

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	32,363	437	2,575	35,375	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,363	437	2,575	35,375	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.25%

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 05/01/1979

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

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

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	342,948	40,775	8,988	392,711		392,711		392,711		1
2	Food Purchase		331,704		331,704		331,704	(3,220)	328,484		2
3	Housekeeping	104,202	36,989		141,191		141,191		141,191		3
4	Laundry	105,447	34,118		139,565		139,565		139,565		4
5	Heat and Other Utilities			205,835	205,835		205,835		205,835		5
6	Maintenance	23,720	154,645		178,365		178,365	(6,625)	171,740		6
7	Other (specify):* Security	29,033			29,033		29,033		29,033		7
8	TOTAL General Services	605,350	598,231	214,823	1,418,404		1,418,404	(9,845)	1,408,559		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,020,684	103,916	243,913	1,368,513		1,368,513		1,368,513		10
10a	Therapy	65,371			65,371		65,371		65,371		10a
11	Activities	32,421	32,269		64,690		64,690		64,690		11
12	Social Services	550			550		550		550		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,119,026	136,185	254,713	1,509,924		1,509,924		1,509,924		16
	C. General Administration										
17	Administrative	314,706			314,706		314,706	(75,106)	239,600		17
18	Directors Fees										18
19	Professional Services			167,213	167,213		167,213		167,213		19
20	Dues, Fees, Subscriptions & Promotions			37,932	37,932	1,413	39,345	(37,932)	1,413		20
21	Clerical & General Office Expenses	349,775		169,683	519,458	(1,413)	518,045	(70,683)	447,362		21
22	Employee Benefits & Payroll Taxes			552,185	552,185		552,185		552,185		22
23	Inservice Training & Education			4,001	4,001		4,001		4,001		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			26,526	26,526		26,526		26,526		25
26	Insurance-Prop.Liab.Malpractice			181,117	181,117		181,117		181,117		26
27	Other (specify):*										27
28	TOTAL General Administration	664,481		1,138,657	1,803,138		1,803,138	(183,721)	1,619,417		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,388,857	734,416	1,608,193	4,731,466		4,731,466	(193,566)	4,537,900		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							118,751	118,751			30
31	Amortization of Pre-Op. & Org.			26,067	26,067		26,067		26,067			31
32	Interest			33,257	33,257		33,257	342,852	376,109			32
33	Real Estate Taxes			(313)	(313)		(313)	234,560	234,247			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(725,070)	4,530			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Mortgage Insurance							80,198	80,198			36
37	TOTAL Ownership			788,611	788,611		788,611	51,291	839,902			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)	2,388,857	734,416	2,516,707	5,639,980		5,639,980	(142,275)	5,497,705			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: **01/01/2009**

Ending: **12/31/2009**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,021)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25,112)	21		18
19	Entertainment				19
20	Contributions	(1,640)	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	(36,292)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,065)		\$	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)	56,367		34
35	Other- Attach Schedule	(127,577)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (71,210)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (142,275)		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					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: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PARKING INCOME	\$ (5,070)	34	1
2	INTEREST INCOME	(6)	32	2
3	VENDING INCOME	(3,220)	2	3
4	MISC. INCOME	(4,545)	21	4
5	OWNERS COMPENSATION	(75,106)	17	5
6	NON-ALLOWABLE PURCH. RELATED PARTY	(19,482)	21	6
7	NON-ALLOWABLE MARKET. RELATED PARTY	(13,523)	21	7
8	NON-ALLOWABLE FOOD SERVICE. RELATED PAI	0	1	8
9				9
10	DEFERRED MAINTENANCE- PRIOR YEARS	13,887	6	10
11	DEFERRED MAINTENANCE- CURRENT YEAR	(20,512)	6	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		(127,577)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0046102

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(3,220)	0	0	0	0	0	0	0	0	0	0	(3,220)	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	(6,625)	0	0	0	0	0	0	0	0	0	0	(6,625)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,845)	0	0	0	0	0	0	0	0	0	0	(9,845)	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	(75,106)	0	0	0	0	0	0	0	0	0	0	(75,106)	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	(37,932)	0	0	0	0	0	0	0	0	0	0	(37,932)	20
21	Clerical & General Office Expenses	(70,683)	0	0	0	0	0	0	0	0	0	0	(70,683)	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	(183,721)	0	0	0	0	0	0	0	0	0	0	(183,721)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(193,566)	0	0	0	0	0	0	0	0	0	0	(193,566)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0046102

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	118,751	0	0	0	0	0	0	0	0	0	118,751	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6)	342,858	0	0	0	0	0	0	0	0	0	342,852	32
33	Real Estate Taxes	0	234,560	0	0	0	0	0	0	0	0	0	234,560	33
34	Rent-Facility & Grounds	(5,070)	(720,000)	0	0	0	0	0	0	0	0	0	(725,070)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	80,198	0	0	0	0	0	0	0	0	0	80,198	36
37	TOTAL Ownership	(5,076)	56,367	0	51,291	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)	(198,642)	56,367	0	(142,275)	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
<u>SEE ATTACHED SCHEDULE</u>						

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	<u>34 RENT</u>	\$ <u>720,000</u>	<u>SHERWIN MANOR REALTY</u>	<u>100.00%</u>	\$	\$ <u>(720,000)</u>	1
2	V	<u>30 DEPRECIATION</u>				<u>118,751</u>	<u>118,751</u>	2
3	V	<u>32 INTEREST EXPENSE</u>				<u>342,858</u>	<u>342,858</u>	3
4	V	<u>33 REAL ESTATE TAXES</u>				<u>234,560</u>	<u>234,560</u>	4
5	V	<u>36 MORTGAGE INSURANCE</u>				<u>80,198</u>	<u>80,198</u>	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		\$ 720,000			\$ 776,367	\$ * 56,367	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

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

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0046102 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	\$ 125,273	L17,C1	1
2	ABE OSINA	ASST. ADMIN		28.68		73		Salary	189,433	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	67,616	L21,C1	4
5	DEVORA OSINA	CLERICAL		4.00		45		Salary	38,933	L21,C1	5
6	DEVORAH OSINA	DIETARY		4.00		5		Salary	8,573	L1,C1	6
7	HANNA OSINA	CLERICAL		1.33		15		Salary	10,179	L21,C1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 462,281		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: 01/01/2009

Ending: 2/31/2009

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	Name of Lender	2		3	4	5	6		8	9	10						
		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 Mortgage		X	Capital	\$38,343.00		\$ 6,035,000	\$ 6,017,847		6.9500	\$ 190,877	1					
2	BANK LEUMI		x				5,000,000				151,981	2					
3												3					
4												4					
5												5					
Working Capital																	
6	BANK LEUMI		X	Line of credit			200,000		6/09		33,257	6					
7												7					
8												8					
9	TOTAL Facility Related				\$38,343.00		\$ 11,235,000	\$ 6,017,847			\$ 376,115	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 11,235,000	\$ 6,017,847			\$ 376,115	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 376,115 Line # 32

* 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

1. Real Estate Tax accrual used on 2008 report.		\$	257,071	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.)		\$	234,560	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(22,511)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	256,758	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.		\$	234,247	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	243,099	8	
	2005	245,573	9	
	2006	234,736	10	
	2007	232,230	11	
	2008	234,560	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 CPA

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 2008 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 2008.

	(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>11-29-314-026-0000</u>	<u>NURSING HOME</u>	\$ <u>8,218.07</u>	\$ <u>8,218.07</u>
2.	<u>11-29-314-027-0000</u>	<u>NURSING HOME</u>	\$ <u>6,938.07</u>	\$ <u>6,938.07</u>
3.	<u>11-29-314-028-0000</u>	<u>NURSING HOME</u>	\$ <u>109,863.12</u>	\$ <u>109,863.12</u>

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILTIES</u>	<u>47,313</u>	<u>1979</u>	<u>\$ 123,000</u>	1
2					2
3	<u>TOTALS</u>	<u>47,313</u>		<u>\$ 123,000</u>	3

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0046102

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	219	1979	1979	\$ 2,919,751	\$ 88,477	33	\$ 88,477	\$	\$ 2,705,835	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		16,559	10
11	LEASEHOLD IMPROVEMENTS		1992	23,487	746	31.5	746		12,806	11
12	LEASEHOLD IMPROVEMENTS		1993	11,285	358	31.5	358		5,998	12
13	LEASEHOLD IMPROVEMENTS		1993	5,825	149	39	149		2,456	13
14	LEASEHOLD IMPROVEMENTS		1994	34,686	890	39	890		13,526	14
15	ELECTRIC OUTLETS		1995	843	22	39	22		337	15
16	WHEELCHAIR RAMP		1995	4,800	123	39	123		1,837	16
17	VARIOUS ELECTRICAL WORK		1995	19,870	509	39	509		7,396	17
18	REPLACE STACK, VENT, CAST IRON DRAIN		1996	2,202	56	39	56		773	18
19	INSTALL NEW TOWER MOTOR, RAIN SHIELD, HEATER		1996	1,675	43	39	43		593	19
20	INSTALL CEILING FAN, NEW FIXTURE IN BATHROOM		1996	1,008	26	39	26		359	20
21	CONNECT GAS FOR KITCHEN COOKING EQUIPMENT		1996	1,200	31	39	31		427	21
22	INSTALL FLUORESCENT FIXTURES IN RESIDENT ROOMS		1996	56,385	1,446	39	1,446		19,964	22
23	REMODELING		1997	112,292	2,879	39	2,879		35,870	23
24	REPLACEMENT HOT WATER HEATERS		1998	25,065	643	39	643		8,368	24
25	FURNISH & INSTALL NEW FIRE SMOKE DUMPERS		1998	7,234	185	39	185		2,120	25
26	NEW SHOWER VALVE, SOIL PIPE		1998	1,739	45	39	45		515	26
27	REPAIR AIR CONDITIONING		1998	11,080	284	39	284		3,255	27
28	INSTALL NEW RECESSED CANS, FIXTURES ILLUMINATING EXT		1998	7,249	186	39	186		2,131	28
29	REPLACEMENT COOLING TOWER		1999	25,622	657	39	657		6,872	29
30	ELECTRICAL WORK FRONT OF BUILDING, OFFICE AREA		1999	17,362	445	39	445		4,654	30
31	CORRIDOR SYSTEM		1999	3,311	85	39	85		889	31
32	WATER COOLER		1999	2,414	62	39	62		648	32
33	LAUNDRY DOMESTIC HOT WATER HEATER		2000	11,789	302	39	302		2,857	33
34	INSTALL NEW FENCE		2000	7,840	523	15	523		4,908	34
35	FLUORESCENT LIGHTING		2000	13,041	335	39	335		3,169	35
36	INSTALLED SMOKERS EXHAUST SYSTEM		2000	6,748	173	39	173		1,636	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

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	\$	\$ 18,289	37
38	SWITCH GEAR FOR AIR CONDITIONING	2002	10,000	364	27.5	364		2,715	38
39	VARIOUS ELECTRICAL WORK	2002	71,684	2,607	27.5	2,607		19,444	39
40	WATER HEATER, CHILLER VALAVES, RE-KEY ALL LOCKS	2002	8,928	324	27.5	324		2,417	40
41	PLUMBING & HEATING	2003	4,822	381	27.5	381		2,151	41
42	RETUBE BOILER	2003	11,242	400	27.5	400		2,564	42
43	FIRE ALARM SYSTEM	2003	19,953	700	27.5	700		4,499	43
44	AIR CONDITION SYSTEM	2003	55,100	1,832	27.5	1,832		11,908	44
45	ELECTRIC WORK	2005	9,028	464	27.5	464		2,088	45
46	ELEVATOR IMPROVEMENTS	2007	47,068	1,712	27.5	1,712	0	4,280	46
47	ELEVATOR IMPROVEMENTS (INCLUDED AS OF 2009)	2007	84,432	3,070	27.5	3,070	(0)	3,070	47
48	ELEVATOR IMPROVEMENTS (INCLUDED AS OF 2009)	2008	8,000	291	27.5	291	0	291	48
49	ELEVATOR IMPROVEMENTS	2009	4,711	171	27.5	171	(0)	171	49
50	FIRE ALARM SYSTEM	2009	16,934	308	27.5	308	0	308	50
51	ROOF	2009	8,640	157	27.5	157	(0)	157	51
52	CARPET (INCLUDED AS OF 2009)	2008	2,067	75	27.5	75	(0)	75	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)		\$ 3,822,483	\$ 115,658		\$ 115,658	\$ (0)	\$ 2,950,185	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 403,618	\$ 3,168	\$ 3,168	\$		\$ 385,089	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	646,447					646,447	73
74								74
75	TOTALS	\$ 1,050,065	\$ 3,168	\$ 3,168	\$		\$ 1,031,536	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)	\$ 4,995,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,826	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)	\$ 3,981,721	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$	\$ 223,673	1
2	Cash-Patient Deposits	96,673	96,673	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,416,984	2,416,984	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	87,110		7
8	Accounts Receivable (owners or related parties)	75,044	3,639,128	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,675,811	\$ 6,376,458	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		4,302	12
13	Land		123,000	13
14	Buildings, at Historical Cost		2,919,751	14
15	Leasehold Improvements, at Historical Cost	124,784	902,732	15
16	Equipment, at Historical Cost	8,792	1,050,065	16
17	Accumulated Depreciation (book methods)		(3,981,721)	17
18	Deferred Charges	502,053	664,000	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		533,629	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 635,629	\$ 2,215,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,311,440	\$ 8,592,216	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 391,780	\$ 391,780	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,243	84,243	30
31	Accrued Taxes Payable (excluding real estate taxes)	70,175	70,175	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES- OTHER	119,198	119,198	36
37	RELATED PARTY PAYABLE	3,190,113	3,190,113	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,855,509	\$ 3,855,509	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,035,184	1,035,184	39
40	Mortgage Payable		6,017,848	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,035,184	\$ 7,053,032	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,890,693	\$ 10,908,541	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,579,253)	\$ (2,316,325)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,311,440	\$ 8,592,216	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,918,492)	1
2	Restatements (describe):	(254,023)	2
3			3
4	PRIOR PERIOD ADJUSTMENT		4
5	RECORD PURCHASES MADE IN 2007 & 2008	94,499	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,078,016)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	498,763	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 498,763	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,579,253)	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	\$ 6,125,902	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,125,902	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	3,220	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)	\$ 3,220	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Parking Income	5,070	28
28a	Miscellaneous Income	4,545	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,615	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,138,743	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,418,404	31
32	Health Care	1,509,924	32
33	General Administration	1,803,138	33
B. Capital Expense			
34	Ownership	788,611	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)*	\$ 5,639,980	40
41	Income before Income Taxes (line 30 minus line 40)**	498,763	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 498,763	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: **01/01/2009**

Ending:

12/31/2009

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	\$ 104,111	\$ 50.05	1
2	Assistant Director of Nursing	172	172	8,771	50.99	2
3	Registered Nurses	752	752	19,832	26.37	3
4	Licensed Practical Nurses	13,199	14,657	333,960	22.79	4
5	CNAs & Orderlies	54,387	56,771	558,240	9.83	5
6	CNA Trainees					6
7	Licensed Therapist	2,570	2,705	65,370	24.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	89	89	889	9.99	9
10	Activity Assistants	2,389	2,588	31,532	12.18	10
11	Social Service Workers	55	55	550	10.00	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,086	34,067	16.33	13
14	Head Cook	2,086	2,318	39,704	17.13	14
15	Cook Helpers/Assistants	20,902	22,547	264,948	11.75	15
16	Dishwashers					16
17	Maintenance Workers	2,434	2,560	23,720	9.27	17
18	Housekeepers	10,107	10,691	104,202	9.75	18
19	Laundry	7,551	8,696	105,447	12.13	19
20	Administrator	2,086	2,086	125,273	60.05	20
21	Assistant Administrator	2,080	2,080	189,433	91.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,124	18,438	291,334	15.80	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	2,483	2,647	58,441	22.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	2,245	2,357	29,033	12.32	33
34	TOTAL (lines 1 - 33)	147,877	156,375	\$ 2,388,857 *	\$ 15.28	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	84	\$ 8,988	L1C3	35
36	Medical Director	40	10,800	L9C3	36
37	Medical Records Consultant	71	4,256	L10C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	63	2,816	L10C3	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)	258	\$ 26,860		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	6,784	233,763	L10C3	51
52	Certified Nurse Assistants/Aides	171	3,078	L10C3	52
53	TOTAL (lines 50 - 52)	6,955	\$ 236,841		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JOSEPH OSINA	ADMINISTRATOR	27	\$ 125,273	Workers' Compensation Insurance	\$ 30,884	IDPH License Fee	\$	
ABE OSINA	ASST ADMIN	29	189,433	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	207,039	Health Care Worker Background Check		
				Employee Health Insurance	264,049	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	1,413	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension Plan Contributions	50,213			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 314,706					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 1,413	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
KRUPNICK BOKOR KAGDA BR	ACCOUNTING		\$ 17,250			\$	Out-of-State Travel	\$
GALETSIS AND ASSOCIATES	ACCOUNTING		6,800					
DUANE MORRIS	LEGAL		143,163				In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 167,213	TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	

* Attach copy of IMRF notifications

**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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINTING/DECORATING 2002	\$ 11,500	3YRS	\$ 1,917	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING 2003	4,000	3YRS	1,333	667							
3	PAINTING/DECORATING 2004	10,000	3YRS	3,333	3,333	1,667						
4	PAINTING/DECORATING 2005	21,425	3YRS	7,142	7,142	3,571						
5	PAINTING/DECORATING 2006	11,400	3YRS	1,900	3,800	3,800	1,900					
6	PAINTING/DECORATING 2007	5,300	3YRS		883	1,767	1,767	883				
7	PAINTING/DECORATING 2008	20,404	3YRS			3,401	6,801	6,801	3,401			
8	PAINTING/DECORATING 2009	20,512	3YRS				3,419	6,837	6,837	3,419		
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 104,541		\$ 15,625	\$ 15,825	\$ 14,206	\$ 13,887	\$ 14,521	\$ 10,238	\$ 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 ASSOCIATION
- (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. \$ 480 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? 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? N/A
 - 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 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
 Support for Owners Management Cap
 12/31/2009

0028530

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

Owners		Compensation	Cap	Disallowed
Joseph Osina		\$ 125,273.00	\$119,800	\$ 5,473.00
Abe Osina		\$ 189,433.00	\$119,800	\$ 69,633.00
Total		\$ 314,706.00	\$ 239,600.00	\$ 75,106.00

