

		FOR BHF USE					

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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: 0032763

Facility Name: Sharon Health Care Pines

Address: 3614 North RochellePeoria61604
NumberCityZip Code

County: Peoria

Telephone Number: (309) 685-8800Fax #: (309) 686-8609

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 TemplinTelephone Number: (630) 361-2868
Email Address:

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) 361-2868Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Pines # 0032763 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	116	Intermediate (ICF)	116	42,340	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	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									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	2,969	33,286	1,736				366	38,357	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,969	33,286	1,736				366	38,357	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 90.59%

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

Medicare Intermediary N/A

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 Pines # 0032763 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	289,409	42,348	9,259	341,016		341,016		341,016			1
2	Food Purchase		391,042		391,042		391,042		391,042			2
3	Housekeeping	323,129	31,701		354,830		354,830		354,830			3
4	Laundry		18,443		18,443		18,443		18,443			4
5	Heat and Other Utilities			171,656	171,656		171,656	1,362	173,018			5
6	Maintenance	62,205		108,436	170,641		170,641	(674)	169,967			6
7	Other (specify):* Waste Disposal			12,081	12,081		12,081		12,081			7
8	TOTAL General Services	674,743	483,534	301,432	1,459,709		1,459,709	688	1,460,397			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,098,727	137,759	23,016	3,259,502		3,259,502		3,259,502			10
10a	Therapy		(620)	1,063	443		443		443			10a
11	Activities	58,990	8,758	1,967	69,715		69,715		69,715			11
12	Social Services	278,438			278,438		278,438		278,438			12
13	CNA Training											13
14	Program Transportation			19,643	19,643		19,643		19,643			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,436,155	145,897	63,689	3,645,741		3,645,741		3,645,741			16
	C. General Administration											
17	Administrative	202,387		379,346	581,733		581,733	(316,650)	265,083			17
18	Directors Fees											18
19	Professional Services			72,945	72,945		72,945	608	73,553			19
20	Dues, Fees, Subscriptions & Promotions			21,515	21,515		21,515	(4,245)	17,270			20
21	Clerical & General Office Expenses	132,574	28,117	9,584	170,275		170,275	(4,092)	166,183			21
22	Employee Benefits & Payroll Taxes			561,307	561,307		561,307		561,307			22
23	Inservice Training & Education			4,030	4,030		4,030		4,030			23
24	Travel and Seminar			1,919	1,919		1,919		1,919			24
25	Other Admin. Staff Transportation			10,404	10,404		10,404	(383)	10,021			25
26	Insurance-Prop.Liab.Malpractice			153,434	153,434		153,434	229	153,663			26
27	Other (specify):*							2,030	2,030			27
28	TOTAL General Administration	334,961	28,117	1,214,484	1,577,562		1,577,562	(322,503)	1,255,059			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,445,859	657,548	1,579,605	6,683,012		6,683,012	(321,815)	6,361,197			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			27,569	27,569		27,569	16,340	43,909			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			69,031	69,031		69,031	9,050	78,081			33
34	Rent-Facility & Grounds			130,571	130,571		130,571	(122,422)	8,149			34
35	Rent-Equipment & Vehicles			22,161	22,161		22,161		22,161			35
36	Other (specify):*											36
37	TOTAL Ownership			249,332	249,332		249,332	(97,032)	152,300			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			792,086	792,086		792,086		792,086			42
43	Other (specify):* Disallowed Costs	258,569		145,047	403,616		403,616	(403,616)				43
44	TOTAL Special Cost Centers	258,569		937,133	1,195,702		1,195,702	(403,616)	792,086			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,704,428	657,548	2,766,070	8,128,046		8,128,046	(822,463)	7,305,583			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	(4,311)	43		4
5	Telephone, TV & Radio in Resident Rooms	(3,899)	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	8,519	30		9
10	Interest and Other Investment Income	(20,866)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(43,740)	43		18
19	Entertainment	(125)	43		19
20	Contributions	(22,950)	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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(68,440)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(271,728)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (427,540)		\$	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)	(394,923)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (394,923)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (822,463)		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	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(4,286)	20	2
3				3
4				4
5	Miscellaneous Income Offset	(60)	21	5
6	Patient Clothing	(205)	43	6
7	Disallow 50% of Admission Director as Marketing	(8,172)	21	7
8	Marketing Expense	(1,377)	43	8
9	Capitalized R&M	(2,800)	06	9
10	Expensed Improvement under \$2500	4,124	21	10
11	Non-Allowable Expense - Wages	(258,569)	43	11
12	Auto Expense-Marketing	(383)	25	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
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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	(271,728)		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.		\$ 1,092	\$ 1,092	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		2,126	2,126	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		26	26	3
4	V	21	Clerical & General		Barton Management Inc.		16	16	4
5	V	26	Insurance		Barton Management Inc.		229	229	5
6	V	33	Real Estate Taxes		Barton Management Inc.		5,298	5,298	6
7	V	34	Rent Office Space	20,400	Barton Management Inc.		7,778	(12,622)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 20,400			\$ 16,565	\$ * (3,835)	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.

☒ 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	\$ 379,346	Redwood Management		\$	(379,346)	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			\$ 379,346			\$ 64,726	\$ * (314,620)	39

* 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	5	Utilities	\$	Peoria Forest Partnership		\$ 270	\$ 270	15
16	V	19	Professional Fees		Peoria Forest Partnership		608	608	16
17	V	20	Licenses		Peoria Forest Partnership		15	15	17
18	V	30	Depreciation		Peoria Forest Partnership		7,821	7,821	18
19	V	32	Interest		Peoria Forest Partnership		20,866	20,866	19
20	V	33	Real Estate Tax		Peoria Forest Partnership		3,752	3,752	20
21	V	34	Rent	109,800	Peoria Forest Partnership			(109,800)	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			\$ 109,800			\$ 33,332	\$ * (76,468)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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, I	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 Elms, Inc.	Peoria						5
6	Thornton Heights Terrace	Chicago Heights						6
7	Sharon Health Care Willows, Inc.	Peoria						7
8	Sharon Health Care Woods, Inc.	Peoria						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
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19								19
20								20
21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	40,287	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	12.67%	See Att. Sch 7A	4.00	9.52%	Salary	34,094	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.12%	See Att. Sch 7A	3.00	5.45%	Salary	34,031	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	\$ 134,622		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 Pines # 0032763 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	\$	42,340	\$ 1,092	1
2	6	Repairs & Maintenance	Available Days	496,213	8	24,917		42,340	2,126	2
3	20	Dues, Licenses, Fees	Available Days	496,213	8	300		42,340	26	3
4	21	Clerical & General	Available Days	496,213	8	183		42,340	16	4
5	26	Insurance	Available Days	496,213	8	2,690		42,340	229	5
6	33	Real Estate Taxes	Available Days	496,213	8	62,084		42,340	5,298	6
7	34	Rent Office Space	Available Days	496,213	8	91,160		42,340	7,778	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	\$		\$ 16,565	25

Facility Name & ID Number Sharon Health Care Pines # 0032763 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 Pines # 0032763 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	\$	116	\$ 270	1
2	19	Professional Fees	Bed Size	582	4	3,050		116	608	2
3	20	Licenses	Bed Size	582	4	75		116	15	3
4	30	Depreciation	Bed Size	582	4	39,241		116	7,821	4
5	32	Interest	Bed Size	582	4	104,686		116	20,866	5
6	33	Real Estate Tax	Bed Size	582	4	18,826		116	3,752	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	\$		\$ 33,332	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										20,866	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	20,866	9
	B. Non-Facility Related*												
10	Interest Income		X									(20,866)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(20,866)	14
15	TOTALS (line 9+line14)						\$				\$		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' PREPARATION REPORT

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.		\$	65,703	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		\$	65,884	2
3. Under or (over) accrual (line 2 minus line 1).				\$	181	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	68,849	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.				\$	78,081	7
Assessed Value from Real Estate Tax Bill:	2024	728,390	8			
Real Estate Tax Bill for Calendar Year:	2020	64,184	9			
	2021	63,680	10			
	2022	61,788	11			
	2023	62,873	12			
	2024	65,884	13			
2025 Accrual = \$65,884 x 1.045 = \$68,849						

FOR BHF USE ONLY		
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 Pines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032763

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. 13-25-427-014	Long Term Care Property	\$ 65,884.20	\$ 65,884.20
2. 05-19-112-017-0000	Allocated from Barton Management	\$ 124,168.59	\$ 5,298.00
3. See Attached	Allocated from Peoria Forest	\$ 18,825.76	\$ 3,752.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 208,878.55	\$ 74,934.20

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:

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 Health Care Willows - Facility 218 Beds
Sharon Health Care Elms- Facility 96 Beds
Sharon Health Care Woods - Facility 152 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

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. 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

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	\$ 127,123	1
2	Allocated from Peoria Forest		1999	7,143	2
3	TOTALS			\$ 134,266	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Pines

0032763

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	116		1991	1972	\$ 2,208,525	\$	31.5	\$	\$	2,208,525
5										
6										
7										
8										
	Improvement Type**									
9	Various		1987		4,748		20			4,748
10	Various		1988		31,896		20			31,896
11	Various		1989		20,183		20			20,183
12	Various		1990		10,549		20			10,549
13	Various		1991		2,580		20			2,580
14	Various		1992		15,639		20			15,639
15	Various		1993		3,764		20			3,764
16	Various		1994		33,543		20			33,543
17	Various		1995		11,702		20			11,702
18	Various		1996		4,012		20			4,012
19	Various		1997		14,815		20			14,815
20	Various		1998		27,567		20			27,567
21	Various		1999		25,473		20			25,473
22	Various		2000		4,404		20			4,404
23	Various		2001		34,460		20			34,460
24	Various		2002		8,876		20			8,876
25	Various		2003		10,166		20			10,166
26	Various		2004		13,297		20			13,297
27	Various		2005		49,034		20			49,034
28	Various		2006		40,115		20			40,115
29	Various		2007		93,696		20			93,696
30	Various		2008		130,151		20			130,151
31	Various		2009		70,088		20	562	562	70,088
32	Various		2011		4,822		20			4,822
33	Various		2012		51,914		20	1,239	1,239	43,445
34	Various		2014		51,483		20	2,574	2,574	28,756
35	Various		2015		99,509		20	4,975	4,975	53,259
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	Various	2017	\$ 17,261	\$	20	\$ 863	\$ 863	\$ 7,160	37
38	Various	2018	4,539		20	227	227	1,608	38
39	Various	2019	174,361		20	8,720	8,720	55,437	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,273,172	\$		\$ 19,160	\$ 19,160	\$ 3,063,770	70

Facility Name & ID Number Sharon Health Care Pines

0032763

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		\$ 3,273,172	\$		\$ 19,160	\$ 19,160	\$ 3,063,770	1
2	Furnace Repair	2020	2,825		20	141	141	846	2
3	Replace Concrete Slab	2020	5,050		20	253	253	1,518	3
4	Intalld Quartz Countertop	2020	8,974		20	449	449	2,694	4
5	Roof Repair - E & D Wings, D Wing Fascia/Soffit Repair	2020	3,242		20	162	162	972	5
6	Dining Rm Compressor Repair	2020	2,922		20	146	146	876	6
7	Install Keypads On Doors - Main Entry Double Door,Patio Doors	2021	7,474		20	374	374	1,870	7
8	Install Keypad On Door, Wall Mount	2021	2,530		20	127	127	635	8
9	Install Nurses Station Hand Sink & Eye Wash	2021	3,506		20	175	175	875	9
10	Installation Of Outdoor Conditioner Unit	2022	4,800		20	240	240	960	10
11	Installation Of New Fire Hydrant	2023	13,750		20	688	688	2,064	11
12	Installation Of New Furnace In E Wing Left Side	2023	16,160		20	808	808	2,424	12
13	New Walk In Freezer	2024	4,678		20	234	234	468	13
14	Install New AC Unit - Wing A	2024	6,800		20	340	340	680	14
15	Install New AC Unit - Wing C	2024	6,800		20	340	340	680	15
16	Install 2 New Navien 240-A Tankless Water Heaters	2023	11,486		20	574	574	1,148	16
17	Install New Kawneer Exterior Aluminum Door with Automatic D	2023	9,200		20	460	460	920	17
18	Remove & Replace Ceiling-Resident Bedroom	2024	3,484		20	174	174	348	18
19	Install Wall Mount Charging Stations	2024	3,906		20	195	195	390	19
20	Install Drywall-Bedroom	2025	3,000		20	75	75	75	20
21	Install 12 Windows	2025	10,740		20	269	269	269	21
22	Install 10 Ton Rooftop Air Conditioner	2025	23,790		20	595	595	595	22
23	Install 48 Windows	2025	41,170		20	1,029	1,029	1,029	23
24	Remove and Replace Shingles on Roof	2025	6,203		20	155	155	155	24
25	Install Drywall-Bedroom	2025	2,800		20	70	70	70	25
26									26
27									27
28	Allocated from Peoria Forest	1991	46,678		31.5	1,408	1,408	35,914	28
29	Allocated from Peoria Forest	2019	44,935		39	1,284	1,284	8,666	29
30									30
31									31
32	Financial Statement Depreciation			27,569			(27,569)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,570,075	\$ 27,569		\$ 29,925	\$ 2,356	\$ 3,130,911	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	\$85,271	\$	\$8,452	\$8,452	10 Yrs	\$45,032	71
72	Current Year Purchases	14,305		1,431	1,431	10 Yrs	1,431	72
73	Fully Depreciated Assets	710,285					710,285	73
74								74
75	TOTALS	\$809,861	\$	\$9,883	\$9,883		\$756,748	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				5	3,486	77
78		TRACTOR	2009	2,183				5	2,183	78
79		2024 Ford Transit	2024	20,504		4,101	4,101	5	8,202	79
80	TOTALS			\$29,159	\$	\$4,101	\$4,101		\$16,857	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)	\$4,543,361	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$27,569	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$43,909	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$16,340	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,904,516	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.

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				371			5
6	Allocated from Barton Management				7,778			6
7	TOTAL				\$ 8,149			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: \$ 22,161 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					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 Pines

IDPH License ID Number: 0032763

Fiscal Year End: 12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	18,398
Copiers	3,444
Lundry Equipment	319
Total - Line 16	22,161

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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.)

	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		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	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 987,593	\$ 987,593	1
2	Cash-Patient Deposits	107,493	107,493	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,648)	1,242,894	1,242,894	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,400,000	1,400,000	5
6	Prepaid Insurance	61,737	61,737	6
7	Other Prepaid Expenses	38,530	38,530	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	358,588	358,588	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,196,835	\$ 4,196,835	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		134,266	13
14	Buildings, at Historical Cost		2,208,525	14
15	Leasehold Improvements, at Historical Cost	957,505	1,361,550	15
16	Equipment, at Historical Cost	710,828	839,020	16
17	Accumulated Depreciation (book methods)	(1,432,349)	(3,904,516)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 235,984	\$ 638,845	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,432,819	\$ 4,835,680	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,373	\$ 201,373	26
27	Officer's Accounts Payable	100,000	100,000	27
28	Accounts Payable-Patient Deposits	107,492	107,492	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	408,105	408,105	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	10,854	10,854	31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,849	68,849	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	269,013	269,013	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,165,686	\$ 1,165,686	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	Due to Related Party	689,673	689,673	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 689,673	\$ 689,673	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,855,359	\$ 1,855,359	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,577,460	\$ 2,980,321	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,432,819	\$ 4,835,680	48

Facility Name:Sharon Health Care Pines

IDPH License ID Number:0032763

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
Advance	4,900	4,900
Interest Receivable	41,122	41,122
Payroll Exchange	1,067	1,067
Quality Incentive Payment	124,846	124,846
Due from HFS-C.N.A. Tenure	186,653	186,653
Total - Line 9	358,588	358,588

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Resident Credit Balances	268,137	268,137
Deferred SRT Liabilty	876	876
Total - Line 36	269,013	269,013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,296,419	1
2	Restatements (describe):		2
3	Accrued Distribution	(450,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,846,419	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	981,041	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	(250,000)	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)	\$ 731,041	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,577,460	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Pines

0032763

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	\$ 11,527,799	1
2	Discounts and Allowances for all Levels	(3,146,102)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,381,697	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***	81,791	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 81,791	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CNA Initiative Revenue	388,640	28
28a	See Attached Schedule 19A	256,959	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 645,599	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,109,087	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,459,709	31
32	Health Care	3,645,741	32
33	General Administration	1,577,562	33
	B. Capital Expense		
34	Ownership	249,332	34
	C. Ancillary Expense		
35	Special Cost Centers	403,616	35
36	Provider Participation Fee	792,086	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,128,046	40
41	Income before Income Taxes (line 30 minus line 40)**	981,041	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 981,041	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 646,449	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,247,463	45
46	MMAI-Medicaid is the Primary Payer	377,985	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	109,800	48
49	Medicare Part A		49
50	Other-(specify)		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)	\$ 8,381,697	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Sharon Health Care Pines

IDPH License ID Number: 0032763

Fiscal Year End: 12/31/2025

Schedule 19A

XVII. Income Statement

Line 28a Other Revenue (specify):

Description	Amount
Miscellaneous Income	60
Quality Incentive Payment	256,899
Total - Line 28a	256,959

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,106	2,218	\$ 113,195	\$ 51.03	1
2	Assistant Director of Nursing	2,247	2,585	129,974	50.28	2
3	Registered Nurses	10,198	10,656	506,605	47.54	3
4	Licensed Practical Nurses	11,352	11,947	435,760	36.47	4
5	CNAs & Orderlies	74,515	81,184	1,913,193	23.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,146	3,304	58,990	17.85	10
11	Social Service Workers	10,078	10,860	278,438	25.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,635	14,742	289,409	19.63	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,513	62,205	24.75	17
18	Housekeepers	18,634	19,716	323,129	16.39	18
19	Laundry					19
20	Administrator	1,960	2,080	130,461	62.72	20
21	Assistant Administrator					21
22	Other Administrative	506	506	71,926	142.15	22
23	Office Manager					23
24	Clerical	6,352	6,479	132,574	20.46	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					31
32	Other Health Care(specify)					32
33	Other(specify) Non Allowable Exp (adj P	1,236	1,236	258,569	209.20	33
34	TOTAL (lines 1 - 33)	157,885	170,026	\$ 4,704,428 *	\$ 27.67	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	\$ 9,259	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	36	1,967	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) MDS Consultant	213	19,181	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	249	\$ 50,207		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION 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:		1/1/2025		Page 21							
				# 0032763				Ending:		12/31/2025							
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		%		Amount		Description		Amount		Description		Amount			
Randall Bauer		Executive Director		0		\$ 130,461		Workers' Compensation Insurance		\$ 47,218		IDPH License Fee		\$ 1,997			
Gary Weintraub		Other Administrative		12.67%		34,094		Unemployment Compensation Insurance		20,302		Advertising: Employee Recruitment		3,359			
Anca Zota-Oviedo		Other Administrative		1.12%		34,031		FICA Taxes		330,718		Health Care Worker Background Check					
Stan Aron		Other Administrative		19.46%		3,801		Employee Health Insurance		152,431		(Indicate # of checks performed 114)		3,993			
								Employee Meals				Patient Background Checks					
								Illinois Municipal Retirement Fund (IMRF)*				Association Dues (total from pg 22, #4)					
								401K Contribution		7,913		Relias		6,033			
								Other Employee Benefit		1,560		Licenses & Permits		1,847			
								Christmas Expense		1,165		Peoria Forest Allocation		15			
TOTAL (agree to Schedule V, line 17, col. 1)												Barton Mgmt Home Office Allocation		26			
(List each licensed administrator separately.)						\$ 202,387						Less: Public Relations Expense		()			
B. Administrative - Other												PAC and Lobbying payments		()			
Description						Amount						All non-allowable advertising		()			
Redwood Management-Management Fees (Eliminated in Col 7)						\$ 379,346											
								TOTAL (agree to Schedule V, line 22, col.8)		\$ 561,307		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,270			
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 379,346		E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
Paychex		Payroll Processing				\$ 12,878						\$		Out-of-State Travel		\$	
Personnel Planners		Unemployment Consultant				1,020											
Netsmart		Computer Expense				3,857		N/A									
Wellsky		Computer Expense				2,041								In-State Travel			
Galaxy		Computer Expense				4,410											
Cohn Reznick		Accounting Fees				14,105											
Point Click Care		E.H.R. Software				20,727											
Constant Virtual Solutions		Computer Expense				6,625								Seminar Expense		1,919	
Waystar		Billing Software				1,454											
Templin Healthcare Accounting Svc		Accounting Fees				51											
Pension Performance		Superannuation Consultant				3,861											
See Attached Schedule 21A						1,916								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL		\$				(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)						\$ 72,945								TOTAL		\$ 1,919	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Sharon Health Care Pines

IDPH License ID Number: 0032763

Fiscal Year End: 12/31/2025

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Intuit	Computer Expense	\$ 37
Sonic Wall	Computer Expense	1,088
Go Daddy	Computer Expense	302
Marcum LLP	Accounting Fees	489
Total		1,916

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (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>N/A</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>N/A</u> | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|------------|--------------|
| | |
| | |
| <u>N/A</u> | |
| | |
| | Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 36,480 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. \$ 792,086
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.