,443	9.19	10
11	Social Service Workers	248	263	2,884	10.97	11
12	Dietician					12
13	Food Service Supervisor	21,223	22,970	237,721	10.35	13
14	Head Cook	2,033	2,250	35,143	15.62	14
15	Cook Helpers/Assistants	2,086	2,086	34,067	16.33	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,834	14,357	132,759	9.25	18
19	Laundry	7,394	8,156	88,615	10.87	19
20	Administrator	2,086	2,086	146,343	70.15	20
21	Assistant Administrator	2,086	2,086	247,455	118.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,483	27,460	335,780	12.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,866	2,240	45,540	20.33	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	4,190	4,424	49,284	11.14	33
34	TOTAL (lines 1 - 33)	137,714	162,969	\$ 2,438,861 *	\$ 14.97	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	152	\$ 9,108	L1,C3	35
36	Medical Director	48	10,800	L9,C3	36
37	Medical Records Consultant	96	4,224	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	18	180	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	\$ 24,312		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	162	\$ 10,507	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	275	9,633	L10,C3	52
53	TOTAL (lines 50 - 52)	437	\$ 20,140		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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINTING/DECORATING 1999	\$ 8,000	3YRS	\$ 1,333	\$ 1,667							
2	PAINTING/DECORATING 2000	10,000	3YRS	3,333	1,667							
3	PAINTING/DECORATING 2001	5,000	3YRS	1,665	1,665	835						
4	PAINTING/DECORATING 2002	11,500	3YRS	1,917	3,833	3,833	1,917					
5	PAINTING/DECORATING 2003	4,000	3YRS		667	1,333	1,333	667				
6	PAINTING/DECORATING 2004	10,000	3YRS			1,667	3,333	3,333	1,667			
7	PAINTING/DECORATING 2005	21,425	3YRS			3,570	7,142	7,142	3,571			
8	PAINTING/DECORATING 2006	11,400					1,900	3,800	3,800	1,900		
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 81,325		\$ 8,248	\$ 7,832	\$ 11,238	\$ 15,625	\$ 14,942	\$ 9,038	\$ 1,900	\$	\$

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102

Report Period Beginning: 01/01/06

Ending: 12/31/06

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. ILLINOIS HEALTHCARE ASSOCIATION \$7948
- (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 during this cost report period. \$ 119,903
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. \$ 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? 0%
- 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 \$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.

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	
Eliezer 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	

Sherwin Manor
 Support for Owners Management Cap
 12/31/2006

0046102

Beds		219
Location		Chicago
Percentile		90th
Maximum Compensation limitation for 2004 cost reports		\$119,800

Owners		Compensation	Cap	Disallowed
Joseph Osina		\$ 146,343.00	\$119,800	\$ 26,543.00
Abe Osina		\$ 247,455.00	\$119,800	\$ 127,655.00
Total		\$ 393,798.00	\$ 239,600.00	\$ 154,198.00

Sherwin Manor
Staff Transportation

0046102

Gas	30,157.00
Auto Repairs	35,137.00
City Stickers	
Parking and tolls	
Total Auto Expense	65,294.00