FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0032789

Facility Name: Sharon Health Care Elms

Address: 3611 North Rochelle (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: 309-685-4412 **Fax #** 309-685-4480

HFS ID Number:

Date of Initial License for Current Owners: 8/15/87

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Anca Oviedo **Telephone Number:** 814-441-8200
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 1/1/10 to 12/31/10 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) Anca Oviedo
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,574			2,574	8
9	SNF/PED					9
10	ICF	26,021	123	92	26,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,595	123	92	28,810	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.54%

D. How many bed-hold days during this year were paid by the Department?
5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 2,574

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,427	18,375	6,607	182,409		182,409		182,409			1
2	Food Purchase		188,718		188,718		188,718	1,299	190,017			2
3	Housekeeping	145,689		24,143	169,832		169,832		169,832			3
4	Laundry	86,296	24,829		111,125		111,125		111,125			4
5	Heat and Other Utilities			110,707	110,707		110,707	749	111,456			5
6	Maintenance	124,036		71,238	195,274		195,274	(2,989)	192,285			6
7	Other (specify):*											7
8	TOTAL General Services	513,448	231,922	212,695	958,065		958,065	(941)	957,124			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,363,329	133,130	27,775	1,524,234		1,524,234		1,524,234			10
10a	Therapy											10a
11	Activities	47,190	2,900	2,954	53,044		53,044		53,044			11
12	Social Services	90,626		16,185	106,811		106,811		106,811			12
13	CNA Training											13
14	Program Transportation			4,079	4,079		4,079	(4,079)				14
15	Other (specify):* Restorative	48,836			48,836		48,836		48,836			15
16	TOTAL Health Care and Programs	1,549,981	136,030	65,393	1,751,404		1,751,404	(4,079)	1,747,325			16
	C. General Administration											
17	Administrative	77,855		150,000	227,855		227,855	27,030	254,885			17
18	Directors Fees											18
19	Professional Services			37,647	37,647		37,647	470	38,117			19
20	Dues, Fees, Subscriptions & Promotions			6,148	6,148		6,148	(373)	5,775			20
21	Clerical & General Office Expenses	58,299		451,571	509,870		509,870	(417,282)	92,588			21
22	Employee Benefits & Payroll Taxes			387,154	387,154		387,154	2,220	389,374			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,372	3,372		3,372		3,372			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,170	64,170		64,170	78	64,248			26
27	Other (specify):*							47	47			27
28	TOTAL General Administration	136,154		1,100,062	1,236,216		1,236,216	(387,810)	848,406			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,199,583	367,952	1,378,150	3,945,685		3,945,685	(392,830)	3,552,855			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sharon Health Care Elms #0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,078	39,078		39,078	72,500	111,578			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							62,963	62,963			32
33	Real Estate Taxes			54,964	54,964		54,964	4,380	59,344			33
34	Rent-Facility & Grounds			105,185	105,185		105,185	(100,491)	4,694			34
35	Rent-Equipment & Vehicles			31,061	31,061		31,061		31,061			35
36	Other (specify):*											36
37	TOTAL Ownership			230,288	230,288		230,288	39,352	269,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,616	431,510	438,126		438,126		438,126			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,616	485,165	491,781		491,781		491,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,199,583	374,568	2,093,603	4,667,754		4,667,754	(353,478)	4,314,276			45

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,174	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	1,299	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,079)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,350)	21		19
20	Contributions	(2,929)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(409,003)	21		24
25	Fund Raising, Advertising and Promotional	(783)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,251)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (412,922)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	59,444		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,444		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (353,478)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Sharon Health Care Elms

ID# 0032789

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ (4,251)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,251)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Sharon Health Care Elms **#** 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	1,299	0	0	0	0	0	0	0	0	0	0	1,299	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	749	0	0	0	0	0	0	749	5
6	Maintenance	(4,251)	0	0	0	1,262	0	0	0	0	0	0	(2,989)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,952)	0	0	0	2,011	0	0	0	0	0	0	(941)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,079)	0	0	0	0	0	0	0	0	0	0	(4,079)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,079)	0	0	0	0	0	0	0	0	0	0	(4,079)	16
	C. General Administration													
17	Administrative	0	0	0	27,030	0	0	0	0	0	0	0	27,030	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	470	0	0	0	0	0	0	0	0	470	19
20	Fees, Subscriptions & Promotions	(783)	0	410	0	0	0	0	0	0	0	0	(373)	20
21	Clerical & General Office Expenses	(417,282)	0	0	0	0	0	0	0	0	0	0	(417,282)	21
22	Employee Benefits & Payroll Taxes	0	0	0	2,220	0	0	0	0	0	0	0	2,220	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	78	0	0	0	0	0	0	78	26
27	Other (specify):*	0	0	0	0	47	0	0	0	0	0	0	47	27
28	**TOTAL General Administration**	(418,065)	0	880	29,250	125	0	0	0	0	0	0	(387,810)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(425,096)	0	880	29,250	2,136	0	0	0	0	0	0	(392,830)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Elms # 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	12,174	0	60,326	0	0	0	0	0	0	0	0	72,500	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	62,963	0	0	0	0	0	0	0	0	62,963	32
33	Real Estate Taxes	0	0	1,799	0	2,581	0	0	0	0	0	0	4,380	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(9,906)	0	0	0	0	0	0	(100,491)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,174	0	34,503	0	(7,325)	0	0	0	0	0	0	39,352	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(412,922)	0	35,383	29,250	(5,189)	0	0	0	0	0	0	(353,478)	45

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Peoria Forest Partnership	100.00%	$ 470	$ 470	15
16	V	20	Dues, Fees, Subs		Peoria Forest Partnership		410	410	16
17	V	30	Depreciation		Peoria Forest Partnership		60,326	60,326	17
18	V	32	Interest		Peoria Forest Partnership		62,963	62,963	18
19	V	33	Real Estate Tax		Peoria Forest Partnership		1,799	1,799	19
20	V								20
21	V								21
22	V	34	Rent	90,585	Peoria Forest Partnership			(90,585)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,585			$ 125,968	$ * 35,383	39

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Redwood Management	100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V	17	Salary-J. Shlofrock				18,056	18,056	19
20	V	22	Payroll Taxes-JS				1,483	1,483	20
21	V								21
22	V								22
23	V								23
24	V	17	Salary-S. Aron				8,974	8,974	24
25	V	22	Payroll Taxes-SA				737	737	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V	17	Management Fees						31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 29,250	$ * 29,250	39

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Barton Management	100.00%	$ 749	$ 749	15
16	V	6	Repairs and Maint		Barton Management		1,262	1,262	16
17	V	26	Insurance		Barton Management		78	78	17
18	V	27	Emp. Ben. Gen. Admin		Barton Management		47	47	18
19	V	33	Real Estate Taxes		Barton Management		2,581	2,581	19
20	V	34	Rent Office Space		Barton Management		4,494	4,494	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	Rent		Barton Management			(14,400)	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			$			$ 9,211	$ * (5,189)	39

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Shlofrock	Owner	Administrative	15.30	See Attached	6.5	0.16	Alloc Rdwd	$ 18,056		1
2											2
3	Elisa Shlofrock-Zusman	Owner	Administrative	12.08	See Attached		0.12				3
4											4
5	Rick Duros	Owner	Administrative	7.91	See Attached		0.12				5
6	Stan Aron	Owner	Administrative	15.28	See Attached	3.5	5.00	Alloc Rdwd	8,974		6
7	Gary Weintraub	Owner	Legal	9.95	See Attached		0.12				7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,030		13

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

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Bed Size	585	4	$ 2,805	$	98	$ 470	1
2	20	Dues, Fees, Subs	Bed Size	585	4	2,450		98	410	2
3	30	Depreciation	Bed Size	585	4	360,112		98	60,326	3
4	32	Interest	Bed Size	585	4	375,852		98	62,963	4
5	33	Real Estate Tax	Bed Size	585	4	10,741		98	1,799	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					$ 751,960	$		$ 125,968	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Redwood Management
Street Address: 465 Central Ave, Suite 100
City / State / Zip Code: Northfield, IL 60093
Phone Number: (847-441-8200
Fax Number: (847-441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4	17	Salary-J. Shlofrock	Avg Hours Worked	36	6	100,000	100,000	7	18,056	4
5	27	Payroll Taxes-JS	Avg Hours Worked	36	6	8,211		7	1,483	5
6										6
7	17	Salary-S. Aron	Avg Hours Worked	39	5	100,000	100,000	4	8,974	7
8	27	Payroll Taxes-SA	Avg Hours Worked	39	5	8,217		4	737	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					$ 216,428	$ 200,000		$ 29,250	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Barton Management, Inc.
Street Address: 465 Central Ave, Suite 100
City / State / Zip Code: Northfield, IL 60093
Phone Number: (847-441-8200
Fax Number: (847-441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Rental Income	562,164	9	$ 11,770	$	35,770	$ 749	1
2	6	Repairs ans Maint	Rental Income	562,164	9	19,835		35,770	1,262	2
3	26	Insurance	Rental Income	562,164	9	1,231		35,770	78	3
4	27	Emp.Ben.Gen.Admin.	Rental Income	562,164	9	739		35,770	47	4
5	33	Real Estate Taxes	Rental Income	562,164	9	40,562		35,770	2,581	5
6	34	Rent Office Space	Rental Income	562,164	9	70,633		35,770	4,494	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					$ 144,770	$		$ 9,211	25

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Allocated from Peoria Forest	X									62,963	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 62,963	14
15	TOTALS (line 9+line14)						$	$			$ 62,963	15

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

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

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

Facility Name & ID Number Sharon Health Care Elms **#** 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 46,011	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.)		$ 54,121	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,110	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,234	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 59,344	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	40,737	8
	2006	44,371	9
	2007	44,379	10
	2008	45,566	11
	2009	48,657	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Sharon Healthcare Willows - Facility - 219 Beds
Sharon Healthcare Woods - Facility - 152 Beds
Sharon Healthcare Pines - Facility - 116 Beds
Peoria Forest Partnership

F. 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 107,214	1
2	Allocation-Peoria Forest			6,024	2
3	TOTALS			$ 113,238	3

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Elms COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032789

CONTACT PERSON REGARDING THIS REPORT

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-25-426-016	Nursing Home Property	$ 49,741.00	$ 49,741.00
2.	See Attached	Home Office	$ 10,741.00	$ 1,799.00
3.	See Attached	Building Co.	$ 40,562.00	$ 2,581.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,044.00	$ 54,121.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	5,207	165	20		(165)	3,819	9
10	Various			1988	4,581	124	20		(124)	3,460	10
11	Various			1989	1,877	60	20		(60)	1,273	11
12	Various			1990	6,666	134	20	333	199	5,188	12
13	Various			1991	23,422	713	20	1,171	458	14,911	13
14	Various			1992	19,136	575	20	957	382	11,577	14
15	Various			1994	9,731	250	20	487	237	4,076	15
16	Various			1995	2,723	69	20	136	67	1,072	16
17	Various			1996	4,103	106	20	206	100	1,532	17
18	Various			1997	19,387	497	20	970	473	6,617	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

See Page 12A, Line 70 for total

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1991		$ 1,862,634	$	35	$ 53,218	$ 53,218	$	4
5			1991		39,368		31.5	1,250	1,250		5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

See Page 12A, Line 70 for total

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations(Page12-Rep & Page12ARep)		1,902,001	60,326		60,327	1	1,177,997	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,998,834	$ 63,019		$ 64,587	$ 1,568	$ 1,231,522	70

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,998,834	$ 63,019		$ 64,587	$ 1,568	$ 1,231,522	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,711	2
3	Lawn Repair	1998	625	16	20	31	15	202	3
4	Water Softener	1998	1,700	44	20	85	41	548	4
5	Phone Shelf	1998	207	5	20	10	5	66	5
6	Rooftop Unit	1998	1,472	38	20	74	36	471	6
7	Amer II Minuteman	1998	272	7	20	14	7	87	7
8	Patio Ramp	1998	538	14	20	27	13	170	8
9	Roofing	1998	3,187	82	20	159	77	998	9
10	Drapes	1998	5,805	149	20	290	141	1,793	10
11	Heat Condenser	1999	1,203	31	20	60	29	365	11
12	Windows	1999	81	2	20	4	2	25	12
13	Garage Door	1999	142	4	20	7	3	44	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	1,124	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	781	15
16	Windows	1999	481	12	20	24	12	145	16
17	Concrete Parking Lot	1999	969	25	20	48	23	277	17
18	Roof	1999	996	26	20	50	24	285	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	564	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	453	20
21	Renovation Design	2000	2,561	66	20	128	62	693	21
22	Renovation Design	2000	1,950	50	20	98	48	519	22
23	Garbage Disposal	2000	791	20	20	40	20	209	23
24	Water Heater	2000	345	9	20	17	8	91	24
25	Parking Spaces	2000	89	2	20	4	2	23	25
26	Parking Spaces	2000	3,720	95	20	186	91	973	26
27	Drapery	2000	5,588	143	20	279	136	1,451	27
28	Nurse Call Station	2000	3,544	91	20	177	86	920	28
29	Renovation Project	2000	398	10	20	20	10	102	29
30	Electrical Work	2001	1,427	37	20	71	34	361	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	6,339	31
32	Exit Door	2001	2,391	61	20	120	59	600	32
33	Renovation Design	2001	2,864	73	20	143	70	719	33
34	TOTAL (lines 1 thru 33)		$ 2,082,481	$ 65,163		$ 68,768	$ 3,605	$ 1,254,631	34

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,082,481	$ 65,163		$ 68,768	$ 3,605	$ 1,254,631	1
2	Garage	2001	965	25	20	48	23	243	2
3	Drapery	2001	6,320	162	20	316	154	1,559	3
4	Install Drapery	2001	662	17	20	33	16	164	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	300	5
6	Gas Water Heater	2001	2,481	64	20	124	60	602	6
7	Compact Water Booster	2001	1,247	32	20	62	30	303	7
8	Drapery	2001	1,622	42	20	81	39	393	8
9	Install Roof	2001	4,357	112	20	218	106	1,056	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	232	10
11	Water Heater	2001	4,496	115	20	225	110	1,071	11
12	Replace Shingles	2001	923	24	20	46	22	220	12
13	Replace Refrig System	2001	1,092	28	20	55	27	258	13
14	Replace Shingles	2001	1,221	31	20	61	30	288	14
15	Flooring	2001	90	2	20	5	3	21	15
16	Parking Posts	2002	281	7	20	14	7	63	16
17	2 Exit Doors	2002	769	20	20	38	18	160	17
18	Roof Repair	2003	961	25	20	48	23	182	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	309	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	359	20
21	Duct Work	2003	2,598	67	20	130	63	469	21
22	Flooring	2003	3,190	82	20	160	78	576	22
23	Roof	2004	4,760	119	20	238	119	818	23
24	Kitchen Floor	2004	994	25	20	50	25	165	24
25	Kitchen Floor	2004	1,133	28	20	57	29	185	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	227	26
27	Rooftop Unit	2004	1,803	46	20	90	44	291	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	479	28
29	Lobby Rehab	2005	4,550	117	20	227	110	656	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	191	30
31	Back Doors	2005	2,310	59	20	116	57	333	31
32	Locks for Lobby	2005	873	22	20	44	22	126	32
33	Bathroom Repairs	2005	979	25	20	49	24	139	33
34	TOTAL (lines 1 thru 33)		$ 2,144,851	$ 66,758		$ 71,887	$ 5,129	$ 1,267,069	34

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,144,851	$ 66,758		$ 71,887	$ 5,129	$ 1,267,069	1
2	Lobby Rehab	2005	959	25	20	48	23	136	2
3	Remodeling Project-Frt Bldg	2005	729	19	20	36	17	104	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	323	4
5	Ceiling Tile	2005	2,876	74	20	144	70	403	5
6	Front Lobby Renovation	2005	110	3	20	6	3	15	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	1,221	7
8	Carpet-Activity Room	2005	1,680	43	20	84	41	235	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	326	9
10	Dishroom Work	2005	796	20	20	40	20	108	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	87	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	79	12
13	Water Heater	2005	4,817	124	20	241	117	633	13
14	Ceiling Tiles	2005	604	15	20	30	15	78	14
15	Ceiling Tiles	2006	725	19	20	36	17	92	15
16	Condensing Unit	2006	1,040	27	20	52	25	117	16
17	Replace Ceilings	2006	6,769	174	20	338	164	730	17
18	Closet Wall Work	2006	890	23	20	45	22	96	18
19	Sidewalk	2006	7,888	202	20	394	192	851	19
20	Window Treatments	2006	1,504	39	20	75	36	159	20
21	Plumbing Services	2007	3,235	83	20	161	78	322	21
22	Picnic Pad	2007	2,123	54	20	106	52	211	22
23	Drapery, Valances	2007	600	46	20	30	(16)	185	23
24	Replace Water Heater	2007	1,184	136	20	59	(77)	979	24
25	Add Rock to Drive	2007	4,949	127	20	247	120	460	25
26	Water Booster	2007	215	17	20	11	(6)	66	26
27	Sidewalk	2007	1,298	150	20	65	(85)	1,074	27
28	RTU-Roof Top Unit	2007	444	34	20	22	(12)	137	28
29	Wall Pks/Emergency Lighting	2007	7,700	197	20	385	188	683	29
30	Cubicle Curtains	2007	5,848	150	20	292	142	519	30
31	Windows	2007	2,044	235	20	102	(133)	1,691	31
32	Kitchen Exhaust Duckwork	2007	2,218	57	20	111	54	192	32
33	Dining Room Flooring	2007	6,950	178	20	347	169	572	33
34	TOTAL (lines 1 thru 33)		$ 2,229,740	$ 69,406		$ 76,128	$ 6,722	$ 1,279,953	34

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12D, Carried Forward		$ 2,229,740	$ 69,406		$ 76,128	$ 6,722	$ 1,279,953	1
2	Electrical Worl Alarm	2007	2,779	320	20	139	(181)	2,299	2
3	Alarm	2007	1,547	178	20	77	(101)	1,280	3
4	Landscaping Work	2007	2,050	158	20	103	(55)	630	4
5	Roof Top Units	2007	12,870	330	20	643	313	1,004	5
6	Generator Study	2007	1,776	46	20	89	43	139	6
7	Water Softener Maintenance	2007	3,750	96	20	187	91	292	7
8	Remodel Halls	2008	1,956	50	20	98	48	148	8
9	Nursing Station	2008	6,800	174	20	340	166	487	9
10	Cabinets	2008	3,190	306	20	159	(147)	2,731	10
11	Renovate Hallways	2008	2,368	61	20	118	57	164	11
12	Fence	2008	8,542	365	20	427	62	5,255	12
13	Landscaping Work	2008	718	31	20	36	5	442	13
14	Landscaping Work	2008	942	40	20	47	7	580	14
15	Landscaping Work	2008	735	31	20	37	6	452	15
16	Alarm System	2008	801	21	20	40	19	47	16
17	Borders	2008	1,361	35	20	68	33	77	17
18	New Walk	2008	1,268	33	20	63	30	69	18
19	Shower Room	2008	2,201	56	20	110	54	115	19
20	Shower Room	2008	1,633	42	20	82	40	85	20
21	Shower Room Door	2008	1,429	37	20	71	34	75	21
22	Dining Room Flooring	2007	37,289	956	20	1,864	908	2,988	22
23	Drywall Removal	2009	6,200	159	20	310	151	312	23
24	Roof Deck-Insulation	2009	23,682	607	20	1,184	577	1,139	24
25	Picnic Shelter Fence	2009	5,300	252	20	265	13	3,034	25
26	Generator	2009	84,443	2,165	20	4,222	2,057	4,063	26
27	Remodel Shower Room	2009	1,522	39	20	76	37	60	27
28	Exhaust Fan	2009	4,700		20	235	235	4,700	28
29	Parking Lot-Swale	2009	750	36	20	37	1	429	29
30	Regrade Trenches	2009	834	40	20	42	2	478	30
31	Vinyl Fence	2009	2,777	132	20	139	7	1,590	31
32	Concrete-Parking Lot	2009	14,238	676	20	712	36	8,151	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,470,191	$ 76,878		$ 88,148	$ 11,270	$ 1,323,268	34

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12E, Carried Forward		$ 2,470,191	$ 76,878		$ 88,148	$ 11,270	$ 1,323,268	1
2	Concrete-Patio,Walkway	2009	7,037	334	20	352	18	4,029	2
3	Shower Room-Remodel	2009	788	20	20	39	19	30	3
4	Regrade, Seed Around Shelter	2009	1,200	57	20	60	3	687	4
5	Tile-Downspouts	2009	1,356	64	20	68	4	776	5
6	Replace Cable Lighting	2009	1,202	31	20	60	29	42	6
7	Roof Top Unit w/ Gas Heat	2009	8,600	221	20	430	209	267	7
8	Roof Repair	2009	751	19	20	38	19	20	8
9	Park Bench Canopy	2008	7,488	719	20	374	(345)	6,410	9
10	Carpet	2010	1,122	1,122	20	56	(1,066)	1,122	10
11	Doors & Frames	2010	3,882	12	20	194	182	12	11
12	Repipe Water Lines	2010	3,023	3	20	151	148	3	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,506,640	$ 79,480		$ 89,970	$ 10,490	$ 1,336,666	34

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 93,783	$ 8,002	$ 16,936	$ 8,934	10	$ 83,074	71
72	Current Year Purchases	11,924	11,923	2,255	(9,668)	10	11,924	72
73	Fully Depreciated Assets	461,571				10	460,817	73
74								74
75	TOTALS	$ 567,278	$ 19,925	$ 19,191	$ (734)		$ 555,815	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 Chevy Van	2001	$ 2,463	$	$	$	5	$ 2,463	76
77		2001 Dodge Van	2004	2,945				5	2,945	77
78		2008 Chevy Express	2009	10,244		2,049	2,049	5	10,244	78
79		Tractor	2009	1,844		369	369	5	1,844	79
80	TOTALS			$ 17,496	$	$ 2,418	$ 2,418		$ 17,496	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,204,652	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,405	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,579	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,174	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,909,977	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	Alloc-Barton Mgmt				2,581			5
6								6
7	TOTAL				$ 2,581 **			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: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 31,061 Description: ____
(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 & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Sharon Health Care Elms **#** 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 **(last day of reporting year)**

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	$ 710,177	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	505,043		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,053		6
7	Other Prepaid Expenses	7,155		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,252,428	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	604,635		15
16	Equipment, at Historical Cost	398,356		16
17	Accumulated Depreciation (book methods)	(546,312)		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)**	$ 456,679	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,709,107	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,365	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,966		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,913		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,234		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,132,681		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,443,159	$	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)**	$ 1,443,159	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 265,948	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,709,107	$	48

***(See instructions.)**

Facility Name & ID Number Sharon Health Care Elms # 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 693,454	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 693,454	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(427,506)	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)**	$ (427,506)	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)**	$ 265,948	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,220,804	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,220,804	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***	14,651	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,651	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	192	28
28a	Vending Income	5,259	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,451	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,240,906	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	958,065	31
32	Health Care	1,751,404	32
33	General Administration	1,236,216	33
	B. Capital Expense		
34	Ownership	230,288	34
	C. Ancillary Expense		
35	Special Cost Centers	438,126	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,667,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	(426,848)	41
42	**Income Taxes**	(658)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (427,506)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,080	$ 60,753	$ 29.21	1
2	Assistant Director of Nursing	1,840	2,080	48,304	23.22	2
3	Registered Nurses					3
4	Licensed Practical Nurses	23,467	25,115	541,384	21.56	4
5	CNAs & Orderlies	58,671	61,991	689,124	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,631	4,992	47,190	9.45	10
11	Social Service Workers	5,696	6,264	90,626	14.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,951	15,586	157,427	10.10	15
16	Dishwashers					16
17	Maintenance Workers	9,076	10,255	124,036	12.10	17
18	Housekeepers	14,196	15,384	145,689	9.47	18
19	Laundry	9,033	9,728	86,296	8.87	19
20	Administrator	2,080	2,080	77,855	37.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,189	3,497	58,299	16.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,962	2,170	23,764	10.95	31
32	Other Health C: Restorative	4,087	4,434	48,836	11.01	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,775	165,656	$ 2,199,583 *	$ 13.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	140	$ 7,105	1-3	35
36	Medical Director	228	14,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	194	8,735	10-3	40
41	Occupational Therapy Consultant	246	11,069	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	136	6,171	10-3	43
44	Activity Consultant	66	2,954	11-3	44
45	Social Service Consultant	190	4,762	12-3	45
46	Other(specify)				46
47	Psychiatric Director	126	11,423	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,422	$ 68,419		49

C. CONTRACT NURSES

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Ford	Administrator	0	$ 77,855
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,855

B. Administrative - Other

Description	Amount
Redwood Management	$ 150,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 150,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		37,647
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 37,647

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,471
Unemployment Compensation Insurance	24,361
FICA Taxes	161,669
Employee Health Insurance	93,081
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plan Contribution	25,686
Employee Benefits	12,106
TOTAL (agree to Schedule V, line 22, col.8)	$ 389,374

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,033
Health Care Worker Background Check	
(Indicate # of checks performed 56)	560
Patient Background Checks 83	830
License & Fees & Permits	2,345
Dues & Subscriptions	1,007
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,775

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,372
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,372

**See instructions.

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	2004	$ 98	4	$ 16	$	$	$	$	$	$	$	$
2	Painting & Decorating	2005	0	4	0	0	0						
3	Painting & Decorating	2006	1,444	4	481	481	241						
4	Painting & Decorating	2007	1,312	4	219	437	437	219					
5	Painting & Decorating	2008	188	4		31	63	63	31				
6	Painting & Decorating	2010	5,101	4				850	1,700	1,700	851		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,143		$ 716	$ 949	$ 741	$ 1,132	$ 1,731	$ 1,700	$ 851	$	$

Facility Name & ID Number Sharon Health Care Elms # 0032789 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes, only 'CNA's**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,850** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,665**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **N/A**
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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
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?
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.