

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0032789

Facility Name: Sharon Health Care Elms

Address: 3611 North Rochelle Peoria 61604
Number City Zip Code

County: Peoria

Telephone Number: (309) 685-4412 Fax #: (309) 685-4480

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1987

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

X "Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 <u>N/A</u>					
	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	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				360		1,720		2,080	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	2,385	16,420	554		1,813		1,607	22,779	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,385	16,420	554	360	1,813	1,720	1,607	24,859	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 70.94%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 8/15/1987

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 8/15/1987 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 96

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	269,287	31,445	10,481	311,213		311,213		311,213			1
2	Food Purchase		262,942		262,942		262,942	(190)	262,752			2
3	Housekeeping	286,618	25,961		312,579		312,579		312,579			3
4	Laundry	61,332	25,303		86,635		86,635		86,635			4
5	Heat and Other Utilities			168,646	168,646		168,646	1,127	169,773			5
6	Maintenance	121,162		109,819	230,981		230,981	(22,785)	208,196			6
7	Other (specify):* Waste Disposal			18,545	18,545		18,545		18,545			7
8	TOTAL General Services	738,399	345,651	307,491	1,391,541		1,391,541	(21,848)	1,369,693			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,695,084	171,959	393,609	3,260,652		3,260,652		3,260,652			10
10a	Therapy	30,305	115,744	78,951	225,000		225,000		225,000			10a
11	Activities	116,475	5,910	1,575	123,960		123,960		123,960			11
12	Social Services	213,659		1,575	215,234		215,234		215,234			12
13	CNA Training											13
14	Program Transportation			23,024	23,024		23,024		23,024			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,055,523	293,613	516,734	3,865,870		3,865,870		3,865,870			16
	C. General Administration											
17	Administrative	162,469		189,673	352,142		352,142	(126,977)	225,165			17
18	Directors Fees											18
19	Professional Services			82,675	82,675		82,675	503	83,178			19
20	Dues, Fees, Subscriptions & Promotions			29,073	29,073		29,073	(5,587)	23,486			20
21	Clerical & General Office Expenses	156,433	36,615	27,477	220,525		220,525	(1,652)	218,873			21
22	Employee Benefits & Payroll Taxes			569,717	569,717		569,717		569,717			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,508	2,508		2,508		2,508			24
25	Other Admin. Staff Transportation			4,549	4,549		4,549	(266)	4,283			25
26	Insurance-Prop.Liab.Malpractice			132,238	132,238		132,238	190	132,428			26
27	Other (specify):*							2,030	2,030			27
28	TOTAL General Administration	318,902	36,615	1,037,910	1,393,427		1,393,427	(131,759)	1,261,668			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,112,824	675,879	1,862,135	6,650,838		6,650,838	(153,607)	6,497,231			29

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

SEE ACCOUNTANTS' PREPARATION 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			71,976	71,976		71,976	10,891	82,867			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							4,095	4,095			32
33	Real Estate Taxes			60,313	60,313		60,313	7,489	67,802			33
34	Rent-Facility & Grounds			111,297	111,297		111,297	(104,548)	6,749			34
35	Rent-Equipment & Vehicles			68,647	68,647		68,647		68,647			35
36	Other (specify):*											36
37	TOTAL Ownership			312,233	312,233		312,233	(82,073)	230,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,821	234,947	327,768		327,768		327,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			486,930	486,930		486,930		486,930			42
43	Other (specify):* Disallowed Costs	119,412		204,717	324,129		324,129	(324,129)				43
44	TOTAL Special Cost Centers	119,412	92,821	926,594	1,138,827		1,138,827	(324,129)	814,698			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,232,236	768,700	3,100,962	8,101,898		8,101,898	(559,809)	7,542,089			45

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

SEE ACCOUNTANTS' PREPARATION 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	(4,316)	43		4
5	Telephone, TV & Radio in Resident Rooms	(7,515)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,418	30		9
10	Interest and Other Investment Income	(13,173)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(190)	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	(3,575)	43		18
19	Entertainment	(125)	43		19
20	Contributions	(16,759)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,196)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(151,738)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (365,169)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(194,640)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (194,640)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (559,809)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (1,334)	20	1
2	Other Expenses Related to Lobbying Activities	(4,286)	20	2
3				3
4	Disallow 50% of Admission Director as Marketing	(6,709)	21	4
5	Marketing Expense	(231)	43	5
6	Capitalized R & M over \$2500	(24,544)	6	6
7	Expense Fixed Assets under \$2500	5,044	21	7
8	Non-Allowable Expense	(119,412)	43	8
9	Auto Expense - Marketing	(266)	25	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(151,738)		49

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 Ownership Listing-1		See Page 6-Supplemental		See Page 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

☐ 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	5	Utilities	\$	Barton Management Inc.		\$ 904	\$ 904	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		1,759	1,759	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		21	21	3
4	V	21	Clerical & General		Barton Management Inc.		13	13	4
5	V	26	Insurance		Barton Management Inc.		190	190	5
6	V	33	Real Estate Taxes		Barton Management Inc.		4,384	4,384	6
7	V	34	Rent Office Space	20,400	Barton Management Inc.		6,437	(13,963)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 20,400			\$ 13,708	\$ * (6,692)	14

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

SEE ACCOUNTANTS' PREPARATION 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.

X 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	Management Fees	\$ 189,673	Redwood Management		\$	(189,673)	15
16	V	17	Salary - J. Shlofrock		Redwood Management		26,210	26,210	16
17	V	17	Management Fee - S. Aron		Redwood Management		36,486	36,486	17
18	V	27	Payroll Taxes - J. Shlofrock		Redwood Management		2,030	2,030	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			\$ 189,673			\$ 64,726	\$ * (124,947)	39

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.

☒ X

 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	\$	Peoria Forest Partnership		\$ 223	\$ 223	15
16	V	19	Professional Fees		Peoria Forest Partnership		503	503	16
17	V	20	Licenses		Peoria Forest Partnership		12	12	17
18	V	30	Depreciation		Peoria Forest Partnership		6,473	6,473	18
19	V	32	Interest		Peoria Forest Partnership		17,268	17,268	19
20	V	33	Real Estate Tax		Peoria Forest Partnership		3,105	3,105	20
21	V	34	Rent	90,585	Peoria Forest Partnership			(90,585)	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			\$ 90,585			\$ 27,584	\$ * (63,001)	39

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Barton Senior Residences of Zion (SLF)	Zion						1
2	Central Plaza Residential Home	Chicago			Barton Management	Northfield	Bookkeeping	2
3	Clayton Residential Home	Chicago			Peoria Forest Partners	Northfield	Building & Dietary	3
4	Barton Senior Residences of Chicago (SLF)	Chicago			Redwood Managemen	Northfield	Management Co.	4
5	Sharon Health Care Woods, Inc.	Peoria						5
6	Thornton Heights Terrace	Chicago Heights						6
7	Sharon Health Care Pines, Inc.	Peoria						7
8	Sharon Health Care Willows, Inc.	Peoria						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

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	29.20%	See Att. Sch 7A	6.50	15.48%	Alloc Salary	\$ 26,210	17-7	1
2	Stan Aron	Shareholder	Administrative	19.46%	See Att. Sch 7A	4.00	10.81%	Sal. Alloc Mgmt Fe	39,958	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	12.67%	See Att. Sch 7A	4.00	9.52%	Salary	21,426	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.12%	See Att. Sch 7A	3.00	5.45%	Salary	20,885	17-1	4
5	Richard Duros	COO	Administrative	0.00%	See Att. Sch 7A	5.00	11.24%				5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 108,479		13

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

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Cental 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	496,213	8	\$ 12,800	\$	35,040	\$ 904	1
2	6	Repairs & Maintenance	Available Days	496,213	8	24,917		35,040	1,759	2
3	20	Dues, Licenses, Fees	Available Days	496,213	8	300		35,040	21	3
4	21	Clerical & General	Available Days	496,213	8	183		35,040	13	4
5	26	Insurance	Available Days	496,213	8	2,690		35,040	190	5
6	33	Real Estate Taxes	Available Days	496,213	8	62,084		35,040	4,384	6
7	34	Rent Office Space	Available Days	496,213	8	91,160		35,040	6,437	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					\$ 194,134	\$		\$ 13,708	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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	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	17	Salary - J. Shlofrock	Average Hours Worked	31	5	125,000	125,000	6.50	\$ 26,210	1
2	17	Management Fee - S. Aron	Average Hours Worked	23	5	209,794		4.00	36,486	2
3	27	Payroll Taxes - J. Shlofrock	Average Hours Worked	31	5	9,679		6.50	2,030	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					\$ 344,473	\$ 125,000		\$ 64,726	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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	5	Utilities	Bed Size	582	4	\$ 1,353	\$	96	\$ 223	1
2	19	Professional Fees	Bed Size	582	4	3,050		96	503	2
3	20	Licenses	Bed Size	582	4	75		96	12	3
4	30	Depreciation	Bed Size	582	4	39,241		96	6,473	4
5	32	Interest	Bed Size	582	4	104,686		96	17,268	5
6	33	Real Estate Tax	Bed Size	582	4	18,826		96	3,105	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					\$ 167,231	\$		\$ 27,584	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												5
	Working Capital											
6	Allocated from Peoria Forest	X									17,268	6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 17,268	9
	B. Non-Facility Related*											
10	Interest Income		X						Offset Interest Income		(13,173)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (13,173)	14
15	TOTALS (line 9+line14)						\$				\$ 4,095	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.) SEE ACCOUNTANTS' PREPARATION 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	57,142	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.)		2024		\$	57,576	2
3. Under or (over) accrual (line 2 minus line 1).				\$	434	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	59,879	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.		Allocated from Barton Management			4,384	
		Allocated from Peoria Forest			3,105	
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.				\$	67,802	7
Assessed Value from Real Estate Tax Bill:	2024	636,540	8			
Real Estate Tax Bill for Calendar Year:	2020	56,116	9			
	2021	55,676	10			
	2022	54,021	11			
	2023	54,945	12			
	2024	57,576	13			
2025 Accrual = \$57,576 x 1.04 = \$59,879						
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Elms COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032789

CONTACT PERSON REGARDING THIS REPORT Anca Oviedo

TELEPHONE (847) 441-8200 FAX #: (847) 441-0800

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 13-25-426-016	Nursing Home Property	\$ 57,576.20	\$ 57,576.20
2. 05-19-112-017-0000	Allocated from Barton Mgmt	\$ 124,168.59	\$ 4,384.00
3. See Attached	Allocated from Peoria Forest	\$ 18,825.76	\$ 3,105.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 200,570.55	\$ 65,065.20

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

24,372

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 Health Care Willows - Facility 218 Beds

Sharon Health Care Woods- Facility 152 Beds

Sharon Health Care Pines - Facility 116 Beds

Peoria Forest Partnership - Dietary Building

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

I. Are you presently operating under a sublease agreement?

N/A

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒

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

K. 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	Allocated from Peoria Forest		1991	\$ 107,397	1
2	Allocated from Peoria Forest		1999	6,035	2
3	TOTALS			\$ 113,432	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	96		1991	1972	\$ 1,865,823	\$		\$	\$	\$ 1,865,823
5										
6										
7										
8										
	Improvement Type**									
9	Various		1987		5,207		20			5,207
10	Various		1988		4,581		20			4,581
11	Various		1989		1,877		20			1,877
12	Various		1990		6,666		20			6,666
13	Various		1991		23,422		20			23,422
14	Various		1992		19,136		20			19,136
15	Various		1994		9,731		20			9,731
16	Various		1995		2,723		20			2,723
17	Various		1996		4,103		20			4,103
18	Various		1997		19,387		20			19,387
19	Various		1998		18,953		20	151	151	18,953
20	Various		1999		13,776		20	417	417	13,776
21	Various		2000		18,986		20	949	949	18,753
22	Various		2001		59,593		20	2,980	2,980	57,978
23	Various		2002		1,050		20	52	52	978
24	Various		2003		10,364		20	519	519	9,427
25	Various		2004		10,079		20	504	504	8,995
26	Various		2005		40,481		20	2,025	2,025	35,049
27	Various		2006		18,816		20	940	940	15,688
28	Various		2007		100,869		20	4,507	4,507	83,955
29	Various		2008		41,432		20	990	990	37,252
30	Various		2009		159,312		20	6,359	6,359	130,344
31	Various		2010		6,905		20	345	345	5,023
32	Various		2011		40,411		20	2,021	2,021	28,787
33	Various		2012		78,265		20	1,720	1,720	66,513
34	Various		2013		8,731		20	171	171	8,731
35	Various		2014		109,950		20	160	160	108,518
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2015	65,363		20	3,268	\$ 3,268	\$ 34,818	37
38	Various	2016	\$ 14,785	\$	20	\$ 739	739	7,312	38
39	Various	2017	11,569		20	579	579	4,958	39
40	Various	2018	259,695		20	12,985	12,985	98,438	40
41	Various	2019	49,915		20	2,496	2,496	17,006	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,101,956	\$		\$ 44,877	\$ 44,877	\$ 2,773,908	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,101,956	\$		\$ 44,877	\$ 44,877	\$ 2,773,908	1
2	Water Heater	2020	4,493		20	225	225	1,350	2
3	Gas/Electric Hvac Unit	2020	9,750		20	488	488	2,928	3
4	Concrete Work	2020	6,324		20	316	316	1,896	4
5	Install Room Tone Visual Light Call System	2021	43,418		20	2,171	2,171	10,855	5
6	Replace Leaking 100 Gallon Water Heater & Piping	2022	9,586		20	479	479	1,916	6
7	47 Overbed Lights	2022	7,893		20	395	395	1,580	7
8	Wall Mounted Ipad Charging Stations	2023	2,720		20	136	136	408	8
9	Replace Bad Piping, Installation Of New Compressor	2023	5,079		20	254	254	762	9
10	Walk In Freezer	2024	3,952		20	198	198	396	10
11	Replace Vinyl Flooring/Cove Base - C Wing	2024	19,804		20	990	990	1,980	11
12	Install New Heat Exchanger & Inducer-A Wing Left Side	2024	5,011		20	251	251	502	12
13	Install New Heat Exchanger - C Wing Right Side	2024	3,906		20	195	195	390	13
14	Install 2 New 240-A Tankless Water Heaters	2024	14,000		20	700	700	1,400	14
15	Install New Mag Lock/Power Supply/25' Line from Fire Alarm Pa	2024	3,738		20	187	187	374	15
16	Install New Carrier 4 Ton RTU Roof Top Unit	2024	15,800		20	790	790	1,580	16
17	Install New GreenHeck Hi Static Fan - Wings A, B & C	2024	12,600		20	630	630	1,260	17
18	Install 10 Sliding Windows	2024	8,950		20	448	448	896	18
19	Install 20 Sliding Windows	2025	17,500		20	438	438	438	19
20	Install 20 Sliding Windows	2025	19,620		20	491	491	491	20
21	Remodel Wing C-Drywall/Painting/LightFixtures/								21
22	Bathrooms/Flooring	2025	158,327		20	3,958	3,958	3,958	22
23	Install 4 Ton Rooftop HVAC	2025	19,935		20	498	498	498	23
24	Install 5 Ton RTU	2025	19,916		20	498	498	498	24
25	Repair 2' Pipe Above Rm C10	2025	3,011		20	75	75	75	25
26	12 Cameras	2025	2,527		20	63	63	63	26
27	Repair Roof-Shingle Tear Off	2025	7,650		20	191	191	191	27
28	Repair Concrete Sidewalk-Ramp/Left Side of Bldg, Roadway Patc	2025	3,689		20	92	92	92	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,531,155	\$		\$ 60,034	\$ 60,034	\$ 2,810,685	34

SEE ACCOUNTANTS' PREPARATION 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		\$ 3,531,155	\$		\$ 60,034	\$ 60,034	\$ 2,810,685	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	Financial Statement Depreciation			71,976			(71,976)		14
15									15
16									16
17									17
18									18
19	Allocated from Peoria Forest	1991	39,435		31.5	1,190	1,190	30,341	19
20	Allocated from Peoria Forest	2019	37,962		35	1,085	1,085	7,321	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)		\$ 3,608,552	\$ 71,976		\$ 62,309	\$ (9,667)	\$ 2,848,347	34

SEE ACCOUNTANTS' PREPARATION 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	\$169,423	\$	\$16,304	\$16,304	10 Yrs	\$111,803	71
72	Current Year Purchases	7,885		789	789		789	72
73	Fully Depreciated Assets	861,720					861,720	73
74								74
75	TOTALS	\$1,039,028	\$	\$17,093	\$17,093		\$974,312	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		1996 CHEV VAN	2001	\$2,463	\$	\$	\$	5	\$2,463	76
77		2001 DODGE RAM	2004	2,945				5	2,945	77
78		2008 CHEVY EXPRESS	2009	10,244				5	10,244	78
79		See Attached Schedule 13A		34,996		3,465	3,465	5	24,603	79
80	TOTALS			\$50,648	\$	\$3,465	\$3,465		\$40,255	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,811,660	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$71,976	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$82,867	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,891	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,862,914	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

Facility Name: Sharon Health Care Elms

IDPH License ID Number: 0032789

Fiscal Year End: 12/31/2025

Schedule 13A

D. Vehicle Costs. (See instructions.)*

	Use	Model, Make and Year		Year Acquired 3		4 Cost	Current Book Depreciation 5	Straight Line Depreciation	Adjustments	Life in Years 8	Accumulated Depreciation	
	Facility	Tractor		2009	\$	1,844	\$	\$	0	5	\$ 1,844	
	Facility	2011 Ford		2014		15,829			0	5	15,829	
	Facility	2024 Ford Transit		2024		17,323		3,465	3,465	5	6,930	
									0			
79	TOTALS				\$	34,996	0	\$ 3,465	\$ 3,465		\$ 24,603	79

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				312			5
6	Allocated from Barton Management				6,437			6
7	TOTAL				\$ 6,749			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?
16. Rental Amount for movable equipment: \$ 68,647 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name:

Sharon Health Care Elms

IDPH License ID Number:

0032789

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	61,483
Copiers	6,845
Lundry Equipment	319
Total - Line 16	68,647

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

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	39(3)	hrs	\$	1,923	\$ 94,463	\$	1,923	\$ 94,463	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		249	19,964		249	19,964	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		2,648	118,124		2,648	118,124	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				88,079		88,079	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ancillary Exp-Veterans					78,951	115,744		194,695	12
13	Other (specify): Lab/Xray/Medical Supplies					2,396	4,742		7,138	13
14	TOTAL			\$	4,820	\$ 313,898	\$ 208,565	4,820	\$ 522,463	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' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 507,597	\$ 507,597	1
2	Cash-Patient Deposits	21,737	21,737	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000)	1,204,029	1,204,029	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,175	56,175	6
7	Other Prepaid Expenses	35,983	35,983	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	197,191	197,191	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,022,712	\$ 2,022,712	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		113,432	13
14	Buildings, at Historical Cost		1,865,823	14
15	Leasehold Improvements, at Historical Cost	1,100,682	1,742,729	15
16	Equipment, at Historical Cost	834,709	1,089,676	16
17	Accumulated Depreciation (book methods)	(1,600,287)	(3,862,914)	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) Const in Progress			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 335,104	\$ 948,746	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,357,816	\$ 2,971,458	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 192,254	\$ 192,254	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,737	21,737	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	313,412	313,412	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,075	11,075	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,879	59,879	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	216,137	216,137	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 814,494	\$ 814,494	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 814,494	\$ 814,494	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,543,322	\$ 2,156,964	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,357,816	\$ 2,971,458	48

Facility Name: Sharon Health Care Elms

IDPH License ID Number: 0032789

Fiscal Year End: 12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
Advance	2,500	2,500
State Replacement Tax Deposit	23,000	23,000
Interest Receivable	563	563
Due from HFS-C.N.A. Tenure	171,128	171,128
Total - Line 9	197,191	197,191

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Resident Credit Balances	215,979	215,979
Deferred SRT Liabilty	158	158
Total - Line 36	216,137	216,137

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,434,316	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,434,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,005	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 109,005	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,543,322	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,650,043	1
2	Discounts and Allowances for all Levels	124,489	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,774,532	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,677	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 129,677	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	1,593	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)	\$ 1,593	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,173	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,173	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	C.N.A. Initiative Revenue	282,927	28
28a	Quality Incentive Payment	9,001	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 291,928	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,210,903	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,391,541	31
32	Health Care	3,865,870	32
33	General Administration	1,393,427	33
	B. Capital Expense		
34	Ownership	312,233	34
	C. Ancillary Expense		
35	Special Cost Centers	651,897	35
36	Provider Participation Fee	486,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,101,898	40
41	Income before Income Taxes (line 30 minus line 40)**	109,005	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 109,005	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 623,660	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,293,713	45
46	MMAI-Medicaid is the Primary Payer	144,867	46
47	MMAI-Medicare is the Primary Payer	215,626	47
48	Private Pay	553,500	48
49	Medicare Part A	1,030,211	49
50	Other-(specify) Veterans	912,955	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,774,532	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,936	2,064	\$ 107,791	\$ 52.22	1
2	Assistant Director of Nursing	2,331	2,435	111,242	45.68	2
3	Registered Nurses	9,559	10,041	470,439	46.85	3
4	Licensed Practical Nurses	8,711	9,043	330,138	36.51	4
5	CNAs & Orderlies	63,554	67,284	1,540,407	22.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,070	1,218	30,305	24.88	8
9	Activity Director					9
10	Activity Assistants	5,833	6,219	116,475	18.73	10
11	Social Service Workers	9,172	10,307	213,659	20.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,158	14,035	269,287	19.19	15
16	Dishwashers					16
17	Maintenance Workers	4,380	4,755	121,162	25.48	17
18	Housekeepers	13,709	16,583	286,618	17.28	18
19	Laundry	3,619	3,859	61,332	15.89	19
20	Administrator	1,960	2,080	116,686	56.10	20
21	Assistant Administrator					21
22	Other Administrative	506	506	45,783	90.48	22
23	Office Manager					23
24	Clerical	7,147	7,461	156,433	20.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,784	2,007	46,319	23.08	31
32	Other Health Care(specify)					32
33	Other(specify) See Att Sch 20A	2,572	2,708	208,160	76.87	33
34	TOTAL (lines 1 - 33)	151,001	162,605	\$ 4,232,236 *	\$ 26.03	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	Monthly	\$ 10,481	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,575	L11, C3	44
45	Social Service Consultant	Monthly	1,575	L12, C3	45
46	Other(specify) MDS Consultant	Monthly	15,987	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 49,418		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	5,780	375,822	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,780	\$ 375,822		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Sharon Health Care Elms

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Non Allowable Expense (adj P5A)	716	716	119,412	166.78
MDS Coordinator	1,856	1,992	88,748	44.55
TOTAL	2,572	2,708	208,160	

Facility Name: Sharon Health Care Elms

IDPH License ID Number: 0032789

Fiscal Year End: 12/31/2025

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Sonic Wall	Computer Expense	\$ 900
Go Daddy	Computer Expense	731
Intuit	Computer Expense	31
Equifax Workforce Solutions	Insurance Consultant	604
Netsmart	Computer Expense	3,857
Tiger Direct	Computer Expense	826
Jordan Healthcare Group	Operational Consulting	1,312
HCPCS Inc	Computer Expense	545
Carbonite	Computer Expense	773
Total		9,579

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes, only CNAs
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>1,334</u> |
| | |
| | |
| | <u>1,334</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>1,334</u> |
| | |
| | |
| | <u>1,334</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>2,668</u> |
| | |
| | |
| | <u>2,668</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 994 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 486,930
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (12) 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% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.