



Facility Name & ID Number Sharon Health Care Elms

# 0032789 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 N/A

	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	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	14,809	243	12,490	27,542	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,809	243	12,490	27,542	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.00%

D. How many bed-hold days during this year were paid by the Department? None (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

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 08/15/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/15/1987 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 98 and days of care provided 4,256

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name &amp; ID Number

Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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
	<b>A. General Services</b>										
1	Dietary	163,456	17,942	7,907	189,305		189,305		189,305		1
2	Food Purchase		184,065		184,065		184,065	(16)	184,049		2
3	Housekeeping	171,880	22,101		193,981		193,981		193,981		3
4	Laundry	72,445	20,593		93,038		93,038		93,038		4
5	Heat and Other Utilities			99,658	99,658		99,658	(2,900)	96,758		5
6	Maintenance	40,598		138,336	178,934		178,934	(2,449)	176,485		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>448,379</b>	<b>244,701</b>	<b>245,901</b>	<b>938,981</b>		<b>938,981</b>	<b>(5,365)</b>	<b>933,616</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,300	18,300		18,300		18,300		9
10	Nursing and Medical Records	1,449,713	144,352	27,487	1,621,552		1,621,552	(19,962)	1,601,590		10
10a	Therapy	125,860	10,088	43,469	179,417		179,417	(10,088)	169,329		10a
11	Activities	56,869	3,613	1,425	61,907		61,907		61,907		11
12	Social Services	119,543			119,543		119,543		119,543		12
13	CNA Training										13
14	Program Transportation			4,750	4,750		4,750		4,750		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,751,985</b>	<b>158,053</b>	<b>95,431</b>	<b>2,005,469</b>		<b>2,005,469</b>	<b>(30,049)</b>	<b>1,975,420</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	117,854		162,000	279,854		279,854	(109,001)	170,853		17
18	Directors Fees										18
19	Professional Services			46,342	46,342		46,342	819	47,161		19
20	Dues, Fees, Subscriptions & Promotions			12,243	12,243		12,243	(5,534)	6,709		20
21	Clerical & General Office Expenses	154,593	1,818	334,329	490,740		490,740	(303,324)	187,416		21
22	Employee Benefits & Payroll Taxes			423,164	423,164		423,164		423,164		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,533	1,533		1,533		1,533		24
25	Other Admin. Staff Transportation			10,669	10,669		10,669		10,669		25
26	Insurance-Prop.Liab.Malpractice			56,485	56,485		56,485	109	56,594		26
27	Other (specify):*							3,783	3,783		27
28	<b>TOTAL General Administration</b>	<b>272,447</b>	<b>1,818</b>	<b>1,046,765</b>	<b>1,321,030</b>		<b>1,321,030</b>	<b>(413,148)</b>	<b>907,882</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,472,811</b>	<b>404,572</b>	<b>1,388,097</b>	<b>4,265,480</b>		<b>4,265,480</b>	<b>(448,563)</b>	<b>3,816,917</b>		<b>29</b>

\*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 &amp; ID Number

Sharon Health Care Elms

#0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			48,955	48,955		48,955	99,469	148,424			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							40,943	40,943			32
33	Real Estate Taxes			51,653	51,653		51,653	4,737	56,390			33
34	Rent-Facility & Grounds			105,235	105,235		105,235	(99,054)	6,181			34
35	Rent-Equipment & Vehicles			10,869	10,869		10,869		10,869			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			216,712	216,712		216,712	46,094	262,806			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,615	445,030	619,645		619,645		619,645			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,796	195,796		195,796		195,796			42
43	Other (specify):*	24,964		1,545	26,509		26,509	(26,509)	0			43
44	<b>TOTAL Special Cost Centers</b>	24,964	174,615	642,371	841,950		841,950	(26,509)	815,441			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,497,775	579,187	2,247,180	5,324,142		5,324,142	(428,977)	4,895,165			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(3,563)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	46,331	30		9
10	Interest and Other Investment Income	(2,996)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(58,290)	21		18
19	Entertainment	(1,641)	21		19
20	Contributions	(5,643)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(228,801)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(74,908)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (329,528)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(99,450)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (99,450)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (428,977)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Sharon Health Care Elms

ID# 0032789

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,041)	21	1
2	Veterans	(19,962)	10	2
3	Marketing	(1,545)	43	3
4	Bank Charges	(13,551)	21	4
5	Additional R&M	3,234	06	5
6	Capitalized R&M	(6,992)	06	6
7	Veterans - Therapy	(10,088)	10A	7
8	Non Allowable Compensation	(24,964)	43	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	<b>Total</b>	(74,908)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Elms# 0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(16)											(16)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,563)		663									(2,900)	5
6	Maintenance	(3,758)		1,309									(2,449)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(7,337)</b>		<b>1,972</b>									<b>(5,365)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(19,962)											(19,962)	10
10a	Therapy	(10,088)											(10,088)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(30,049)</b>											<b>(30,049)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative					(109,001)							(109,001)	17
18	Directors Fees													18
19	Professional Services			283	536								819	19
20	Fees, Subscriptions & Promotions	(5,643)		67	42								(5,534)	20
21	Clerical & General Office Expenses	(303,324)											(303,324)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			109									109	26
27	Other (specify):*					3,783							3,783	27
28	<b>TOTAL General Administration</b>	<b>(308,967)</b>		<b>459</b>	<b>578</b>	<b>(105,218)</b>							<b>(413,148)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(346,353)</b>		<b>2,431</b>	<b>578</b>	<b>(105,218)</b>							<b>(448,563)</b>	<b>29</b>



STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15 Ending:

12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	46,331			53,138								99,469	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,996)			43,939								40,943	32
33	Real Estate Taxes			2,922	1,815								4,737	33
34	Rent-Facility & Grounds			(8,469)	(90,585)								(99,054)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>43,335</b>		<b>(5,547)</b>	<b>8,307</b>								<b>46,094</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(26,509)											(26,509)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(26,509)</b>											<b>(26,509)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(329,528)</b>		<b>(3,116)</b>	<b>8,885</b>	<b>(105,218)</b>							<b>(428,977)</b>	<b>45</b>

Facility Name & ID Number

Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 PG 6-Supplemental		See PG 6-Supplemental		See PG 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 663	\$	663	15
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.	100.00%	1,309		1,309	16
17	V	19 PROFESSIONAL FEES		BARTON MANAGEMENT INC.	100.00%	283		283	17
18	V	20 DUES, LICENSES, FEES		BARTON MANAGEMENT INC.	100.00%	67		67	18
19	V	26 INSURANCE		BARTON MANAGEMENT INC.	100.00%	109		109	19
20	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.	100.00%	2,922		2,922	20
21	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.	100.00%	5,931		5,931	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34 RENT	14,400	BARTON MANAGEMENT INC.	100.00%			(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		\$ 14,400			\$ 11,284	\$ *	(3,116)	39

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

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	19 PROFESSIONAL FEES	\$	PEORIA FOREST PARTNERSHIP	100.00%	\$ 536	\$	536	15
16	V	20 DUES, FEES, SUBS.		PEORIA FOREST PARTNERSHIP	100.00%	42		42	16
17	V	30 DEPRECIATION		PEORIA FOREST PARTNERSHIP	100.00%	53,138		53,138	17
18	V	32 INTEREST		PEORIA FOREST PARTNERSHIP	100.00%	43,939		43,939	18
19	V	33 REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP	100.00%	1,815		1,815	19
20	V	34 RENT	90,585	PEORIA FOREST PARTNERSHIP	100.00%			(90,585)	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		\$ 90,585			\$ 99,470	\$ *	8,885	39

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

**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 SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT	100.00%	20,968	\$	20,968	15
16	V	27 PAYROLL TAXES-JS		REDWOOD MANAGEMENT	100.00%	1,868		1,868	16
17	V								17
18	V	17 SALARY-S. ARON		REDWOOD MANAGEMENT	100.00%	24,653		24,653	18
19	V	17 MANAGEMENT FEES - S. ARON		REDWOOD MANAGEMENT	100.00%	7,379		7,379	19
20	V	27 PAYROLL TAXES-SA		REDWOOD MANAGEMENT	100.00%	1,914		1,914	20
21	V								21
22	V	17 MANAGEMENT FEES	162,000					(162,000)	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		\$ 162,000			\$ 56,782	\$ *	(105,218)	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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



**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Sharon Health Care Elms

#

0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	26.71%	See Attached	6.50	15.48%	Alloc. Salary	\$ 20,968	17-7	1	
2	Anca Zota-Oviedo	Shareholder	Administrative	1.02%	See Attached	3.00	5.45%	Alloc. Salary	14,209	17-1	2	
3	Gary Weintraub	Shareholder	Administrative	11.58%	See Attached	4.00	10.81%	Alloc. Salary	13,638	17-1	3	
4	Stan Aron	Shareholder	Administrative	17.80%	See Attached	4.00	10.81%	Alloc. Salary	32,032	17-7	4	
5	Rick Duros	COO	Administrative		See Attached	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	\$ 80,847		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:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 CENTRAL 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 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	AVAILABLE DAYS	500,425	8	\$ 9,276	\$ 35,770	\$ 663	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	500,425	8	18,320	35,770	1,309	2
3	19	PROFESSIONAL FEES	AVAILABLE DAYS	500,425	8	3,962	35,770	283	3
4	20	DUES, LICENSES, FEES	AVAILABLE DAYS	500,425	8	940	35,770	67	4
5	26	INSURANCE	AVAILABLE DAYS	500,425	8	1,522	35,770	109	5
6	33	REAL ESTATE TAXES	AVAILABLE DAYS	500,425	8	40,881	35,770	2,922	6
7	34	RENT OFFICE SPACE	AVAILABLE DAYS	500,425	8	82,971	35,770	5,931	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					\$ 157,872	\$	\$ 11,284	25



Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	19	PROFESSIONAL FEES	BED SIZE	585	4	\$ 3,200	\$ 98	\$ 536	1
2	20	DUES, FEES, SUBS.	BED SIZE	585	4	250	98	42	2
3	30	DEPRECIATION	BED SIZE	585	4	317,203	98	53,138	3
4	32	INTEREST	BED SIZE	585	4	262,286	98	43,939	4
5	33	REAL ESTATE TAX	BED SIZE	585	4	10,835	98	1,815	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					\$ 593,774	\$	\$ 99,470	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization REDWOOD MANAGEMENT  
 Street Address 465 CENTRAL AVE. ,SUITE 100  
 City / State / Zip Code NORTHFIELD, IL. 60093  
 Phone Number ( 847) 441-8200  
 Fax Number ( 847) 441-0800

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED 31	5	100,000	100,000	7	20,968	1
2	27	PAYROLL TAXES-JS	AVG HOURS WORKED 31	5	8,910		7	1,868	2
3									3
4	17	SALARY-S. ARON	AVG HOURS WORKED 16	4	98,610	98,610	4	24,653	4
5	17	MANAGEMENT FEES - S. ARO	AVG HOURS WORKED 16	4	29,516		4	7,379	5
6	27	PAYROLL TAXES-SA	AVG HOURS WORKED 16	4	7,657		4	1,914	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				\$ 244,693	\$ 198,610		\$ 56,782	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Sharon Health Care Elms

# 0032789 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number

Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	Allocated from Peoria Forest	X								43,939	6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 43,939	9							
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X							(2,996)	10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (2,996)	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 40,943	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:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									20										

\* 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' COMPILATION 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2014 report.		\$	<b>52,427</b>	<b>1</b>															
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.)		\$	<b>55,757</b>	<b>2</b>															
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,330</b>	<b>3</b>															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>53,060</b>	<b>4</b>															
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>															
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>56,390</b>	<b>7</b>															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<b>54,121</b>	<b>8</b>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>		<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>
<b>FOR BHF USE ONLY</b>																			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$	<b>13</b>																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>																	
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>																	
	2011	<b>50,754</b>	<b>9</b>																
	2012	<b>50,391</b>	<b>10</b>																
	2013	<b>50,411</b>	<b>11</b>																
	2014	<b>51,020</b>	<b>12</b>																
<b>2015 Accrual = \$51,020 x 1.04 = \$53,061</b>																			
<b>Allocated from Barton Management: \$2,922</b>																			
<b>Allocated from Peoria Forest: \$1,815</b>																			

**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:

01/01/15

Ending:

12/31/15

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Sharon Healthcare Willows-Facility- 219 Beds

Sharon Healthcare Woods-Facility- 152 Beds

Sharon Healthcare Pines-116 Beds

Peoria Forest Partnership-Dietary Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>107,214</u>	<u>1</u>
2	<u>Allocation Peoria Forest</u>			<u>6,024</u>	<u>2</u>
3	<b>TOTALS</b>			\$ <b>113,238</b>	<b>3</b>

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	98	1991	1972	\$ 1,862,634	\$ 51,950	35	\$ 59,139	\$ 7,189	\$ 1,461,219	4
5	98	1991	1991	39,368	1,188	31.5	1,188		18,413	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1987	5,207		20			8,160	9
10	Various		1988	4,581		20			7,335	10
11	Various		1989	1,877		20			2,836	11
12	Various		1990	6,666		20			10,548	12
13	Various		1991	23,422		20	1,171	1,171	31,198	13
14	Various		1992	19,136		20	957	957	24,173	14
15	Various		1994	9,731		20	487	487	9,682	15
16	Various		1995	2,723		20	136	136	2,293	16
17	Various		1996	4,103		20	206	206	3,194	17
18	Various		1997	19,387		20	970	970	13,278	18
19	Various		1998	18,953		20	947	947	11,717	19
20	Various		1999	13,776		20	688	688	7,541	20
21	Various		2000	18,986		20	949	949	9,263	21
22	Various		2001	59,593		20	2,980	2,980	28,178	22
23	Various		2002	1,050		20	52	52	458	23
24	Various		2003	10,364		20	519	519	4,237	24
25	Various		2004	10,079		20	504	504	3,955	25
26	Various		2005	40,481		20	2,024	2,024	14,804	26
27	Various		2006	18,816		20	940	940	6,288	27
28	Various		2007	100,869		20	4,598	4,598	38,145	28
29	Various		2008	41,432		20	1,537	1,537	25,753	29
30	Various		2009	165,380		20	8,034	8,034	66,636	30
31	Various		2010	8,027		20	345	345	2,695	31
32	Various		2011	40,411		20	2,020	2,020	8,582	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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								68
69					48,955		(48,955)	69
70		\$ 2,547,052	\$ 102,093		\$ 90,391	\$ (11,702)	\$ 1,820,582	70

\*\*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	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,547,052	\$ 102,093		\$ 90,391	\$ (11,702)	\$ 1,820,582	1
2	Water Heater	2012	5,637		20	1,127	1,127	4,509	2
3	Doors & Frames	2012	4,010		20	401	401	1,537	3
4	Smoke Wall In Attic	2012	12,500		20	1,250	1,250	4,792	4
5	Lighting Retrofit	2012	21,721		20	2,172	2,172	8,326	5
6	Roof Repairs - C Wing, B Wing, E Wing	2012	34,397		20	1,720	1,720	5,446	6
7	Gutters And Downspouts	2013	2,805		20	281	281	771	7
8	Built In Closets & Cabinets In Kitchen	2013	5,926		20	593	593	1,679	8
9	Custom Built In Wardrobes	2014	31,893		20	6,379	6,379	11,694	9
10	Custom Built In Wardrobes	2014	64,960		20	12,992	12,992	19,488	10
11	Drapery	2014	9,889		20	1,978	1,978	2,472	11
12	Ceramic Tile	2014	3,208		20	160	160	174	12
13	Windows, Doors & Alarms	2015	21,965		20	915	915	915	13
14	Water Heater	2015	3,809		20	143	143	143	14
15	Hallway Repairs	2015	3,960		20	149	149	149	15
16	Concrete For Sliding Doors	2015	13,842		20	461	461	461	16
17	Backflow Installation	2015	6,200		20	129	129	129	17
18	Security System	2015	8,594		20	286	286	286	18
19	Painted Rooms Asc And B2-B16 & 8 Bathrooms	2015	2,760		20	138	138	138	19
20	Install New Copper Water Piping For Restrooms/Kitchen	2015	4,233		20	212	212	212	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	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		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	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		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	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	TOTAL (lines 1 thru 33)	\$ 2,809,359	\$ 102,093		\$ 121,876	\$ 19,783	\$ 1,883,905	34

\*\*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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

\*\*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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	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:

01/01/15

Ending:

12/31/15

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	\$ 157,871	\$	\$ 20,737	\$ 20,737	10	\$ 102,346	71
72	Current Year Purchases	26,884		1,089	1,089	10	1,089	72
73	Fully Depreciated Assets	684,568				10	684,568	73
74								74
75	TOTALS	\$ 869,323	\$	\$ 21,826	\$ 21,826		\$ 788,003	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		See Attached	Various	\$ 33,325	\$	\$ 4,721	\$ 4,721	5	\$ 17,614	76
77										77
78										78
79										79
80	TOTALS			\$ 33,325	\$	\$ 4,721	\$ 4,721		\$ 17,614	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)	\$ 3,825,245	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,093	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,424	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 46,331	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,689,522	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.

**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				250			5
6	Allocated from Barton Mgmt				5,931			6
7	TOTAL				\$ 6,181			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: \$ 10,868 Description: See Attached Schedule

(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

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. /2016 \$ \_\_\_\_\_

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	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	39 - 03	hrs	\$		\$ 174,733	\$		\$ 174,733	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			67,472			67,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			202,825			202,825	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				144,539		144,539	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						30,076		30,076	13
14	TOTAL			\$		\$ 445,030	\$ 174,615		\$ 619,645	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.

Facility Name & ID Number Sharon Health Care Elms# 0032789Report Period Beginning: 01/01/15Ending: 12/31/15

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 684,945	\$	1
2	Cash-Patient Deposits	620		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,784,720		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,795		6
7	Other Prepaid Expenses	15,732		7
8	Accounts Receivable (owners or related parties)	300,000		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,813,812	\$	10
<b>B. Long-Term Assets</b>				
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	720,780		15
16	Equipment, at Historical Cost	642,696		16
17	Accumulated Depreciation (book methods)	(1,079,836)		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):	(100,000)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 183,640	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,997,452	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 291,049	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,561		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,437		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,060		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	700,393		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,269,600	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,269,600	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,727,852	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,997,452	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,771,914</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Bad Debts, Office Clerical Barton, State Replacement Tax</b>	<b>(84,596)</b>	<b>3</b>
<b>4</b>	<b>Actg Fees, Union Pension Contribution, Activity Supplies</b>	<b>(5,132)</b>	<b>4</b>
<b>5</b>	<b>Rounding</b>	<b>6</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,682,192</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>145,660</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(100,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>45,660</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,727,852</b>	<b>24</b> *

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

Facility Name &amp; ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning: 01/01/15

Ending:

12/31/15

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,362,974	1
2	Discounts and Allowances for all Levels	(8,797)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,354,177	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	913,321	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 913,321	8
<b>C. Other Operating Revenue</b>			
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	168,857	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,383	19
20	Radiology and X-Ray	3,010	20
21	Other Medical Services	17,017	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 198,267	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,996	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,996	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	1,041	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,041	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,469,802	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	938,981	31
32	Health Care	2,005,469	32
33	General Administration	1,321,030	33
<b>B. Capital Expense</b>			
34	Ownership	216,712	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	646,154	35
36	Provider Participation Fee	195,796	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,324,142	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	145,660	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 145,660	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,512,964	44
45	Private Pay - Net Inpatient Revenue	138,823	45
46	Medicare - Net Inpatient Revenue	513,213	46
47	Other-(specify) <u>Veteran</u>	137,649	47
48	Other-(specify) <u>Managed Care</u>	51,528	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,354,177	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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:

01/01/15

Ending:

12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 76,837	\$ 36.94	1
2	Assistant Director of Nursing	2,029	2,190	61,542	28.10	2
3	Registered Nurses	12,142	13,490	361,832	26.82	3
4	Licensed Practical Nurses	12,800	14,213	330,127	23.23	4
5	CNAs & Orderlies	49,902	55,446	596,131	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,164	9,065	125,860	13.88	8
9	Activity Director					9
10	Activity Assistants	5,034	5,275	56,869	10.78	10
11	Social Service Workers	4,986	5,540	119,543	21.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,169	15,355	163,456	10.65	15
16	Dishwashers					16
17	Maintenance Workers	2,028	2,108	40,598	19.26	17
18	Housekeepers	14,200	15,778	171,880	10.89	18
19	Laundry	6,620	7,353	72,445	9.85	19
20	Administrator	2,200	2,200	90,007	40.91	20
21	Assistant Administrator					21
22	Other Administrative	689	689	27,847	40.42	22
23	Office Manager					23
24	Clerical	9,248	9,808	154,593	15.76	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	2,016	2,096	23,244	11.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	740	740	24,964	33.74	33
34	TOTAL (lines 1 - 33)	146,967	163,426	\$ 2,497,775 *	\$ 15.28	34

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

\*\* See instructions.

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	188	\$ 7,907	01-03	35
36	Medical Director	261	18,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant	316	18,302	10a-03	40
41	Occupational Therapy Consultant	304	17,645	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	130	7,522	10a-03	43
44	Activity Consultant	41	1,425	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Consultant - Psychiatric Director	145	7,500	10-03	47
48	RUG Consultants	224	18,187	10-03	48
49	TOTAL (lines 35 - 48)	1,705	\$ 98,588		49

C. CONTRACT NURSES

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



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sherry Ford	Administrator	0.00	\$ 90,007	Workers' Compensation Insurance	\$ 54,499	IDPH License Fee	\$ 1,990	
Gary Weintraub	Administrative	11.58%	13,638	Unemployment Compensation Insurance	44,143	Advertising: Employee Recruitment	251	
Anca Zota-Oviedo	Administrative	1.02%	14,209	FICA Taxes	184,436	Health Care Worker Background Check		
				Employee Health Insurance	121,808	(Indicate # of checks performed 111.5)	1,115	
				Employee Meals		Patient Background Checks	96	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	688	
				Christmas Expense	1,526	Licenses, Permits, & Fees	1,596	
				401K Contribution	9,837	Allocated from Barton Mgmt	67	
				Employee Benefit	6,659	Allocated from Peoria Forest	42	
				Union Pension Contribution	255			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,854	TOTAL (agree to Schedule V, line 22, col.8)	\$ 423,164	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,709	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Redwood Management			\$ 162,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 162,000	TOTAL		\$	Seminar Expense	1,533
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting Fees		\$ 16,910					
Sharon Healthcare Complex	Accounting Fees		1,079					
HK Payroll Services	Accounting Fees		1,271					
Personnel Planners	Unemployment Consultation		1,210					
Paychex of New York LLC	Data Processing - Payroll		2,773					
ADP LLC	Data Processing - Payroll		1,116					
Sharon HC	Data Processing - Payroll		217					
Ability Network	Computer Services		1,898					
Barton Management	Computer Services		3,063					
Sharon HC Complex	Computer Services		1,078					
South Side Bank	Computer Services		27					
See Supplemental Schedule			15,700					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 46,341				Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,533	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Sharon Health Care Elms

# 0032789

Report Period Beginning:

01/01/15

Ending:

12/31/15

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes, Only CNAs
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (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? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,685 Line 10-02
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 195,796  
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- 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? 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**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.