

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0032763</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Sharon Health Care Pines</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3614 N. Rochelle</u> <u>Peoria</u> <u>61604</u>																									
Number City Zip Code																									
County: <u>Peoria</u>																									
Telephone Number: <u>(309) 685-8800</u> Fax # <u>(309) 686-8609</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>08/15/87</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines

0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3	116	Intermediate (ICF)	116	42,340
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	116	TOTALS	116	42,340

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					8
9 SNF/PED					9
10 ICF	32,587	240		32,827	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	32,587	240		32,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.53%

D. How many bed-hold days during this year were paid by the Department? 10 (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 08/15/1987

J. Was the facility purchased or leased after January 1, 1978? YES X Date 08/15/1987 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	203,731	18,365	6,698	228,794		228,794		228,794			1
2	Food Purchase		242,358		242,358		242,358	(18)	242,340			2
3	Housekeeping	178,024	26,143		204,167		204,167		204,167			3
4	Laundry	67,221	16,555		83,776		83,776		83,776			4
5	Heat and Other Utilities			102,916	102,916		102,916	343	103,259			5
6	Maintenance	52,406	402	71,847	124,655		124,655	16,172	140,827			6
7	Other (specify):*											7
8	TOTAL General Services	501,382	303,823	181,461	986,666		986,666	16,497	1,003,163			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,183,111	38,963	14,702	1,236,776		1,236,776	(199)	1,236,577			10
10a	Therapy											10a
11	Activities	66,339	12,595	2,857	81,791		81,791		81,791			11
12	Social Services	186,537		4,836	191,373		191,373		191,373			12
13	CNA Training											13
14	Program Transportation			31,266	31,266		31,266		31,266			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,435,987	51,558	68,061	1,555,606		1,555,606	(199)	1,555,407			16
	C. General Administration											
17	Administrative	118,278			118,278		118,278	24,011	142,289			17
18	Directors Fees											18
19	Professional Services			37,547	37,547		37,547	(10,347)	27,200			19
20	Dues, Fees, Subscriptions & Promotions			18,040	18,040		18,040	(11,621)	6,419			20
21	Clerical & General Office Expenses	93,085	1,875	139,620	234,580		234,580	(30,426)	204,154			21
22	Employee Benefits & Payroll Taxes			397,865	397,865		397,865	(2,873)	394,992			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,577	3,577		3,577		3,577			24
25	Other Admin. Staff Transportation			2,464	2,464		2,464		2,464			25
26	Insurance-Prop.Liab.Malpractice			72,318	72,318		72,318	111	72,429			26
27	Other (specify):*							1,952	1,952			27
28	TOTAL General Administration	211,363	1,875	671,431	884,669		884,669	(29,193)	855,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,148,732	357,256	920,953	3,426,941		3,426,941	(12,895)	3,414,046			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			45,992	45,992		45,992	104,264	150,256			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,824	3,824		3,824	70,401	74,225			32
33	Real Estate Taxes			59,231	59,231		59,231	4,555	63,786			33
34	Rent-Facility & Grounds			124,487	124,487		124,487	(117,334)	7,153			34
35	Rent-Equipment & Vehicles			18,089	18,089		18,089		18,089			35
36	Other (specify):*											36
37	TOTAL Ownership			251,623	251,623		251,623	61,886	313,509			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			63,510	63,510		63,510		63,510			42
43	Other (specify):*	931		5,181	6,112		6,112	(6,112)				43
44	TOTAL Special Cost Centers	931		68,691	69,622		69,622	(6,112)	63,510			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,149,663	357,256	1,241,267	3,748,186		3,748,186	42,880	3,791,066			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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				4
5	Telephone, TV & Radio in Resident Rooms	(545)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32,857	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	02		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				18
19	Entertainment	(7,790)	21		19
20	Contributions	(6,049)	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	(22,513)	21		24
25	Fund Raising, Advertising and Promotional	(5,653)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(177)	20		28
29	Other-Attach Schedule	4,118			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,769)		\$ 0	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)	48,649		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 48,649		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 42,880		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)			\$ 0		47

Report Period Beginning:

Ending:

ID#

0032763

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (80)	21	1
2	Marketing	(5,181)	43	2
3	Penalties	(43)	21	3
4	Patient Clothing	(199)	10	4
5	Additional R&M	14,764	06	5
6	Other Professional Fee - Barton Management	(1,339)	19	6
7	Non Allowable Expense	(931)	43	7
8	PPA-401K Contribution	(2,873)	22	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	0	0		48
49	Total	4,118		49

Sharon Health Care Pines

	ID#	0032763
Report Period Beginning:		01/01/11
Ending:		12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

Summary A

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

X 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			\$			\$	\$	0 1
2	V							0	2
3	V							0	3
4	V							0	4
5	V							0	5
6	V							0	6
7	V							0	7
8	V							0	8
9	V							0	9
10	V							0	10
11	V							0	11
12	V							0	12
13	V							0	13
14	Total			\$ 0			\$ 0	\$ *	0 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	5	UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 888	\$ 888	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.	100.00%	1,408	1,408	16
17	V	20	DUES, LICENSES, FEES		BARTON MANAGEMENT INC.	100.00%	10	10	17
18	V	26	INSURANCE		BARTON MANAGEMENT INC.	100.00%	111	111	18
19	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.	100.00%	2,397	2,397	19
20	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.	100.00%	6,866	6,866	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V	19	COMPUTER SERVICES	9,993				(9,993)	26
27	V	34	RENT	14,400	BARTON MANAGEMENT INC.	100.00%		(14,400)	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			\$ 24,393			\$ 11,680	\$ * (12,713)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	17	SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT	100.00%	18,056	\$ 18,056	15
16	V	27	PAYROLL TAXES-JS		REDWOOD MANAGEMENT	100.00%	1,483	1,483	16
17	V							0	17
18	V	17	SALARY-S. ARON		REDWOOD MANAGEMENT	100.00%	5,955	5,955	18
19	V	27	PAYROLL TAXES-SA		REDWOOD MANAGEMENT	100.00%	469	469	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V	17	MANAGEMENT FEES		REDWOOD MANAGEMENT	100.00%	0	0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			\$ 0			\$ 25,963	\$ * 25,963	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	19	PROFESSIONAL FEES	\$	PEORIA FOREST PARTNERSHIP	100.00%	\$ 985	\$ 985	15
16	V	20	DUES, FEES, SUBS.		PEORIA FOREST PARTNERSHIP		248	248	16
17	V	30	DEPRECIATION		PEORIA FOREST PARTNERSHIP		71,407	71,407	17
18	V	32	INTEREST		PEORIA FOREST PARTNERSHIP		70,401	70,401	18
19	V	33	REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		2,158	2,158	19
20	V	34	RENT	109,800	PEORIA FOREST PARTNERSHIP		0	(109,800)	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			\$ 109,800			\$ 145,199	\$ * 35,399	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	015
16	V								016
17	V								017
18	V								018
19	V								019
20	V								020
21	V								021
22	V								022
23	V								023
24	V								024
25	V								025
26	V								026
27	V								027
28	V								028
29	V								029
30	V								030
31	V								031
32	V								032
33	V								033
34	V								034
35	V								035
36	V								036
37	V								037
38	V								038
39	Total			\$0			\$0	\$*	039

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	015
16	V								016
17	V								017
18	V								018
19	V								019
20	V								020
21	V								021
22	V								022
23	V								023
24	V								024
25	V								025
26	V								026
27	V								027
28	V								028
29	V								029
30	V								030
31	V								031
32	V								032
33	V								033
34	V								034
35	V								035
36	V								036
37	V								037
38	V								038
39	Total			\$0			\$0	\$*	039

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	015
16	V								016
17	V								017
18	V								018
19	V								019
20	V								020
21	V								021
22	V								022
23	V								023
24	V								024
25	V								025
26	V								026
27	V								027
28	V								028
29	V								029
30	V								030
31	V								031
32	V								032
33	V								033
34	V								034
35	V								035
36	V								036
37	V								037
38	V								038
39	Total			\$0			\$0	\$*	039

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	015
16	V								016
17	V								017
18	V								018
19	V								019
20	V								020
21	V								021
22	V								022
23	V								023
24	V								024
25	V								025
26	V								026
27	V								027
28	V								028
29	V								029
30	V								030
31	V								031
32	V								032
33	V								033
34	V								034
35	V								035
36	V								036
37	V								037
38	V								038
39	Total			\$0			\$0	\$*	039

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	015
16	V							0	16
17	V								17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			\$0			\$0	\$*	039

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ANCA OVIEDO	1.000%	BARTON SENIOR RESIDENCES (SLF)	ZION	BARTON MANAGEMENT	NORTHFIELD	BUILDING CO./BOOKER	1
2	ELISA SHLOFROCK-ZUSMAN	15.747%	CENTRAL PLAZA	CHICAGO	PEORIA FOREST PTNSHP	NORTHFIELD	BUILDING & DIETARY C	2
3	ENID KAPLAN	3.564%	CLAYTON RESIDENTIAL HOME, INC.	CHICAGO	REDWOOD MANAGEMENT			3
4	GARY WEINTRAUB	11.315%	GAF LAKE COOK TERRACE, INC	NORTHBROOK				4
5	JEAN SHLOFROCK	13.370%	RUSH BARTON (SLF)	CHICAGO				5
6	JOEL RUBIN	0.300%	SHARON HEALTH CARE ELMS, INC.	PEORIA				6
7	JOHN SHLOFROCK	19.404%	SHARON HEALTH CARE WILLOWS, INC.	PEORIA				7
8	JUDY S RUBIN TRUST	2.020%	SHARON HEALTH CARE WOODS, INC.	PEORIA				8
9	MARIAN SIMON	1.000%	THORNTON HEIGHTS TERRACE, LTD.	CHICAGO HEIGHTS				9
10	MICHAEL KAPLAN	1.120%						10
11	RICHARD DEAN DUROS DECL. OF TRUST	8.988%						11
12	ROBERT KAPLAN	3.564%						12
13	SALAMON DAYAN	1.220%						13
14	STANTON ARON	17.388%						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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	John Shlofrock	Shareholder	Administrative	19.40%	See Attached	6.5	13.83%	Alloc. Salary	\$ 18,056	17-7	1
2	Anca Zota-Oviedo	Shareholder	Administrative	1.00%	See Attached	3	6.00%	Alloc. Salary	8,508	17-1	2
3	Rick Duros	Shareholder	Administrative	8.98%	See Attached	5	10.00%	Alloc. Salary	18,766	17-1	3
4	Gary Weintraub	Shareholder	Legal	11.32%	See Attached	4	9.76%	Alloc. Salary	17,255	17-1	4
5	Stan Aron	Shareholder	Administrative	17.89%	See Attached	3.5	6.36%	Alloc. Salary	5,955	17-7	5
6	Elisa Shlofrock-Zusman	Shareholder	Clerical	15.74%	See Attached	5	11.90%				6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 68,540		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____
Fax Number (_____

	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

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

Name of Related Organization BARTON MANAGEMENT INC.
Street Address 465 CENTRAL AVE.
City / State / Zip Code NORTHFIELD, IL 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAILABLE DAYS	555,055	9	\$ 11,639	\$	42,340	\$ 888	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	555,055	9	18,458		42,340	1,408	2
3	20	DUES, LICENSES, FEES	AVAILABLE DAYS	555,055	9	127		42,340	10	3
4	26	INSURANCE	AVAILABLE DAYS	555,055	9	1,451		42,340	111	4
5	33	REAL ESTATE TAXES	AVAILABLE DAYS	555,055	9	31,421		42,340	2,397	5
6	34	RENT OFFICE SPACE	AVAILABLE DAYS	555,055	9	90,008		42,340	6,866	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 153,104	\$ 0		\$ 11,680	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

Name of Related Organization REDWOOD MANAGEMENT
Street Address 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code NORTHFIELD, IL. 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	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	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	36	6	100,000	100,000	7	18,056	1
2	27	PAYROLL TAXES-JS	AVG HOURS WORKED	36	6	8,216		7	1,483	2
3										3
4	17	SALARY-S. ARON	AVG HOURS WORKED	39	5	66,360	66,360	4	5,955	4
5	27	PAYROLL TAXES-SA	AVG HOURS WORKED	39	5	5,223		4	469	5
6										6
7										7
8										8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 179,799	\$ 166,360		\$ 25,963	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

Name of Related Organization PEORIA FOREST PARTNERSHIP
Street Address 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code NORTHFIELD, IL. 60093
Phone Number (847) 441-8200
Fax Number (847) 441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	BED SIZE	585	4	\$ 4,965	\$	116	\$ 985	1
2	20	DUES, FEES, SUBS.	BED SIZE	585	4	1,250		116	248	2
3	30	DEPRECIATION	BED SIZE	585	4	360,112		116	71,407	3
4	32	INTEREST	BED SIZE	585	4	355,040		116	70,401	4
5	33	REAL ESTATE TAX	BED SIZE	585	4	10,881		116	2,158	5
6										6
7										7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 732,248	\$ 0		\$ 145,199	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

	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						\$	\$		0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

	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						\$	\$		0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

	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						\$			0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

	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						\$			0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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						\$	\$		0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

	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						\$			0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					\$ 0	\$ 0		\$ 0	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	LOC		X	Line of Credit				400,000				3,824	6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	400,000			\$	3,824	9
	B. Non-Facility Related*												
10	Allocated from Peoria Forest		X									70,401	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	70,401	14
15	TOTALS (line 9+line14)						\$	400,000			\$	74,225	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$		\$			\$							1
2																			2
3																			3
4																			4
5																			5
6																			6
7	TOTAL Long-Term																		7
	Working Capital																		
8							\$		\$			\$							8
9																			9
10																			10
11																			11
12																			12
13																			13
14	TOTAL Working Capital																		14
	B. Non-Facility Related*																		
15							\$		\$			\$							15
16																			16
17																			17
18																			18
19																			19
20	TOTAL Non-Facility Related																		20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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.			
1. Real Estate Tax accrual used on 2010 report.			\$	59,350	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.)			\$	62,969	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3,619	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	60,167	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.			\$	63,786	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	47,795	8	
		2007	49,524	9	
		2008	52,876	10	
		2009	57,622	11	
		2010	58,414	12	
2011 Accrual - \$58,414 x 1.03 =\$60,167 (Rounded)					
Allocated from Peoria Forest Partnership: \$2,158					
Allocated from Barton Management: \$2,397					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Sharon Health Care Pines</u>	COUNTY	<u>Peoria</u>
FACILITY IDPH LICENSE NUMBER	<u>0032763</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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? X YES 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Sharon Health Care Pines

COUNTY

Peoria

FACILITY IDPH LICENSE NUMBER

0032763

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 2000 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 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 0.00	\$ 0.00

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 NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

30,272

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

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).

Sharon Healthcare Willows - Facility - 219 Beds

Sharon Healthcare Woods - Facility - 152 Beds

Sharon Healthcare Elms - Facility - 98 Beds

Peoria Forest Partnership - Dietary Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 126,906	1
2	Allocated from Peoria Forest Partnership			7,131	2
3	TOTALS			\$ 134,037	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	116		1991	1972	\$ 2,204,750	\$ 70,001	31.5	\$ 70,001	\$	\$ 1,449,601	4
5			2000	1991	46,598	1,406	31.5	1,406		16,171	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987		4,748		20			4,263	9
10	Various		1988		31,896		20			28,565	10
11	Various		1989		20,183		20			18,503	11
12	Various		1990		10,549		20			9,891	12
13	Various		1991		2,580		20	113	113	2,477	13
14	Various		1992		15,639		20	732	732	14,889	14
15	Various		1993		3,764		20	188	188	3,425	15
16	Various		1994		33,543		20	1,677	1,677	28,807	16
17	Various		1995		11,702		20	585	585	9,652	17
18	Various		1996		4,012		20	201	201	3,084	18
19	Various		1997		14,815		20	741	741	10,607	19
20	Various		1998		27,567		20	1,378	1,378	18,718	20
21	Various		1999		25,473		20	1,274	1,274	15,765	21
22	Various		2000		4,404		20	220	220	2,553	22
23	Various		2001		34,460		20	1,723	1,723	17,784	23
24	Various		2002		8,876		20	444	444	4,297	24
25	Various		2003		10,166		20	1,017	1,017	8,681	25
26	Various		2004		13,297		20	1,330	1,330	10,236	26
27	Various		2005		49,034		20	4,903	4,903	30,486	27
28	Various		2006		40,115		20	4,012	4,012	21,922	28
29	Various		2007		93,696		20	8,953	8,953	38,832	29
30											30
31											31
32											32
33											33
34											34
35											35
36											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

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			45,992			(45,992)		69
70	TOTAL (lines 4 thru 69)		\$ 2,711,867	\$ 117,399		\$ 100,897	\$ (16,502)	\$ 1,769,206	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sharon Health Care Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		\$ 2,711,867	\$ 117,399		\$ 100,897	\$ (16,502)	\$ 1,769,206	1
2	<u>Drapes</u>	2008	11,371		20	2,274	2,274	9,097	2
3	<u>Darpes - Freight</u>	2008			20				3
4	<u>A/C Unit-Servc Breakers</u>	2008	7,050		20	588	588	2,252	4
5	<u>Labor-Remodel</u>	2008	2,518		20	252	252	944	5
6	<u>Office-Remodel</u>	2008	5,317		20	532	532	1,994	6
7	<u>Doors</u>	2008	3,499		20	350	350	1,312	7
8	<u>Sliders</u>	2008	3,225		20	323	323	1,209	8
9	<u>Carpet-Dng, Lvg, Foyer, Corr</u>	2008	51,998		20	7,428	7,428	27,856	9
10	<u>Install-Sliders</u>	2008	800		20	80	80	293	10
11	<u>Locks</u>	2008	2,329		20	233	233	854	11
12	<u>Doors</u>	2008	1,044		20	104	104	383	12
13	<u>Installation, Vents</u>	2008	7,000		20	700	700	2,508	13
14	<u>Bench Canopy</u>	2008	5,395		20	1,079	1,079	3,777	14
15	<u>Delayed Egree Modif</u>	2008	3,142		20	314	314	1,100	15
16	<u>Ice Machine Work</u>	2008	2,292		20	229	229	802	16
17	<u>Relocate Switches, Pwr</u>	2008	2,636		20	264	264	923	17
18	<u>Replace Front Doors</u>	2008	9,180		20	918	918	3,137	18
19	<u>Doorknobs</u>	2008	2,454		20	245	245	838	19
20	<u>Blinds</u>	2008	559		20	112	112	382	20
21	<u>Posts</u>	2008	769		20	77	77	263	21
22	<u>Alarm System</u>	2008	948		20	95	95	316	22
23	<u>Canopy</u>	2008	1,202		20	120	120	391	23
24	<u>Footings-Picnic Shelter</u>	2008	2,954		20	295	295	960	24
25	<u>New Patio</u>	2008	4,565		20	457	457	1,446	25
26	<u>Crane Lift</u>	2008	570		20	114	114	352	26
27	<u>New Roof-South Side Wing</u>	2008	7,174		20	717	717	2,212	27
28	<u>Downspouts</u>	2008	3,127		20	313	313	964	28
29	<u>Insulation - Roof Deck</u>	2009	6,578		20	658	658	1,973	29
30	<u>Insulation - Roof Deck</u>	2009	13,156		20	1,316	1,316	3,947	30
31	<u>Insulation - Roof Deck</u>	2009	6,584		20	658	658	1,865	31
32	<u>Curtains</u>	2009	2,770		20	277	277	739	32
33	<u>Curtains</u>	2009	2,770		20	277	277	739	33
34	TOTAL (lines 1 thru 33)		\$ 2,886,843	\$ 117,399		\$ 122,295	\$ 4,896	\$ 1,845,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12B, Carried Forward		\$ 2,886,843	\$ 117,399		\$ 122,295	\$ 4,896	\$ 1,845,033	1
2	Wallpaper	2009	3,896		20			3,896	2
3	Curtains	2009	2,770		20	277	277	716	3
4	Billiards Room Tables Chairs & Cornices	2009	2,705		20	271	271	676	4
5	Curtains	2009	2,770		20	277	277	693	5
6	Walkway	2009	3,308		20	221	221	551	6
7	Door Plaques	2009	3,000		20	600	600	1,450	7
8	Fire Walls	2009	3,600		20	360	360	840	8
9	Doors	2009	3,308		20	331	331	772	9
10	Ramp System	2009	9,033		20	602	602	1,355	10
11	Water Supply Pipe	2009	3,755		20	376	376	814	11
12	Roof Repair	2009	2,790		20	279	279	581	12
13	Heater	2011	4,822		20	40	40	40	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	TOTAL (lines 1 thru 33)		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12C, Carried Forward		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								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
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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	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$199,654	\$	\$22,879	\$22,879	10	\$154,902	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	412,602		924	924	10	412,602	73
74								74
75	TOTALS	\$612,256	\$	\$23,803	\$23,803		\$567,504	75

D. Vehicle Costs. (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		1998 CHEV VAN	2001	\$2,986	\$	\$		5	\$2,986	76
77		2001 DODGE RAM	2004	3,486		214	214	5	3,486	77
78		TRACTOR	2009	2,183		312	312	5	702	78
79										79
80	TOTALS			\$8,655	\$	\$525	\$525		\$7,174	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)	\$3,687,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$117,399	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$150,256	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$32,857	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,432,095	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
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				287			5
6	Alloc from Barton				6,866			6
7	TOTAL				\$ 7,153			7

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 18,089
- Description: See Attached Schedule

(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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 81,416	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	770,163		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,298		6
7	Other Prepaid Expenses	12,436		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	27,894		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 926,207	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,135,404		16
17	Accumulated Depreciation (book methods)	(691,988)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 443,416	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,369,623	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,341	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,664		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,597		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,248		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,167		32
33	Accrued Interest Payable	764		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	179,900		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 416,681	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	400,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 400,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 816,681	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 552,942	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,369,623	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (723,112)	1
2	Restatements (describe):		2
3	401K Contribution	(3,255)	3
4	Rounding	7	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (726,360)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(411,839)	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) Current Year Contribution	1,691,141	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,279,302	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)	\$ 552,942	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,336,267	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,336,267	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	80	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 80	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,336,347	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	986,666	31
32	Health Care	1,555,606	32
33	General Administration	884,669	33
	B. Capital Expense		
34	Ownership	251,623	34
	C. Ancillary Expense		
35	Special Cost Centers	6,112	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,748,186	40
41	Income before Income Taxes (line 30 minus line 40)**	(411,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (411,839)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,902	2,142	\$ 64,926	\$ 30.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,302	21,369	495,717	23.20	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	512,556	56,619	594,060	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,214	5,570	66,339	11.91	10
11	Social Service Workers	11,534	12,756	186,537	14.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,111	14,445	203,731	14.10	15
16	Dishwashers					16
17	Maintenance Workers	5,830	3,099	52,406	16.91	17
18	Housekeepers	16,558	18,526	178,024	9.61	18
19	Laundry	5,789	6,323	67,221	10.63	19
20	Administrator	3,065	3,241	118,278	36.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,544	6,187	93,085	15.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,164	28,408	13.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	28	28	931	33.25	33
34	TOTAL (lines 1 - 33)	602,353	152,469	\$ 2,149,663 *	\$ 14.10	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	152	\$ 6,698	01-03	35
36	Medical Director	334	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	78	2,857	11-03	44
45	Social Service Consultant	104	4,836	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	258	12,902	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,044	\$ 43,493		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number		Sharon Health Care Pines		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21		Ending:		12/31/11	
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						
Randall Bauer	Administrator	0	\$ 73,749	Workers' Compensation Insurance		\$ 73,178	IDPH License Fee		\$						
Rick Duros	Administrative	8.98	18,766	Unemployment Compensation Insurance		15,637	Advertising: Employee Recruitment		1,217						
Gary Weintraub	Administrative	11.32	17,255	FICA Taxes		164,449	Health Care Worker Background Check		1,271						
Anca Zota-Oviedo	Administrative	1.00	8,508	Employee Health Insurance		91,952	(Indicate # of checks performed 127)								
				Employee Meals			Patient Background Checks	44	440						
				Illinois Municipal Retirement Fund (IMRF)*			Advertising & Promotions		5,830						
				Christmas Expense		2,455	Dues & Subscriptions		2,119						
				Union Pension Contributions		33,337	License, Permits, & Fees		1,114						
				Employee Benefits		9,701	Allocated from Peoria		248						
				401K Contribution		4,283	See Supplemental Schedule		10						
							Less: Public Relations Expense	(							
							Non-allowable advertising		(5,830)						
							Yellow page advertising	(							
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)								
(List each licensed administrator separately.)			\$ 118,278	\$ 394,992			\$ 6,419								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description			Amount	Description	Line #	Amount	Description		Amount						
			\$			\$	Out-of-State Travel		\$						
							In-State Travel								
TOTAL (agree to Schedule V, line 17, col. 3)			\$												
(Attach a copy of any management service agreement)															
C. Professional Services															
Vendor/Payee	Type		Amount												
Frost, Ruttenberg, & Rothblatt	Accounting Fees		\$ 9,500												
Honkamp Krueger & Co	Accounting Fees		2,763												
Sharon Healthcare Complex	Accounting Fees		925												
Barton Management Inc	Accounting Fees		156												
LTC Solutions	Computer Services		1,500												
Health Data Solutions	Computer Services		5,164												
Barton Management Inc	Computer Services		9,993												
Barton Management Inc	Adjusted on Page 5A		1,339				Seminar Expense		3,577						
Alpha Data Services	Payroll Processing		5,266												
Personnel Planners	Unemployment Consultant		940												
							Entertainment Expense	(							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 37,546	\$			TOTAL								
SEE ACCOUNTANTS' COMPILATION REPORT															
* 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	2004	\$ 607		\$ 101	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	2005	1,072		358	179							
3	Painting & Decorating	2006	4,454		1,485	1,485	742						
4	Painting & Decorating	2007	1,723		287	574	574	287					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 7,856		\$ 2,231	\$ 2,238	\$ 1,316	\$ 287	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? No
If YES, give association name and amount. N/A

(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? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 973 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. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,510
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14

d. Have vehicle usage logs been maintained? No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No

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. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: N/A

(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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT