

		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: 0032797

Facility Name: Sharon Health Care Willows

Address: 3520 North Rochelle Peoria 61604
Number City Zip Code

County: Peoria

Telephone Number: (309) 685-0451 Fax # (309) 688-4495

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:

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) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Willows # 0032797 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	218	Intermediate (ICF)	218	79,570	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	218	TOTALS	218	79,570	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	4,167	35,302	1,503		502		666	42,140	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,167	35,302	1,503		502		666	42,140	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 52.96%

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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	404,314	84,310	9,109	497,733		497,733		497,733			1
2	Food Purchase		458,854		458,854		458,854	(54)	458,800			2
3	Housekeeping	483,334	52,103		535,437		535,437		535,437			3
4	Laundry		22,609		22,609		22,609		22,609			4
5	Heat and Other Utilities			345,855	345,855		345,855	2,560	348,415			5
6	Maintenance	64,350		152,890	217,240		217,240	(9,945)	207,295			6
7	Other (specify):* Waste Disposal			22,533	22,533		22,533		22,533			7
8	TOTAL General Services	951,998	617,876	530,387	2,100,261		2,100,261	(7,439)	2,092,822			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,480,387	148,907	301,119	3,930,413		3,930,413		3,930,413			10
10a	Therapy	114,040	12,533	943	127,516		127,516		127,516			10a
11	Activities	126,117	1,568	1,575	129,260		129,260		129,260			11
12	Social Services	420,497		1,575	422,072		422,072		422,072			12
13	CNA Training											13
14	Program Transportation			8,563	8,563		8,563		8,563			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,141,041	163,008	337,775	4,641,824		4,641,824		4,641,824			16
	C. General Administration											
17	Administrative	194,141			194,141		194,141	62,696	256,837			17
18	Directors Fees											18
19	Professional Services			100,498	100,498		100,498	1,142	101,640			19
20	Dues, Fees, Subscriptions & Promotions			21,831	21,831		21,831	(4,210)	17,621			20
21	Clerical & General Office Expenses	118,838	25,703	17,368	161,909		161,909	(5,246)	156,663			21
22	Employee Benefits & Payroll Taxes			758,041	758,041		758,041		758,041			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,965	2,965		2,965		2,965			24
25	Other Admin. Staff Transportation			7,310	7,310		7,310	(1,252)	6,058			25
26	Insurance-Prop.Liab.Malpractice			172,913	172,913		172,913	431	173,344			26
27	Other (specify):*							2,030	2,030			27
28	TOTAL General Administration	312,979	25,703	1,080,926	1,419,608		1,419,608	55,591	1,475,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,406,018	806,587	1,949,088	8,161,693		8,161,693	48,152	8,209,845			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			171,621	171,621		171,621	(68,958)	102,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							31,262	31,262			32
33	Real Estate Taxes			132,028	132,028		132,028	17,008	149,036			33
34	Rent-Facility & Grounds			220,792	220,792		220,792	(205,775)	15,017			34
35	Rent-Equipment & Vehicles			74,153	74,153		74,153		74,153			35
36	Other (specify):*											36
37	TOTAL Ownership			598,594	598,594		598,594	(226,463)	372,131			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			542	542		542		542			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			774,010	774,010		774,010		774,010			42
43	Other (specify):* Disallowed Costs	187,666		67,390	255,056		255,056	(255,056)				43
44	TOTAL Special Cost Centers	187,666		841,942	1,029,608		1,029,608	(255,056)	774,552			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,593,684	806,587	3,389,624	9,789,895		9,789,895	(433,367)	9,356,528			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	(4,814)	43		4
5	Telephone, TV & Radio in Resident Rooms	(2,012)	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	(83,657)	30		9
10	Interest and Other Investment Income	(7,950)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	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	(1,930)	43		18
19	Entertainment	(125)	43		19
20	Contributions	(15,449)	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	(24,644)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,782)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(216,054)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (371,471)		\$	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)	(61,896)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (61,896)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (433,367)		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	Disallow 50% of Admission Director as Marketing	(8,454)	21	4
5	Marketing Expense	(3,634)	43	5
6	Capitalized R&M	(13,941)	06	6
7	Expense Fixed Assets under \$2500	3,179	21	7
8	Non-Allowable Expense - Wages	(187,666)	43	8
9	Auto Expense-Marketing	(1,252)	25	9
10				10
11				11
12				12
13				13
14				14
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(216,054)		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.		\$ 2,053	\$ 2,053	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		3,996	3,996	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		48	48	3
4	V	21	Clerical & General		Barton Management Inc.		29	29	4
5	V	26	Insurance		Barton Management Inc.		431	431	5
6	V	33	Real Estate Taxes		Barton Management Inc.		9,956	9,956	6
7	V	34	Rent Office Space	20,400	Barton Management Inc.		14,617	(5,783)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 20,400			\$ 31,130	\$ * 10,730	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	\$	Redwood Management		\$		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			\$			\$ 64,726	\$ * 64,726	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.

☒ 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		\$ 507	\$ 507	15
16	V	19	Professional Fees		Peoria Forest Partnership		1,142	1,142	16
17	V	20	Licenses		Peoria Forest Partnership		28	28	17
18	V	30	Depreciation		Peoria Forest Partnership		14,699	14,699	18
19	V	32	Interest		Peoria Forest Partnership		39,212	39,212	19
20	V	33	Real Estate Tax		Peoria Forest Partnership		7,052	7,052	20
21	V	34	Rent	199,992	Peoria Forest Partnership			(199,992)	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			\$ 199,992			\$ 62,640	\$ * (137,352)	39

Ownership Listing-1

ID# 0032797

Barton Management, Ir

Operator/Licensee

Ownership

Percentage

1	Stan	Aron	Buffalo Grove	IL	19.46410	17.93180	1	
2	John	Shlofrock	Northfield	IL	29.20424	19.51753	25.00000	2
3	Gary	Weintraub	Northfield	IL	12.66666	22.20748	25.00000	3
4	Eliza	Zusman	Deerfield	IL	25.11103	21.31083	25.00000	4
5								5
6	Richard Dean Duros Decl. of Trust							6
7	Beneficiary:							7
8	Richard	Duros	Vernon Hills	IL	10.06142	15.03427	25.00000	8
9								9
10	Anca	Oviedo	Highland Park	IL	1.11943			10
11	Marian	Simon	Chicago	IL	1.11943			11
12	Michael	Kaplan	Highland Park	IL	1.25375	3.99810		12
13								13
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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 Pines, Inc.	Peoria						7
8	Sharon Health Care Woods, Inc.	Peoria						8
9								9
10								10
11								11
12								12
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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	40,705	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	12.67%	See Att. Sch 7A	4.00	9.52%	Salary	35,275	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.12%	See Att. Sch 7A	3.00	5.45%	Salary	32,588	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	\$ 134,778		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 Willows # 0032797 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	\$	79,570	\$ 2,053	1
2	6	Repairs & Maintenance	Available Days	496,213	8	24,917		79,570	3,996	2
3	20	Dues, Licenses, Fees	Available Days	496,213	8	300		79,570	48	3
4	21	Clerical & General	Available Days	496,213	8	183		79,570	29	4
5	26	Insurance	Available Days	496,213	8	2,690		79,570	431	5
6	33	Real Estate Taxes	Available Days	496,213	8	62,084		79,570	9,956	6
7	34	Rent Office Space	Available Days	496,213	8	91,160		79,570	14,617	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	\$		\$ 31,130	25

Facility Name & ID Number Sharon Health Care Willows # 0032797 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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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 Willows # 0032797 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	\$	218	\$ 507	1
2	19	Professional Fees	Bed Size	582	4	3,050		218	1,142	2
3	20	Licenses	Bed Size	582	4	75		218	28	3
4	30	Depreciation	Bed Size	582	4	39,241		218	14,699	4
5	32	Interest	Bed Size	582	4	104,686		218	39,212	5
6	33	Real Estate Tax	Bed Size	582	4	18,826		218	7,052	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	\$		\$ 62,640	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										39,212	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 39,212	9
	B. Non-Facility Related*												
10	Interest Income		X							Interest Income Offset		(7,950)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (7,950)	14
15	TOTALS (line 9+line14)						\$					\$ 31,262	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.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Willows COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032797

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. 13-25-427-009	Long Term Care Facility	\$ 64,289.52	\$ 64,289.52
2. 13-25-427-012	Long Term Care Facility	\$ 61,721.60	\$ 61,721.60
3. 05-19-112-017-0000	Allocated from Barton Management	\$ 124,168.59	\$ 9,956.00
4. See Attached	Allocated from Peoria Forest Partners	\$ 18,825.76	\$ 7,052.00
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 269,005.47	\$ 143,019.12

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:

B. General Construction Type:

Exterior

Frame

Number of Stories

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 Woods - Facility 152 Beds

Sharon Health Care Elms- Facility 96 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?

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

X

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1		2		3		4	
	Use		Square Feet		Year Acquired		Cost	
1	Allocated from Peoria Forest				1991		\$ 238,904	
2	Allocated from Peoria Forest				1999		13,424	
3	TOTALS						\$ 252,328	

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	218		1991	1972	\$ 4,150,504	\$	35	\$	\$	\$ 4,150,504	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	12,982		20			12,982	9
10	Various			1990	15,966		20			15,966	10
11	Various			1991	1,595		20			1,595	11
12	Various			1992	13,429		20			13,429	12
13	Various			1993	5,656		20			5,656	13
14	Various			1994	3,579		20			3,579	14
15	Various			1995	29,692		20			29,692	15
16	Various			1996	13,113		20			13,113	16
17	Various			1997	189,520		20			189,520	17
18	Various			1998	45,613		20			45,613	18
19	Various			1999	24,560		20			24,560	19
20	Various			2000	33,805		20			33,805	20
21	Various			2001	62,770		20			62,770	21
22	Various			2002	11,323		20			11,323	22
23	Various			2003	30,154		20			30,154	23
24	Various			2004	5,317		20			5,317	24
25	Various			2005	34,104		20			34,104	25
26	Various			2006	39,852		20			39,852	26
27	Various			2007	161,530		20			161,530	27
28	Various			2008	53,530		20			53,530	28
29	Various			2009	172,657		20	1,137	1,137	168,680	29
30	Various			2010	25,257		20			25,257	30
31	Various			2011	19,824		20			19,824	31
32	Various			2012	81,914		20	1,850	1,850	70,869	32
33	Various			2013	35,726		20	1,355	1,355	35,475	33
34	Various			2014	153,011		20	7,651	7,651	87,280	34
35	Various			2015	337,539		20	16,878	16,878	179,183	35
36											36

*Total beds on this schedule must agree with page 2.

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

XI. OWNERSHIP COSTS (continued)

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

1 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	2016	\$ 19,638	\$	20	\$ 826	\$ 826	\$ 11,141	37
38	Various	2017	80,413		20	4,021	4,021	35,873	38
39	Various	2018	176,293		20	8,814	8,814	66,446	39
40	Various	2019	44,620		20	2,231	2,231	14,551	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)		\$ 6,085,486	\$		\$ 44,763	\$ 44,763	\$ 5,653,173	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 Willows

0032797

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		\$ 6,085,486	\$		\$ 44,763	\$ 44,763	\$ 5,653,173	1
2	Roofing Work - Sheet Over Existing Sheating	2020	8,676		20	434	434	2,604	2
3	Hvac - Replace Rooftop Unit	2020	4,394		20	220	220	1,320	3
4	Compressor Repair - North Side Dining	2020	4,404		20	220	220	1,320	4
5	Replace Concrete - Handicap Area & Garbage Area	2020	7,197		20	360	360	2,160	5
6	100 Gallon Water Heater	2022	6,500		20	325	325	1,300	6
7	Installation Of Outdoor 4 Ton Conditioner Unit	2022	4,840		20	242	242	968	7
8	Aos 36Kw Electric Heater	2022	8,414		20	421	421	1,684	8
9	Work On Sanitary Sewer System	2022	9,276		20	464	464	1,856	9
10	Install 120 Gallon Water Heater,Leaking Supply Piping	2022	10,942		20	547	547	2,188	10
11	Install Fire Alarm Control Panel, Led Annunciator	2022	3,846		20	192	192	768	11
12	Plumbing - Install New Water Softener	2022	2,730		20	137	137	548	12
13	Installation Of New Fire Hydrant	2023	13,750		20	688	688	2,064	13
14	Replace Carpet In North Building	2023	2,541		20	127	127	381	14
15	3 Wall Ptac Units	2023	2,502		20	125	125	375	15
16	3 Wall Ptac Units	2023	3,331		20	167	167	501	16
17	5 Wall Ptac Units	2023	4,170		20	209	209	627	17
18	4 Wall Ptac Units	2023	3,336		20	167	167	501	18
19	Repair Leaks On Dry System	2023	4,229		20	211	211	633	19
20	Install New Heater For Kitchen And Laundry Area	2023	2,646		20	132	132	396	20
21	Replacement Of Delayed Egress Maglock For Door	2023	3,060		20	153	153	459	21
22	New Compressor, Blower Motor For Cooling Unit	2023	5,558		20	278	278	834	22
23	New Furnace/AC Condenser/Coil/Line Sets - B Wing Right Side	2024	18,600		20	930	930	1,860	23
24	Install 2 New 6 Ton HVAC Roof Top Units-Rear Dining Rm	2024	27,200		20	1,360	1,360	2,720	24
25	New Walk In Freezer	2024	4,840		20	242	242	484	25
26	Rewire and Replace Smoke Detectors East Side of H Wing	2024	3,120		20	156	156	312	26
27	Install New Kawneer Exterior Aluminum Door with Automatic Dc	2024	9,200		20	460	460	920	27
28	4 PTAC Units	2024	3,336		20	167	167	334	28
29	Repair Fire Alarms and Compressor	2024	9,566		20	478	478	956	29
30	Repair and Replaced Partial Roof-Wing B	2024	29,788		20	1,489	1,489	2,978	30
31	Excavate and Install New Sewer Pipe 10ft out to City Main	2024	5,437		20	272	272	544	31
32	Replace Partial Roof-Wing C	2024	16,240		20	812	812	1,624	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,329,155	\$		\$ 56,948	\$ 56,948	\$ 5,689,392	34

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 Willows

0032797

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	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		\$ 6,329,155	\$		\$ 56,948	\$ 56,948	\$ 5,689,392	1
2	Install New Furnace/Condenser Units	2025	34,800		20	870	870	870	2
3	New High Static Exhaust Fan/Repair & Install New Duct &	2025	14,840		20	371	371	371	3
4	Ceiling Exhaust Grills in Shower Rms				20				4
5	Install 2 New Furnaces & AC Units-E Wing	2025	44,320		20	1,108	1,108	1,108	5
6	Install 6 PTAC Units	2025	3,689		20	92	92	92	6
7	Replace 300 Sprinkler Heads	2025	12,244		20	306	306	306	7
8	Replace HVAC-Hall D	2025	9,770		20	244	244	244	8
9	Replace HVAC-Hall E	2025	11,380		20	285	285	285	9
10	Replace HVAC-Office	2025	16,490		20	412	412	412	10
11	Replace HVAC-Hall D	2025	12,220		20	306	306	306	11
12	Install 11 New Windows	2025	9,845		20	246	246	246	12
13	Replace Roof-Front	2025	4,200		20	105	105	105	13
14	Install 35 New Windows-Halls F,G,H and Office	2025	35,920		20	898	898	898	14
15	Install Flooring-Dining Room/Nurses Station	2025	81,094		20	2,027	2,027	2,027	15
16	Replaced 4" Pipe-C Hall	2025	3,336		20	83	83	83	16
17	Replace Mag Lock on Door	2025	3,205		20	80	80	80	17
18	Install Mixing Valves/Heat Sink-C and D Halls-Willows South	2025	3,867		20	97	97	97	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	Financial Statement Depreciation			171,621			(171,621)		27
28									28
29									29
30	Allocated from Peoria Forest	1991	87,723		31.5	2,647	2,647	67,495	30
31	Allocated from Peoria Forest	2019	84,446		39	2,413	2,413	16,286	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,802,544	\$ 171,621		\$ 69,538	\$ (102,083)	\$ 5,780,703	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	\$242,086	\$	\$24,420	\$24,420	10 Yrs	\$183,752	71
72	Current Year Purchases	44,625		4,463	4,463	10 Yrs	4,463	72
73	Fully Depreciated Assets	1,099,681					1,099,681	73
74								74
75	TOTALS	\$1,386,392	\$	\$28,883	\$28,883		\$1,287,896	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		1997 DODGE RAM	1999	\$12,821	\$	\$	\$	5	\$12,821	76
77		1998 CHEV VAN	2001	5,449				5	5,449	77
78		2001 DODGE RAM	2004	6,611				5	6,611	78
79		See Attached Schedule 13A		103,100		4,242	4,242	5	90,373	79
80	TOTALS			\$127,981	\$	\$4,242	\$4,242		\$115,254	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)	\$8,569,245	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$171,621	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$102,663	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(68,958)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,183,853	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 Willows

IDPH License ID Number: 0032797

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	2008 Chevy Express		2009	\$	10,244	\$	\$	0	5	\$ 10,244	
	Facility	Tractor		2009		4,121			0	5	4,121	
	Facility	2014 Ford Coach		2014		57,262			0	5	57,262	
	Facility	2011 Nissan Sentra		2017		10,262			0	5	10,262	
	Facility	2024 Ford Transit		2024		21,211		4,242	4,242	5	8,484	
									0			
79	TOTALS				\$	103,100	0	\$ 4,242	\$ 4,242		\$ 90,373	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				400			5
6	Allocated from Barton Management				14,617			6
7	TOTAL				\$ 15,017			7

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 74,153
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name:Sharon Health Care Willows

IDPH License ID Number:0032797

Fiscal Year End:12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	67,980
Copiers	5,497
Water Cooler	39
Laundry Equipment	637
Total - Line 16	74,153

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		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): Lab/Xray					542			542	13
14	TOTAL			\$		\$ 542	\$		\$ 542	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	\$ 15,309	\$ 15,309	1
2	Cash-Patient Deposits	80,117	80,117	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 218,366)	1,370,917	1,370,917	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,287	71,287	6
7	Other Prepaid Expenses	51,121	51,121	7
8	Accounts Receivable (owners or related parties)	189,673	189,673	8
9	Other(specify): See Attached Schedule 17A	393,142	393,142	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,171,566	\$ 2,171,566	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		252,328	13
14	Buildings, at Historical Cost		4,150,504	14
15	Leasehold Improvements, at Historical Cost	2,003,871	2,652,040	15
16	Equipment, at Historical Cost	1,540,641	1,514,373	16
17	Accumulated Depreciation (book methods)	(2,814,892)	(7,183,853)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - 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)	\$ 729,620	\$ 1,385,392	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,901,186	\$ 3,556,958	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 373,786	\$ 373,786	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	80,117	80,117	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	488,961	488,961	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,441	13,441	31
32	Accrued Real Estate Taxes(Sch.IX-B)	131,682	131,682	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident Credit Balances	418,731	418,731	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,506,718	\$ 1,506,718	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 Peoria Forest	462,953	462,953	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 462,953	\$ 462,953	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,969,671	\$ 1,969,671	46
47	TOTAL EQUITY(page 18, line 24)	\$ 931,515	\$ 1,587,287	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,901,186	\$ 3,556,958	48

Facility Name: Sharon Health Care Willows

IDPH License ID Number: 0032797

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
Deferred SRT Benefit	23,058	23,058
Quality Incentive Payment	169,247	169,247
Due from HFS-C.N.A. Tenure	198,337	198,337
Total - Line 9	393,142	393,142

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 381,310	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 381,310	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,205	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)	\$ 550,205	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)	\$ 931,515	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

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	\$ 12,613,914	1
2	Discounts and Allowances for all Levels	(3,027,088)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,586,826	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	4,159	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)	\$ 4,159	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,950	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,950	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>CNA Initiative Revenue</u>	436,644	28
28a	<u>Quality Incentive Payment</u>	304,521	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 741,165	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,340,100	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,100,261	31
32	Health Care	4,641,824	32
33	General Administration	1,419,608	33
	B. Capital Expense		
34	Ownership	598,594	34
	C. Ancillary Expense		
35	Special Cost Centers	255,598	35
36	Provider Participation Fee	774,010	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,789,895	40
41	Income before Income Taxes (line 30 minus line 40)**	550,205	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 550,205	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 942,204	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,982,164	45
46	MMAI-Medicaid is the Primary Payer	339,845	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	150,600	48
49	Medicare Part A		49
50	Other-(specify) <u>Veterans</u>	172,014	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)	\$ 9,586,826	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	2,047	2,279	\$ 121,224	\$ 53.19	1
2	Assistant Director of Nursing	1,877	2,322	114,666	49.38	2
3	Registered Nurses	19,012	20,108	963,277	47.91	3
4	Licensed Practical Nurses	10,411	11,235	414,437	36.89	4
5	CNAs & Orderlies	73,104	77,963	1,859,118	23.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,810	4,278	114,040	26.66	8
9	Activity Director					9
10	Activity Assistants	5,852	6,331	126,117	19.92	10
11	Social Service Workers	18,195	21,148	420,497	19.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,884	19,926	404,314	20.29	15
16	Dishwashers					16
17	Maintenance Workers	1,986	2,599	64,350	24.76	17
18	Housekeepers	22,077	26,628	483,334	18.15	18
19	Laundry					19
20	Administrator	1,960	2,080	122,059	58.68	20
21	Assistant Administrator					21
22	Other Administrative	506	506	72,082	142.45	22
23	Office Manager					23
24	Clerical	4,046	4,161	118,838	28.56	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) See Att P 20A	875	875	195,331	223.24	33
34	TOTAL (lines 1 - 33)	182,642	202,439	\$ 5,593,684 *	\$ 27.63	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	\$ 9,109	L1, C3	35
36	Medical Director	Monthly	24,000	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	29	1,575	L11, C3	44
45	Social Service Consultant	29	1,575	L12, C3	45
46	Other(specify) MDS Consultant	496	24,775	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	553	\$ 62,834		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	7,402	273,887	L10, C3	52
53	TOTAL (lines 50 - 52)	7,402	\$ 273,887		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Sharon Health Care Willows

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	187,666	262.10
Care Plan Coordinator	159	159	7,665	48.21
TOTAL	875	875	195,331	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Amanda Binger	Executive Director	0	\$ 122,059	Workers' Compensation Insurance		\$ 62,631	IDPH License Fee	\$ 1,997	
Gary Weintraub	Other Administrative	12.67%	35,275	Unemployment Compensation Insurance		36,217	Advertising: Employee Recruitment	375	
Anca Zota-Oviedo	Other Administrative	1.12%	32,588	FICA Taxes		398,032	Health Care Worker Background Check		
Stan Aron	Other Administrative	19.46%	4,219	Employee Health Insurance		233,309	(Indicate # of checks performed 107)	3,738	
				Employee Meals			Patient Background Checks 23	820	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				401K Contribution		23,641	Relias	7,125	
				Other Employee Benefit		2,382	Licenses & Permits and Dues	3,490	
				Christmas Expense		1,829	Peoria Forest Allocation	28	
							Barton Mgmt Home Office Allocation	48	
							Less: Public Relations Expense	()	
							PAC and Lobbying payments	()	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,621	
						\$ 758,041			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
				Description	Line #	Amount	Description	Amount	
Description							Out-of-State Travel	\$	
N/A									
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	2,965	
							Entertainment Expense	()	
C. Professional Services							(agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount				TOTAL		
Paychex	Payroll Processing		\$ 16,415				\$		
Personnel Planners	Unemployment Consultant	\$	2,514						
Netsmart	Computer Expense		3,561						
Wellsky	Computer Expense		1,099						
Galaxy	Computer Expense		4,410						
Cohn Reznick	Accounting Fees		14,105						
Point Click Care	E.H.R. Software		42,795						
Constant Virtual Solutions	Computer Expense		6,664						
Waystar	Billing Software		1,896						
Pension Performance	Superannuation Consultant		3,986						
Marcum LLP	Accounting Fees		489						
See Attached Schedule 21A			2,564						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL					

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name: Sharon Health Care Willows

IDPH License ID Number: 0032797

Fiscal Year End: 12/31/2025

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Intuit	Computer Expense	\$ 37
Tiger Connect	Computer Expense	1,012
Templin Healthcare Accounting S	Accounting Fees	51
Go Daddy	Computer Expense	300
Sonic Wall	Computer Expense	776
Equifax Workforce Solutions	Insurance Consultant	388
Total		2,564

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
N/A	
	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.

N/A	
	Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

N/A	
	Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 50,181 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.
This amount is to be recorded on line 42 of Schedule V.

\$ 774,010
- (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?

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.