

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0054163

Facility Name: Sharon Health Care Woods

Address: 3223 W Richwoods Bld Peoria 61604
Number City Zip Code

County: Peoria

Telephone Number: (309) 685-5241 Fax # (309) 688-5746

HFS ID Number:

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

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☒	Corporation	☐	Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 Woods # 0054163 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	152	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	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	4,666	41,761	234		81			46,742
12	SC								12
13	DD 16 OR LESS								13
14	TOTALS	4,666	41,761	234		81			46,742

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 84.25%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? 467 (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
MODIFIED
ACCRUAL ☒ 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 Woods # 0054163 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	299,491	72,449	7,072	379,012		379,012		379,012			1
2	Food Purchase		501,321		501,321		501,321	(9)	501,312			2
3	Housekeeping	368,710	49,415		418,125		418,125		418,125			3
4	Laundry		18,474	750	19,224		19,224		19,224			4
5	Heat and Other Utilities			249,275	249,275		249,275	1,784	251,059			5
6	Maintenance	83,589		152,646	236,235		236,235	(6,964)	229,271			6
7	Other (specify):* Waste Disposal			18,793	18,793		18,793		18,793			7
8	TOTAL General Services	751,790	641,659	428,536	1,821,985		1,821,985	(5,189)	1,816,796			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,205,263	51,494	86,352	1,343,109		1,343,109		1,343,109			10
10a	Therapy											10a
11	Activities	142,059	15,264		157,323		157,323		157,323			11
12	Social Services	979,375		6,000	985,375		985,375		985,375			12
13	CNA Training											13
14	Program Transportation			189	189		189		189			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,326,697	66,758	110,541	2,503,996		2,503,996		2,503,996			16
	C. General Administration											
17	Administrative	377,653		456,382	834,035		834,035	(393,686)	440,349			17
18	Directors Fees											18
19	Professional Services			69,372	69,372		69,372	797	70,169			19
20	Dues, Fees, Subscriptions & Promotions			56,599	56,599		56,599	(25,232)	31,367			20
21	Clerical & General Office Expenses	228,151	37,784	14,611	280,546		280,546	(8,540)	272,006			21
22	Employee Benefits & Payroll Taxes			524,849	524,849		524,849		524,849			22
23	Inservice Training & Education			6,768	6,768		6,768		6,768			23
24	Travel and Seminar			450	450		450		450			24
25	Other Admin. Staff Transportation			16,636	16,636		16,636	(1,939)	14,697			25
26	Insurance-Prop.Liab.Malpractice			201,088	201,088		201,088	301	201,389			26
27	Other (specify):*							2,030	2,030			27
28	TOTAL General Administration	605,804	37,784	1,346,755	1,990,343		1,990,343	(426,269)	1,564,074			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,684,291	746,201	1,885,832	6,316,324		6,316,324	(431,458)	5,884,866			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			46,708	46,708		46,708	20,220	66,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			97,790	97,790		97,790	11,858	109,648			33
34	Rent-Facility & Grounds			585,649	585,649		585,649	(574,927)	10,722			34
35	Rent-Equipment & Vehicles			4,119	4,119		4,119		4,119			35
36	Other (specify):*											36
37	TOTAL Ownership			734,266	734,266		734,266	(542,849)	191,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			135	135		135		135			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* Disallowed Costs	251,453		78,128	329,581		329,581	(329,581)				43
44	TOTAL Special Cost Centers	251,453		78,263	329,716		329,716	(329,581)	135			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,935,744	746,201	2,698,361	7,380,306		7,380,306	(1,303,888)	6,076,418			45

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

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	(6,183)	43		4
5	Telephone, TV & Radio in Resident Rooms	(3,378)	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	9,972	30		9
10	Interest and Other Investment Income	(27,340)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(125)	43		19
20	Contributions	(24,233)	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	(16,198)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,544)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(310,455)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (392,493)		\$	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)	(911,395)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (911,395)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,303,888)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(25,286)	20	2
3				3
4	Capitalized R&M	(9,750)	6	4
5	Expense Improvements/Equip under \$2500	2,148	21	5
6	Patient Clothing	(220)	43	6
7	Resident Stipend	(12,072)	43	7
8	Disallow 50% of Admission Director as Marketing	(10,708)	21	8
9	Marketing Expense	(1,175)	43	9
10	Non-Allowable Expense	(251,453)	43	10
11	Auto Expense-Marketing	(1,939)	25	11
12				12
13				13
14				14
15				15
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(310,455)		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.		\$ 1,431	\$ 1,431	1
2	V	6	Repairs & Maintenance		Barton Management Inc.		2,786	2,786	2
3	V	20	Dues, Licenses, Fees		Barton Management Inc.		34	34	3
4	V	21	Clerical & General		Barton Management Inc.		20	20	4
5	V	26	Insurance		Barton Management Inc.		301	301	5
6	V	33	Real Estate Taxes		Barton Management Inc.		6,941	6,941	6
7	V	34	Rent Office Space	28,800	Barton Management Inc.		10,193	(18,607)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 28,800			\$ 21,706	\$ * (7,094)	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	\$ 456,382	Redwood Management		\$	(456,382)	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			\$ 456,382			\$ 64,726	\$ * (391,656)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Peoria Forest Partnership		\$ 353	\$ 353	15
16	V	19	Professional Fees		Peoria Forest Partnership		797	797	16
17	V	20	Licenses		Peoria Forest Partnership		20	20	17
18	V	30	Depreciation		Peoria Forest Partnership		10,248	10,248	18
19	V	32	Interest		Peoria Forest Partnership		27,340	27,340	19
20	V	33	Real Estate Tax		Peoria Forest Partnership		4,917	4,917	20
21	V	34	Rent	556,320	Peoria Forest Partnership			(556,320)	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			\$ 556,320			\$ 43,675	\$ * (512,645)	39

Ownership Listing-1

ID# 0054163

Barton Management, Ir

Management

Operator/Licensee

Ownership

	First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage	
1	Stan		Aron	Buffalo Grove	IL	19.93282	17.93180		1
2	John		Shlofrock	Northfield	IL	29.07499	19.51753	25.00000	2
3	Gary		Weintraub	Northfield	IL	13.73469	22.20748	25.00000	3
4	Eliza		Zusman	Deerfield	IL	22.53805	21.31083	25.00000	4
5									5
6	Richard Dean Duros Decl. of Trust								6
7	Beneficiary:								7
8	Richard		Duros	Vernon Hills	IL	11.21301	15.03427	25.00000	8
9									9
10	Anca		Oviedo	Highland Park	IL	1.12383			10
11	Marian		Simon	Chicago	IL	1.12383			11
12	Michael		Kaplan	Highland Park	IL	1.25877	3.99810		12
13									13
14									14
15									15
16									16
17									17
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75									75

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 Willows, Inc.	Peoria						8
9								9
10								10
11								11
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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	29.08%	See Att. Sch 7A	6.50	15.48%	Alloc Salary	\$ 26,210	17-7	1
2	Stan Aron	Shareholder	Administrative	19.93%	See Att. Sch 7A	4.00	10.81%	Sal. Alloc Mgmt Fe	42,044	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	13.73%	See Att. Sch 7A	4.00	9.52%	Salary	34,308	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.12%	See Att. Sch 7A	3.00	5.45%	Salary	39,987	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	\$ 142,549		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 Woods # 0054163 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	\$	55,480	\$ 1,431	1
2	6	Repairs & Maintenance	Available Days	496,213	8	24,917		55,480	2,786	2
3	20	Dues, Licenses, Fees	Available Days	496,213	8	300		55,480	34	3
4	21	Clerical & General	Available Days	496,213	8	183		55,480	20	4
5	26	Insurance	Available Days	496,213	8	2,690		55,480	301	5
6	33	Real Estate Taxes	Available Days	496,213	8	62,084		55,480	6,941	6
7	34	Rent Office Space	Available Days	496,213	8	91,160		55,480	10,193	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	\$		\$ 21,706	25

Facility Name & ID Number Sharon Health Care Woods # 0054163 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 Woods # 0054163 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 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	5	Utilities	Bed Size	582	4	\$ 1,353	\$	152	\$ 353	1
2	19	Professional Fees	Bed Size	582	4	3,050		152	797	2
3	20	Licenses	Bed Size	582	4	75		152	20	3
4	30	Depreciation	Bed Size	582	4	39,241		152	10,248	4
5	32	Interest	Bed Size	582	4	104,686		152	27,340	5
6	33	Real Estate Tax	Bed Size	582	4	18,826		152	4,917	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	\$		\$ 43,675	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										27,340	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	27,340	9
	B. Non-Facility Related*												
10	Interest Income		X							Interest Income Offset		(27,340)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(27,340)	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2024 report.				\$	92,649	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		\$	93,353	2
3. Under or (over) accrual (line 2 minus line 1).				\$	704	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	97,087	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.					(1)	
					6,941	
					4,917	
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.				\$	109,648	7
Assessed Value from Real Estate Tax Bill:	2024	1,032,070	8			
Real Estate Tax Bill for Calendar Year:	2020	90,956	9			
	2021	90,242	10			
	2022	87,560	11			
	2023	89,086	12			
	2024	93,353	13			
2025 Accrual = \$93,353 x 1.04 = \$97,087						
				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.

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Woods COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0054163

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)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	13-25-426-019	Long Term Care Property	\$ 93,352.60	\$ 93,352.60
2.	05-19-112-017-0000	Allocated from Barton Management	\$ 124,168.59	\$ 6,941.00
3.	See Attached	Allocated from Peoria Forest	\$ 18,825.76	\$ 4,917.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 236,346.95	\$ 105,210.60

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 Willows - Facility 218 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

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

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		\$ 166,575	
2	Allocated from Peoria Forest				1999		9,360	
3	TOTALS						\$ 175,935	

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	152		1991	1972	\$ 2,893,930	\$	31.5	\$	\$	\$ 2,893,930
5										
6										
7										
8										
	Improvement Type**									
9	Various		1987		18,543		20			18,543
10	Various		1988		20,355		20			20,355
11	Various		1989		7,490		20			7,490
12	Various		1990		39,136		20			39,136
13	Various		1991		7,089		20			7,089
14	Various		1992		45,962		20			45,962
15	Various		1993		19,912		20			19,912
16	Various		1994		15,494		20			15,494
17	Various		1995		21,826		20			21,826
18	Various		1996		23,181		20			23,181
19	Various		1997		48,372		20			48,372
20	Various		1998		43,929		20			43,929
21	Various		1999		72,933		20			72,933
22	Various		2000		39,056		20			39,056
23	Various		2001		16,554		20			16,554
24	Various		2002		4,453		20			4,453
25	Various		2003		14,380		20			14,380
26	Various		2004		9,173		20			9,173
27	Various		2005		19,674		20			19,674
28	Various		2006		21,334		20			21,334
29	Various		2007		52,326		20			52,326
30	Various		2008		158,927		20			158,927
31	Various		2009		125,432		20	5,862	5,862	107,453
32	Various		2012		41,438		20	163	163	40,808
33	Various		2013		21,509		20	828	828	20,549
34	Various		2014		182,440		20	9,121	9,121	104,318
35	Various		2015		7,470		20	374	374	4,085
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	\$ 11,539	\$	20	\$ 577	\$ 577	\$ 5,575	37
38	Various	2017	30,601		20	1,530	1,530	13,583	38
39	Various	2018	41,429		20	2,072	2,072	15,192	39
40	Various	2019	229,518		20	11,476	11,476	76,682	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)		\$ 4,305,405	\$		\$ 32,003	\$ 32,003	\$ 4,002,274	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 Woods

0054163

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		\$ 4,305,405	\$		\$ 32,003	\$ 32,003	\$ 4,002,274	1
2	A/C Surging - Actuator And Fuel Pump Repair	2020	5,692		20	285	285	1,710	2
3	Install 100 Gallon Water Heater	2021	5,327		20	266	266	1,330	3
4	Repair Parking Lot, Broken Slab In Main Drive Way	2021	2,900		20	145	145	725	4
5	Generator Repair - Engine Controller	2021	4,006		20	200	200	1,000	5
6	Installation Of New Door & Frame (Rear Door)	2022	2,585		20	129	129	516	6
7	Generator Repairs - Replace Ecu	2022	6,796		20	340	340	1,360	7
8	New Ac Unit For B Wing Right Side	2023	14,423		20	721	721	2,163	8
9	New Ac Unit For B Wing Left Side	2023	10,311		20	516	516	1,548	9
10	Roof Repair-Install New Shingles,Pipe & Chimney Flashings	2023	43,296		20	2,165	2,165	6,495	10
11	Pipe Burst Repairs - New Graved Coup, Chrome Pendent	2023	6,107		20	305	305	915	11
12	Replacement Of Old Condenser Unit	2023	5,895		20	294	294	884	12
13	Replace Copper Piping & Repair Water Pipe In C Wing	2023	2,573		20	129	129	387	13
14	New Walk In Freezer	2024	6,130		20	307	307	614	14
15	Replace Furnace Control Board & 2 Thermostats in C Wing Left	2024	2,643		20	132	132	264	15
16	Repair Leaking Frozen Sprinkler Pipes-Above A/B Nurses Station	2024	2,777		20	139	139	278	16
17	Replace Water Damaged Drywall and Repaint -Above A/B Nurses	2024	6,350		20	318	318	636	17
18	Install Steel Door/Ceiling Repairs in Storage Rm & Furnace Rm	2024	4,706		20	235	235	470	18
19	Install New AC/Coil and Line Set - C Wing Left Side	2024	7,900		20	395	395	790	19
20	Repair Driveway Near Dumpster and Service Entrance	2024	11,550		20	578	578	1,156	20
21	Replace Control Board/Blower Motor & Wheel - RTU Dining	2024	3,290		20	165	165	330	21
22	Install 10- 4x5 Picture Windows	2024	7,450		20	373	373	746	22
23	Install 10- 4x5 Picture Windows	2024	7,450		20	373	373	746	23
24	Install 20 New Picture Windows	2024	15,500		20	775	775	1,550	24
25	Install 16- 4x5 Picture Windows	2025	13,220		20	331	331	331	25
26	Replaced RTU-Dining Room	2025	20,989		20	525	525	525	26
27	Install 4 Ton RTU-Dining Room	2025	13,493		20	337	337	337	27
28	Install 5 Ton RTU-Auditorium	2025	14,840		20	371	371	371	28
29	Replaced Heat Exchanger, Valves, Inducer on RTU-Nurses Stattio	2025	4,296		20	107	107	107	29
30	Replaced Heat Exchanger, Valves, Inducer on RTU-A Hall	2025	2,820		20	71	71	71	30
31	Installed New Compressor, Replaced Copper-D Hall	2025	2,634		20	66	66	66	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,563,354	\$		\$ 43,096	\$ 43,096	\$ 4,030,695	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,563,354	\$		\$ 43,096	\$ 43,096	\$ 4,030,695	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22	Allocated from Peoria Forest	1991	61,164		31.5	1,845	1,845	47,059	22
23	Allocated from Peoria Forest	2019	58,880		39	1,682	1,682	11,354	23
24									24
25									25
26	Financial Statement Depreciation			46,708			(46,708)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,683,398	\$ 46,708		\$ 46,623	\$ (85)	\$ 4,089,108	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	\$126,470	\$	\$12,806	\$12,806	10 Yrs	\$86,030	71
72	Current Year Purchases	21,248		2,125	2,125	10 Yrs	2,125	72
73	Fully Depreciated Assets	711,297					711,297	73
74								74
75	TOTALS	\$859,015	\$	\$14,931	\$14,931		\$799,452	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	\$3,782	\$	\$	\$	5	\$3,782	76
77		1999 FORD E350	2007	9,334				5	9,334	77
78		1989 CHEVY/C1500	2008	2,400				5	2,400	78
79		See Attached Schedule 13A		114,025		5,374	5,374	5	97,905	79
80	TOTALS			\$129,541	\$	\$5,374	\$5,374		\$113,421	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)	\$5,847,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$46,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$66,928	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$20,220	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,001,981	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 Woods

IDPH License ID Number: 0054163

Fiscal Year End: 12/31/2025

Schedule 13A

D. Vehicle Costs. (See instructions.)*

	Use	Model, Make and Year		Year Acquired 3		4 Cost	Current Book Depreciation 5	Straight Line Depreciation	Adjustments	Life in Years 8	Accumulated Depreciation	
	Facility	Tractor		2009	\$	2,860	\$	\$	0	5	\$ 2,860	
	Facility	2001 HONDA CRV		2013		7,229			0	5	7,229	
	Facility	2003 OLDS ALERO GL		2013		5,263			0	5	5,263	
	Facility	2013 CHEVROLET 3500		2013		33,798			0	5	33,798	
	Facility	Uftring Chevrolet-USED		2014		30,500			0	5	30,500	
	Facility	Plow/Deflector		2014		7,507			0	5	7,507	
	Facility	2024 Ford Transit		2024		26,868		5,374	5,374	5	10,748	
									0			
79	TOTALS				\$	114,025	0	\$ 5,374	\$ 5,374		\$ 97,905	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				529			5
6	Allocated from Barton Management				10,193			6
7	TOTAL				\$ 10,722			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: \$ 4,119 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 Woods

IDPH License ID Number:

0054163

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copiers	3,774
Laundry Equipment	345
Total - Line 16	4,119

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		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): <u>Lab/Xray</u>	39(3)				135			135	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$ 135	\$		\$ 135	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

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 818,639	\$ 818,639	1
2	Cash-Patient Deposits	43,710	43,710	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 393,760)	826,558	826,558	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,000,000	1,000,000	5
6	Prepaid Insurance	76,519	76,519	6
7	Other Prepaid Expenses	36,355	36,355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	40,496	40,496	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,842,277	\$ 2,842,277	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		175,935	13
14	Buildings, at Historical Cost		2,893,930	14
15	Leasehold Improvements, at Historical Cost	1,211,521	1,789,468	15
16	Equipment, at Historical Cost	758,372	988,556	16
17	Accumulated Depreciation (book methods)	(1,661,919)	(5,001,981)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 307,974	\$ 845,908	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,150,251	\$ 3,688,185	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,225	\$ 88,225	26
27	Officer's Accounts Payable	50,000	50,000	27
28	Accounts Payable-Patient Deposits	43,710	43,710	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	380,005	380,005	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,529	8,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,087	97,087	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	658,090	658,090	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,325,646	\$ 1,325,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,325,646	\$ 1,325,646	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,824,605	\$ 2,362,539	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,150,251	\$ 3,688,185	48

Facility Name:Sharon Health Care Woods

IDPH License ID Number:0054163

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	8,570	8,570
Interest Receivable	29,426	29,426
Total - Line 9	40,496	40,496

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,748,542	1
2	Restatements (describe):		2
3	Accrued Distributions	(100,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,648,542	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	226,063	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	(50,000)	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)	\$ 176,063	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,824,605	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sharon Health Care Woods

0054163

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	\$ 14,128,875	1
2	Discounts and Allowances for all Levels	(6,586,337)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,542,538	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***	63,831	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63,831	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,606,369	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,821,985	31
32	Health Care	2,503,996	32
33	General Administration	1,990,343	33
	B. Capital Expense		
34	Ownership	734,266	34
	C. Ancillary Expense		
35	Special Cost Centers	329,716	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,380,306	40
41	Income before Income Taxes (line 30 minus line 40)**	226,063	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 226,063	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 751,568	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,726,579	45
46	MMAI-Medicaid is the Primary Payer	37,691	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	26,700	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)	\$ 7,542,538	56

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,765	16,923	591,388	34.95	4
5	CNAs & Orderlies	27,237	29,552	574,887	19.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,407	7,810	142,059	18.19	10
11	Social Service Workers	32,659	40,392	979,375	24.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,523	16,685	299,491	17.95	15
16	Dishwashers					16
17	Maintenance Workers	2,516	3,293	83,589	25.38	17
18	Housekeepers	19,211	20,921	368,710	17.62	18
19	Laundry					19
20	Administrator	1,960	2,080	197,687	95.04	20
21	Assistant Administrator	1,960	2,080	100,113	48.13	21
22	Other Administrative	506	506	79,853	157.81	22
23	Office Manager					23
24	Clerical	9,227	9,401	228,151	24.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	2,050	38,988	19.02	31
32	Other Health Care(specify)					32
33	Other(specify)Non Allowable Exp (adj P	1,340	1,340	251,453	187.65	33
34	TOTAL (lines 1 - 33)	135,207	153,033	\$3,935,744 *	\$25.72	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	\$7,072	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				44
45	Social Service Consultant				45
46	Other(specify)Psychiatric Director	Monthly	6,000	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$32,872		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	1,420	81,423	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,420	\$81,423		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 Woods		STATE OF ILLINOIS		# 0054163		Report Period Beginning:		1/1/2025		Page 21		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			
Bobby Ford		Executive Director		0		\$ 197,687		Workers' Compensation Insurance		\$ 46,586		IDPH License Fee		\$ 5,828			
Denise McGarvey		Asst. Executive Dir.		0		100,113		Unemployment Compensation Insurance		26,001		Advertising: Employee Recruitment		3,084			
Gary Weintraub		Other Administrative		13.73%		34,308		FICA Taxes		274,792		Health Care Worker Background Check					
Anca Zota-Oviedo		Other Administrative		1.12%		39,987		Employee Health Insurance		158,389		(Indicate # of checks performed 62)		2,170			
Stan Aron		Other Administrative		19.93%		5,558		Employee Meals				Patient Background Checks 52		1,820			
								Illinois Municipal Retirement Fund (IMRF)*				Association Dues (total from pg 22, #4)					
								401K Contribution		14,672		The Joint Commission		8,125			
								Other Employee Benefit		2,781		Relias		7,177			
								Christmas Expense		1,628		Licenses & Permits		3,109			
TOTAL (agree to Schedule V, line 17, col. 1)												Barton Mgmt/Peoria Forest Allocation		54			
(List each licensed administrator separately.)						\$ 377,653						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)						\$ 456,382											
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 456,382		TOTAL (agree to Schedule V, line 22, col.8)		\$ 524,849		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 31,367			
(Attach a copy of any management service agreement)																	
C. Professional Services								E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
Paychex		Payroll Processing				\$ 10,816						\$		Out-of-State Travel		\$	
Personnel Planners		Unemployment Consultant				1,335											
Wellsky		Computer Expense				1,392		N/A									
Constant Virtual Solutions		Computer Expense				10,022								In-State Travel			
Point Click Care		E.H.R. Software				16,492											
Tiger Direct		Computer Expense				1,281											
Galaxy		Computer Expense				4,410											
Pension Performance		Superannuation Consultant				4,987								Seminar Expense		450	
Templin Healthcare Accounting Svc		Accounting Fees				67											
Marcum LLP		Accounting Fees				489											
Cohn Reznick		Accounting Fees				14,105											
See Attached Schedule 21A						3,976								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)						\$ 69,372						TOTAL		\$ 450			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Sharon Health Care Woods

IDPH License ID Number: 0054163

Fiscal Year End: 12/31/2025

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Go Daddy	Computer Expense	\$ 396
Intuit	Computer Expense	48
Sonic Wall	Computer Expense	1,426
Waystar	Computer Expense	2,106
Total		3,976

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.

\$

None

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.

\$

None

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?

Firm Name:

N/A

No
- (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.