FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. **IDPH License ID Number:** 0046102

Facility Name: SHERWIN MANOR NURSING CENTER

Address: 7350 SHERIDAN ROAD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 274-1000 **Fax #** (773 0 274-2353

HFS ID Number:

Date of Initial License for Current Owners: 05/01/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	EFFIE GALETSIS, CPA
	(Firm Name & Address)	GALETSIS & ASSOCIATES 124 WEST LAKE ST, BLOOMINGDALE, IL 60108
	(Telephone)	(630) 924-9800 Fax # (630) 351-2466

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

In the event there are further questions about this report, please contact:
Name: EFFI GALETSIS Telephone Number: (630) 924-9800
Email Address:

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	31,141	1,148	1,740	34,029	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,141	1,148	1,740	34,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.57%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 219 and days of care provided ____________

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	330,949	37,263	9,229	377,441		377,441		377,441			1
2	Food Purchase		317,288		317,288		317,288	(7,915)	309,373			2
3	Housekeeping	111,078	73,163		184,241		184,241		184,241			3
4	Laundry	84,481	42,833		127,314		127,314		127,314			4
5	Heat and Other Utilities			212,007	212,007		212,007		212,007			5
6	Maintenance	39,683	212,454	5,380	257,517		257,517	1,721	259,238			6
7	Other (specify):* Security	29,857			29,857		29,857		29,857			7
8	**TOTAL General Services**	596,048	683,001	226,616	1,505,665		1,505,665	(6,194)	1,499,471			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,209,230	95,926	169,432	1,474,588		1,474,588		1,474,588			10
10a	Therapy	32,759			32,759		32,759		32,759			10a
11	Activities	53,546			53,546		53,546		53,546			11
12	Social Services	20,729			20,729		20,729		20,729			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,316,264	95,926	169,432	1,581,622		1,581,622		1,581,622			16
	C. General Administration											
17	Administrative	289,638			289,638		289,638	(49,695)	239,943			17
18	Directors Fees											18
19	Professional Services			88,677	88,677		88,677		88,677			19
20	Dues, Fees, Subscriptions & Promotions			187,156	187,156		187,156	(39,791)	147,365			20
21	Clerical & General Office Expenses	352,442	37,969	65,725	456,136		456,136	(74,097)	382,040			21
22	Employee Benefits & Payroll Taxes			804,520	804,520		804,520		804,520			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,870	8,870		8,870		8,870			24
25	Other Admin. Staff Transportation			32,076	32,076		32,076		32,076			25
26	Insurance-Prop.Liab.Malpractice			228,543	228,543		228,543		228,543			26
27	Other (specify):*											27
28	**TOTAL General Administration**	642,080	37,969	1,415,567	2,095,616		2,095,616	(163,583)	1,932,034			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,554,392	816,896	1,811,615	5,182,903		5,182,903	(169,777)	5,013,127			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			116,060	116,060		116,060	4,491	120,551			30
31	Amortization of Pre-Op. & Org.			5,128	5,128		5,128		5,128			31
32	Interest			458,043	458,043		458,043	(688)	457,355			32
33	Real Estate Taxes			149,623	149,623		149,623		149,623			33
34	Rent-Facility & Grounds			909,600	909,600		909,600	(96,188)	813,412			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,638,454	1,638,454		1,638,454	(92,385)	1,546,069			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											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,554,392	816,896	3,450,069	6,821,357		6,821,357	(262,162)	6,559,196			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: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,915)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,706)	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	4,491	30		9
10	Interest and Other Investment Income	(688)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(19,901)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,775)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,310)	20		28
29	Other-Attach Schedule PARKING	(2,955)	34		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (66,759)		$	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 Amount	2 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)	(96,188)	34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (96,188)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (162,947)		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 Yes	2 No	3 Amount	4 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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

SHERWIN MANOR NURSING CENTER

ID# 0046102

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINT. - PRIOR YEARS	$ 20,921	6	1
2	DEFERRED MAINT. - CURRENT YEAR	(19,200)	6	2
3				3
4	NON-ALLOWABLE MARKETING SALARY	(17,761)	21	4
5	NON-ALLOW. RELATED PARTY- EXCESS SALARY	(36,434)	21	5
6	NON-ALLOW. OWNERS COMP- EXCESS SALARY	(49,695)	17	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**	(102,170)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,915)	0	0	0	0	0	0	0	0	0	0	(7,915)	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	1,721	0	0	0	0	0	0	0	0	0	0	1,721	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,194)	0	0	0	0	0	0	0	0	0	0	(6,194)	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	(49,695)	0	0	0	0	0	0	0	0	0	0	(49,695)	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	(39,791)	0	0	0	0	0	0	0	0	0	0	(39,791)	20
21	Clerical & General Office Expenses	(74,097)	0	0	0	0	0	0	0	0	0	0	(74,097)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(163,583)	0	0	0	0	0	0	0	0	0	0	(163,583)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(169,777)	0	0	0	0	0	0	0	0	0	0	(169,777)	29

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

	Capital Expense D. Ownership	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)	
30	Depreciation	4,491	0	0	0	0	0	0	0	0	0	0	4,491	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(688)	0	0	0	0	0	0	0	0	0	0	(688)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(96,188)	0	0	0	0	0	0	0	0	0	0	(96,188)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(92,385)	0	0	0	0	0	0	0	0	0	0	(92,385)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(262,162)	0	0	0	0	0	0	0	0	0	0	(262,162)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		RENT	$ 900,000			$	$ (900,000)	1
2	V		DEPRECIATION				116,060	116,060	2
3	V		INTEREST EXPENSE				456,203	456,203	3
4	V		REAL ESTATE TAXES				149,623	149,623	4
5	V		MORTGAGE INSURANCE				51,848	51,848	5
6	V		AMORTIZATION				5,128	5,128	6
7	V		PROPERTY INSURANCE				24,950	24,950	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 900,000			$ 803,812	$ * (96,188)	14

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER, INC # 0028530 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
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	

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	JOSEPH OSINA	ADMINISTRATOR		27.35		40		SALARY	$ 124,930	L17,C1	1
2	ABE OSINA	ASST ADMINISTRATOR		28.68		73		SALARY	164,365	L17,C1	2
3	ROSEANNE OSINA	FOOD SERV. SUPERISOR		0.00		40		SALARY	31,098	L1,C1	3
4	SARAH OSINA	PURCHASING		1.33		40		SALARY	100,056	L21,C1	4
5	DEVORA OSINA	CLERICAL		4.00		45		SALARY	58,020	L21,C1	5
6	HANNAH OSINA	CLERICAL		1.33		15		SALARY	11,566	L21,C1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 490,035		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: 01/01/2010 Ending: 2/31/2010

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 [X]

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Mortage		x	Mortgage	$75,013.00	6/1/2009	$ 6,035,000	$ 5,974,604	7/1/2044	6.9500	$ 69,270	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$75,013.00		$ 6,035,000	$ 5,974,604			$ 69,270	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,035,000	$ 5,974,604			$ 69,270	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 12,722 Line # 26

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

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

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

B. Real Estate Taxes

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

Line	Description		Amount	
1.	Real Estate Tax accrual used on 2009 report.	$	256,758	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.)	$	149,623	2
3.	Under or (over) accrual (line 2 minus line 1).	$	(107,135)	3
4.	Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	192,091	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.	$	84,956	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2005	245,573	8
2006	234,736	9
2007	232,230	10
2008	234,560	11
2009	234,560	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-314-026-0000	NURSING HOME	$ 5,811.96	$ 5,811.96
2.	11-29-314-027-0000	NURSING HOME	$ 4,910.22	$ 4,910.22
3.	11-29-314-028-0000	NURSING HOME	$ 90,799.87	$ 90,799.87
4.	11-29-314-029-0000	NURSING HOME	$ 90,569.27	$ 90,569.27
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 192,091.32	$ 192,091.32

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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? [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	219		1979	1979	$ 2,919,751	$ 88,477	33	$ 88,477	$	$ 2,794,312	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		17,452	10
11	LEASEHOLD IMPROVEMENTS			1992	23,487	746	31.5	746		13,552	11
12	LEASEHOLD IMPROVEMENTS			1993	11,285	358	31.5	358		6,356	12
13	LEASEHOLD IMPROVEMENTS			1993	5,825	149	39	149		2,605	13
14	LEASEHOLD IMPROVEMENTS			1994	34,686	890	39	890		14,416	14
15	ELECTRIC OUTLETS			1995	843	22	39	22		359	15
16	WHEELCHAIR RAMP			1995	4,800	123	39	123		1,960	16
17	VARIOUS ELECTRICAL WORK			1995	19,870	509	39	509		7,905	17
18	REPLACE STACK, VENT, CAST IRON DRAIN			1996	2,202	56	39	56		829	18
19	INSTALL NEW TOWER MOTOR, RAIN SHIELD, HEATER			1996	1,675	43	39	43		636	19
20	INSTALL CEILING FAN, NEW FIXTURE IN BATHROOM			1996	1,008	26	39	26		385	20
21	CONNECT GAS FOR KITCHEN COOKING EQUIPMENT			1996	1,200	31	39	31		458	21
22	INSTALL FLUORESCENT FIXTURES IN RESIDENT ROOMS			1996	56,385	1,446	39	1,446		21,410	22
23	REMODELING			1997	112,292	2,879	39	2,879		38,749	23
24	REPLACEMENT HOT WATER HEATERS			1998	25,065	643	39	643		9,011	24
25	FURNISH & INSTALL NEW FIRE SMOKE DUMPERS			1998	7,234	185	39	185		2,305	25
26	NEW SHOWER VALVE, SOIL PIPE			1998	1,739	45	39	45		560	26
27	REPAIR AIR CONDITIONING			1998	11,080	284	39	284		3,539	27
28	INSTALL NEW RECESSED CANS, FIXTURES ILLUMINATING EXT			1998	7,249	186	39	186		2,317	28
29	REPLACEMENT COOLING TOWER			1999	25,622	657	39	657		7,529	29
30	ELECTRICAL WORK FRONT OF BUILDING, OFFICE AREA			1999	17,362	445	39	445		5,099	30
31	CORRIDOR SYSTEM			1999	3,311	85	39	85		974	31
32	WATER COOLER			1999	2,414	62	39	62		710	32
33	LAUNDRY DOMESTIC HOT WATER HEATER			2000	11,789	302	39	302		3,159	33
34	INSTALL NEW FENCE			2000	7,840	523	15	523		5,431	34
35	FLUORESCENT LIGHTING			2000	13,041	335	39	335		3,504	35
36	INSTALLED SMOKERS EXHAUST SYSTEM			2000	6,748	173	39	173		1,809	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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELECTRIC WORK	2001	$ 86,952	$ 2,229	39	$ 2,229	$	$ 18,518	37
38	SWITCH GEAR FOR AIR CONDITIONING	2002	10,000	364	27.5	364		3,079	38
39	VARIOUS ELECTRICAL WORK	2002	71,684	2,607	27.5	2,607		22,051	39
40	WATER HEATER, CHILLER VALAVES, RE-KEY ALL LOCKS	2002	8,928	324	27.5	324		2,741	40
41	PLUMBING & HEATING	2003	4,822	381	27.5	381		2,532	41
42	RETUBE BOILER	2003	11,242	400	27.5	400		2,964	42
43	FIRE ALARM SYSTEM	2003	19,953	700	27.5	700		5,199	43
44	AIR CONDITION SYSTEM	2003	55,100	1,832	27.5	1,832		13,740	44
45	ELECTRIC WORK	2005	9,028	464	27.5	464		2,552	45
46	ELEVATOR IMPROVEMENTS	2007	47,068	1,712	27.5	1,712	0	5,992	46
47	ELEVATOR IMPROVEMENTS (INCLUDED AS OF 2009)	2007	84,432	3,070	27.5	3,070	(0)	6,140	47
48	ELEVATOR IMPROVEMENTS (INCLUDED AS OF 2009)	2008	8,000	291	27.5	291	0	582	48
49	ELEVATOR IMPROVEMENTS	2009	4,711	171	27.5	171	(0)	342	49
50	FIRE ALARM SYSTEM	2009	16,934	616	27.5	616	0	924	50
51	ROOF	2009	8,640	314	27.5	314	(0)	471	51
52	CARPET (INCLUDED AS OF 2009)	2008	2,067	75	27.5	75	(0)	150	52
53	PARKING LOT REPAVING	2010	13,150	239	27.5	239	(0)	239	53
54	OVEN	2010	4,069	203	10	203	(0)	203	54
55	SPRINKLER SYETM	2010	23,958	436	27.5	436	0	436	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)		$ 3,863,660	$ 117,001		$ 117,001	$ (0)	$ 3,065,186	70

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	943,876					943,876	73
74								74
75	TOTALS	$ 943,876	$	$	$		$ 943,876	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	Transportation	Chevy Trailblazer	2006	$ 74,172	$ 3,550	$ 3,550	$	10	$ 54,771	76
77										77
78										78
79										79
80	TOTALS			$ 74,172	$ 3,550	$ 3,550	$		$ 54,771	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)	$ 5,004,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,551	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,551	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,063,833	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: NON 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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

   IN-HOUSE PROGRAM [ ]
   IN OTHER FACILITY [ ]
   COMMUNITY COLLEGE [ ]
   HOURS PER CNA ____

3. CLINICAL PORTION:

   IN-HOUSE PROGRAM [ ]
   IN OTHER FACILITY [ ]
   HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	N/A	hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,579,253)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,579,253)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(534,173)	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) Common Stock	10,000	15
16	Other (describe) Treasury Stock	(1,079,333)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,603,506)	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)**	$ (3,182,759)	24 *

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 193,134	$ 253,279	1
2	Cash-Patient Deposits	5,985	5,985	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,329,070	2,703,084	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,402	81,811	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): EMPLOYEE LOANS	186,706	186,706	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,779,297	$ 3,230,865	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	7,500	6,037	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		804,795	15
16	Equipment, at Historical Cost		1,115,445	16
17	Accumulated Depreciation (book methods)		(4,141,902)	17
18	Deferred Charges	470,259	634,343	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(7,265)	20
21	Restricted Funds	51,188	769,159	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 528,947	$ 2,223,363	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,308,244	$ 5,454,228	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 655,574	$ 655,574	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,794	108,794	30
31	Accrued Taxes Payable (excluding real estate taxes)	319,616	319,616	31
32	Accrued Real Estate Taxes(Sch.IX-B)		192,091	32
33	Accrued Interest Payable		34,603	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED RENT	90,000	90,000	36
37	OTHER ACCRUED LIABILITIES	38,643	38,643	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,212,627	$ 1,439,321	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,974,604	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	RELATED PARTY PAYABLE	3,332,845		43
44	DUE OT OFFICER	1,152,960	1,223,062	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,485,805	$ 7,197,666	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,698,432	$ 8,636,987	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,390,188)	$ (3,182,759)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,308,244	$ 5,454,228	48

*(See instructions.)

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,274,051	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,274,051	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,575	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,575	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	7,915	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)**	$ 7,915	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	688	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 688	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	PARKING	2,955	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,955	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,287,184	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,505,665	31
32	Health Care	1,581,622	32
33	General Administration	2,095,616	33
	B. Capital Expense		
34	Ownership	1,638,454	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,821,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	(534,173)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (534,173)	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: 01/01/2010 Ending: 12/31/2010

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	2,080	2,080	$	$ 0.00	1
2	Assistant Director of Nursing	297	297	10,198	34.34	2
3	Registered Nurses	2,079	2,117	54,503	25.75	3
4	Licensed Practical Nurses	15,000	16,387	392,127	23.93	4
5	CNAs & Orderlies	59,859	62,976	626,488	9.95	5
6	CNA Trainees					6
7	Licensed Therapist	1,463	1,515	32,759	21.62	7
8	Rehab/Therapy Aides					8
9	Activity Director	536	536	5,246	9.79	9
10	Activity Assistants	4,202	4,380	48,300	11.03	10
11	Social Service Workers	2,080	2,080	20,729	9.97	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,086	34,067	16.33	13
14	Head Cook	1,977	2,194	37,602	17.14	14
15	Cook Helpers/Assistants	19,964	21,366	259,280	12.14	15
16	Dishwashers					16
17	Maintenance Workers	3,530	3,761	39,683	10.55	17
18	Housekeepers	10,585	11,353	111,078	9.78	18
19	Laundry	7,362	8,021	84,481	10.53	19
20	Administrator	2,086	2,086	125,273	60.05	20
21	Assistant Administrator	1,531	1,531		0.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,682	18,841	352,870	18.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,491	2,651	57,124	21.55	31
32	Other Health Care(specify)					32
33	Other(specify) Security	2,009	2,086	29,857	14.31	33
34	TOTAL (lines 1 - 33)	159,899	168,344	$ 2,321,665 *	$ 13.79	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	109	$ 9,229	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant	60	3,680	L1,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)	169	$ 12,909		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	4,533	155,452	L1,C3	51
52	Certified Nurse Assistants/Aides	567	10,300	L1,C3	52
53	TOTAL (lines 50 - 52)	5,100	$ 165,752		53

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOSEPH OSINA	ADMINISTRATOR		$ 125,273
ABE OSINA	ASST. ADMINISTRATOR		164,365
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 289,638

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK BOKOR KAGDA	ACCOUNTING	$ 13,000
GALETSIS & Associates	ACCOUNTING	7,678
FREDDERICK FRANKEL	LEGAL	689
LAMONT E STALLWORTH	LEGAL	2,423
CAPITAL REPORTING	LEGAL	1,742
SCHMIDT AND SALZMAN	LEGAL	158
OGLETREE DREAKING	LEGAL	1,509
DUANE MORRIS	LEGAL	58,415
HOFFMAN, LERMAN & ASS.	LEGAL	3,063
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 88,677

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,552
Unemployment Compensation Insurance	52,204
FICA Taxes	190,222
Employee Health Insurance	392,661
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION CONTRIBUTION	108,405
EMPLOYEE HIRING COSTS	7,796
CHICAGO HEAD TAX	4,680
TOTAL (agree to Schedule V, line 22, col.8)	$ 804,520

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 119,903
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
FRANCHISE TAX	1,217
LICENSE AND PERMITS	17,634
DUES AND SUBSCRIPTIONS	8,611
ADVERTISING	21,060
Less: Public Relations Expense	( )
Non-allowable advertising	(9,750)
Yellow page advertising	(11,310)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 147,365

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
MDS	6,766
ALZHEIMERS	525
DON SEMINAR	1,579
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,870

**See instructions.

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING/DECORATIN	2003	$ 4,000	3 YRS	$ 667	$	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	2004	10,000	3 YRS	3,333	1,667							
3	PAINTING/DECORATIN	2005	21,425	3 YRS	7,142	3,571							
4	PAINTING/DECORATIN	2006	11,400	3 YRS	3,800	3,800	1,900						
5	PAINTING/DECORATIN	2007	5,300	3 YRS	883	1,767	1,767	883					
6	PAINTING/DECORATIN	2008	20,404	3 YRS		3,401	6,801	6,801	3,401				
7	PAINTING/DECORATIN	2009	20,512	3 YRS			3,419	6,837	6,837	3,419			
8	PAINTING/DECORATIN	2010	19,200	3 YRS		3,200	6,400	6,400	3,200				
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 112,241		$ 15,825	$ 17,406	$ 20,287	$ 20,921	$ 13,438	$ 3,419	$	$	$

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 ASS. $7,949**

(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? **10YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,800** Line **10**

(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. $ **NONE** Has any meal income been offset against related costs? ____ Indicate the amount. $ ____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? ____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? ____ 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? ____
d. Have vehicle usage logs been maintained? ____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? ____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? ____
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: ____

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

Sherwin Manor
Non-allowable related Party Postions
12/31/2010

Positions	Name	Related Party	Per W-2	Allocation of duties		Medicare A	Nonallowable Portion	
Food Service Supervisor	Roseanne Osina	yes	19,938	100%		40,019	PASS	
Purchasing Postion	Sarah Osina	yes	88,807	80%	71,045	34,611	36,434	
Marketting Position	Sarah Osina	yes		20%	17,761	0	17,761	
			subtotal	100%	88,807			

Sherwin Manor
Support for Owners Management Cap
12/31/2010

0028530

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

Owners		Compensation	Cap	Disallowed
Joseph Osina		$ 124,930.00	$119,800	$ 5,130.00
Abe Osina		$ 164,365.00	$119,800	$ 44,565.00
Total		$ 289,295.00	$ 239,600.00	$ 49,695.00