		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0032797

Facility Name: Sharon Health Care Willows

Address: 3520 North Rochelle (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

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

Paid Preparer

(Signed) 04/30/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	218	Intermediate (ICF)	218	79,788	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	218	TOTALS	218	79,788	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					8
9	SNF/PED					9
10	ICF	53,093	817	1,725	55,635	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,093	817	1,725	55,635	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.73%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 08/15/1987

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	419,977	71,922	9,412	501,311		501,311		501,311			1
2	Food Purchase		427,720		427,720		427,720	(63)	427,657			2
3	Housekeeping	605,983	64,715		670,698		670,698		670,698			3
4	Laundry		21,771	1,850	23,621		23,621		23,621			4
5	Heat and Other Utilities			253,182	253,182		253,182	(672)	252,510			5
6	Maintenance	98,504		380,649	479,153		479,153	(20,116)	459,037			6
7	Other (specify):*											7
8	TOTAL General Services	1,124,464	586,128	645,093	2,355,685		2,355,685	(20,851)	2,334,834			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,240,068	408,108	54,643	2,702,819		2,702,819	(36,245)	2,666,574			10
10a	Therapy	172,693	5,811		178,504		178,504		178,504			10a
11	Activities	150,709	2,989	1,576	155,274		155,274		155,274			11
12	Social Services	481,128		1,575	482,703		482,703		482,703			12
13	CNA Training											13
14	Program Transportation			8,559	8,559		8,559		8,559			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,044,598	416,908	90,353	3,551,859		3,551,859	(36,245)	3,515,614			16
	C. General Administration											
17	Administrative	319,207		521,459	840,666		840,666	(456,971)	383,695			17
18	Directors Fees											18
19	Professional Services			93,297	93,297		93,297	2,684	95,981			19
20	Dues, Fees, Subscriptions & Promotions			43,642	43,642		43,642	(17,559)	26,083			20
21	Clerical & General Office Expenses	174,192	4,138	292,976	471,306		471,306	(249,620)	221,686			21
22	Employee Benefits & Payroll Taxes			681,384	681,384		681,384		681,384			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,729	3,729		3,729	(2,000)	1,729			24
25	Other Admin. Staff Transportation			3,655	3,655		3,655		3,655			25
26	Insurance-Prop.Liab.Malpractice			204,094	204,094		204,094	244	204,338			26
27	Other (specify):*							2,196	2,196			27
28	TOTAL General Administration	493,399	4,138	1,844,236	2,341,773		2,341,773	(721,026)	1,620,747			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,662,461	1,007,174	2,579,682	8,249,317		8,249,317	(778,122)	7,471,195			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 Willows #0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			61,711	61,711		61,711	163,366	225,077			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							53,574	53,574			32
33	Real Estate Taxes			132,000	132,000		132,000	15,182	147,182			33
34	Rent-Facility & Grounds			227,696	227,696		227,696	(212,409)	15,287			34
35	Rent-Equipment & Vehicles			6,935	6,935		6,935		6,935			35
36	Other (specify):*											36
37	**TOTAL Ownership**			428,342	428,342		428,342	19,713	448,055			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			457,253	457,253		457,253		457,253			42
43	Other (specify):*	79,136		3,641	82,777		82,777	(82,777)	(0)			43
44	**TOTAL Special Cost Centers**	79,136		460,894	540,030		540,030	(82,777)	457,253			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,741,597	1,007,174	3,468,918	9,217,689		9,217,689	(841,186)	8,376,503			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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Reference	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	(2,055)	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	41,207	30		9
10	Interest and Other Investment Income	(3,669)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(214,000)	21		18
19	Entertainment	(347)	21		19
20	Contributions	(9,595)	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	(9,658)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,684)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(165,150)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (376,014)		$	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)	(465,173)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (465,173)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (841,187)		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 Willows

ID# 0032797

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (26,491)	06	1
2	Bank Charges	(7,500)	21	2
3	Miscellaneous Income	(459)	21	3
4	Non-Allowable Compensation	(58,952)	43	4
5	Veterans-Pharmacy	(32,126)	10	5
6	Veterans-Lab Fees	(1,947)	10	6
7	Veterans-Doctor Visits	(1,081)	10	7
8	Resident Stipend	(1,091)	10	8
9	Marketing Director Salary	(20,184)	43	9
10	Marketing Expense	(3,641)	43	10
11	Meals	(4,979)	21	11
12	Non-Allowable Fees	(188)	20	12
13	Additional R&M	3,338	06	13
14	PAC Dues	(7,848)	20	14
15	Non-Allowable Seminar	(2,000)	24	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**	(165,150)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Sharon Health Care Willows

IDF **0032797**

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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													1
2	Food Purchase	(63)											(63)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,055)		1,383									(672)	5
6	Maintenance	(23,153)		3,037									(20,116)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(25,271)		4,420									(20,851)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(36,245)											(36,245)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(36,245)											(36,245)	16
	C. General Administration													
17	Administrative					(456,971)							(456,971)	17
18	Directors Fees													18
19	Professional Services			300	2,384								2,684	19
20	Fees, Subscriptions & Promotions	(17,631)		72									(17,559)	20
21	Clerical & General Office Expenses	(249,627)		7									(249,620)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,000)											(2,000)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			244									244	26
27	Other (specify):*					2,196							2,196	27
28	**TOTAL General Administration**	(269,258)		623	2,384	(454,775)							(721,026)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(330,774)		5,043	2,384	(454,775)							(778,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	41,207			122,159								163,366	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,669)			57,243								53,574	32
33	Real Estate Taxes			7,845	7,337								15,182	33
34	Rent-Facility & Grounds			(12,417)	(199,992)								(212,409)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	37,538		(4,572)	(13,253)								19,713	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(82,777)											(82,777)	43
44	**TOTAL Special Cost Centers**	(82,777)											(82,777)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(376,014)		471	(10,869)	(454,775)							(841,186)	45

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Stan Aron	18.89%	BARTON SENIOR RESIDENCES (SLF)	ZION	BARTON MANAGEMENT	NORTHFIELD	BUILDING CO./BOOKEEPIN	1
2	John Shlofrock	28.34%	CENTRAL PLAZA	CHICAGO	PEORIA FOREST PTNSHP	NORTHFIELD	BUILDING & DIETARY CO.	2
3	Gary Weintraub	12.29%	CLAYTON RESIDENTIAL HOME, INC.	CHICAGO	REDWOOD MANAGEMENT	NORTHFIELD	MANAGEMENT CO	3
4	Eliza Zusman	24.37%	RUSH BARTON (SLF)	CHICAGO				4
5	Duros Trust	9.76%	SHARON HEALTH CARE ELMS, INC.	PEORIA				5
6	Enid Kaplan	2.95%	SHARON HEALTH CARE PINES, INC.	PEORIA				6
7	Anca Oviedo	1.09%	SHARON HEALTH CARE WOODS, INC.	PEORIA				7
8	Marian Simon	1.09%	THORNTON HEIGHTS TERRACE, LTD.	CHICAGO HEIGHTS				8
9	Michael Kaplan	1.22%						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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Inc.		$ 1,383	$ 1,383	15
16	V	6	Repairs & Maintenance		Barton Management Inc.		3,037	3,037	16
17	V	19	Professional Fees		Barton Management Inc.		300	300	17
18	V	20	Dues, Licenses, Fees		Barton Management Inc.		72	72	18
19	V	21	Clerical & General		Barton Management Inc.		7	7	19
20	V	26	Insurance		Barton Management Inc.		244	244	20
21	V	33	Real Estate Taxes		Barton Management Inc.		7,845	7,845	21
22	V	34	Rent Office Space		Barton Management Inc.		14,883	14,883	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	Rent	27,300	Barton Management Inc.			(27,300)	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			$ 27,300			$ 27,771	$ * 471	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$	Peoria Forest Partnership		$	$	15
16	V	19	Professional Fees		Peoria Forest Partnership		2,384	2,384	16
17	V	30	Depreciation		Peoria Forest Partnership		122,159	122,159	17
18	V	32	Interest		Peoria Forest Partnership		57,243	57,243	18
19	V	33	Real Estate Tax		Peoria Forest Partnership		7,337	7,337	19
20	V	34	Rent	199,992	Peoria Forest Partnership			(199,992)	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			$ 199,992			$ 189,123	$ * (10,869)	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	17	Management Fees	521,459	Redwood Management			$ (521,459)	15
16	V								16
17	V	17	Salary - J. Shlofrock		Redwood Management		26,210	26,210	17
18	V	27	Payroll Taxes - J. Shlofrock		Redwood Management		2,196	2,196	18
19	V								19
20	V	17	Management Fee - S. Aron		Redwood Management		38,279	38,279	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			$ 521,459			$ 66,684	$ * (454,775)	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Shareholder	Administrative	28.34%	See attached	6.50	15.48%	Alloc Salary	$ 26,210	17-7	1
2	Stan Aron	Shareholder	Administrative	18.89%	See attached	4.00	10.81%	Sal. Allc Mgmt F	43,706	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	12.29%	See attached	5.00	11.90%	Salary	27,090	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.09%	See attached	6.00	10.91%	Salary	46,265	17-1	4
5	Rick Duros	COO	Administrative	0.00	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	$ 143,271		13

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

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Cental Ave.
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	Available Days	501,818	8	$ 8,697	$	79,788	$ 1,383	1
2	6	Repairs & Maintenance	Available Days	501,818	8	19,103		79,788	3,037	2
3	19	Professional Fees	Available Days	501,818	8	1,885		79,788	300	3
4	20	Dues, Licenses, Fees	Available Days	501,818	8	450		79,788	72	4
5	21	Clerical & General	Available Days	501,818	8	41		79,788	7	5
6	26	Insurance	Available Days	501,818	8	1,534		79,788	244	6
7	33	Real Estate Taxes	Available Days	501,818	8	49,340		79,788	7,845	7
8	34	Rent Office Space	Available Days	501,818	8	93,608		79,788	14,883	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					$ 174,658	$		$ 27,771	25

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	5	Utilities	Bed Size	584	4	$	$	218	$	1
2	19	Professional Fees	Bed Size	584	4	6,386		218	2,384	2
3	30	Depreciation	Bed Size	584	4	327,252		218	122,159	3
4	32	Interest	Bed Size	584	4	153,349		218	57,243	4
5	33	Real Estate Tax	Bed Size	584	4	19,655		218	7,337	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					$ 506,642	$		$ 189,123	25

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	17	Salary - J. Shlofrock	Average Hours Worked	31	5	125,000	125,000	6.50	26,210	1
2	27	Payroll Taxes - J. Shlofrock	Average Hours Worked	31	5	10,472		6.50	2,196	2
3										3
4	17	Management Fee - S. Aron	Average Hours Worked	23	5	220,103		4	38,279	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					$ 355,575	$ 125,000		$ 66,684	25

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Peoria Forest	X									57,243	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 57,243	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,669)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,669)	14
15	TOTALS (line 9+line14)						$	$			$ 53,575	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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 126,662	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.)		$ 263,244	2
3. Under or (over) accrual (line 2 minus line 1).		$ 136,582	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,599	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.		$ 147,181	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	117,815	8
	2016	120,289	9
	2017	121,191	10
	2018	121,208	11
	2019	124,031	12

2020 Accrual = $124,031 x 1.085 = $134,630 -$124,031 prepaid 2021 taxes = $10,599

Allocated from Barton Management = $7,845

Allocated from Peoria Forest Partnership = $7,337

*Line 2 includes $124,031 of prepaid RE Tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Willows COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032797

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-25-427-009	Long Term Care Facility	$ 62,994.98	62,994.98
2.	13-25-427-012	Long Term Care Facility	$ 61,036.42	61,036.42
3.	05-19-112-017-0000	Allocated from Barton Management	$ 98,680.58	7,845.00
4.	See Attached	Allocated from Peoria Forest Partnersl	$ 19,655.42	7,337.13
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 242,367.40	$ 139,213.53

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Willows COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032797

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [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 Health Care Woods - Facility 152 Beds
Sharon Health Care Elms- Facility 98 Beds
Sharon Health Care Pines - Facility 116 Beds
Peoria Forest Partnership - Dietary Building

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			$ 238,904	1
2	Allocated from Peoria Forest Partnership			13,424	2
3	TOTALS			$ 252,328	3

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	218		1991	1972	$ 4,150,504	$ 115,695	35	$ 131,778	$ 16,083	$ 3,914,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	12,982		20			12,276	9
10	Various			1990	15,966		20			14,906	10
11	Various			1991	1,595		20			1,490	11
12	Various			1992	13,429		20			12,865	12
13	Various			1993	5,656		20			5,435	13
14	Various			1994	3,579		20			3,562	14
15	Various			1995	29,692		20			29,683	15
16	Various			1996	13,113		20			13,109	16
17	Various			1997	189,520		20			189,511	17
18	Various			1998	45,613		20			45,611	18
19	Various			1999	24,560		20	3	3	24,558	19
20	Various			2000	33,805		20	762	762	33,603	20
21	Various			2001	62,770		20	3,139	3,139	60,982	21
22	Various			2002	11,323		20	491	491	10,548	22
23	Various			2003	30,154		20	128	128	29,887	23
24	Various			2004	5,317		20			5,317	24
25	Various			2005	34,104		20			34,104	25
26	Various			2006	39,852		20			39,852	26
27	Various			2007	161,530		20	1,575	1,575	158,773	27
28	Various			2008	53,530		20			53,530	28
29	Various			2009	172,656		20	1,610	1,610	162,599	29
30	Various			2010	25,257		20	1,826	1,826	25,256	30
31	Various			2011	19,824		20	1,982	1,982	19,561	31
32	Various			2012	81,914		20	6,523	6,523	56,135	32
33	Various			2013	35,726		20	2,709	2,709	28,701	33
34	Various			2014	153,011		20	7,651	7,651	49,022	34
35	Various			2015	337,539		20	16,877	16,877	94,794	35
36	Various			2016	19,637		20	1,453		6,697	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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		172,168	6,465		5,059	(1,405)	58,483	68
69	Financial Statement Depreciation			61,711			(61,711)		69
70	TOTAL (lines 4 thru 69)		$ 5,956,327	$ 183,870		$ 183,567	$ (1,757)	$ 5,195,771	70

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,956,327	$ 183,870		$ 183,567	$ (304)	$ 5,195,771	1
2	100-Gallon Water Heater	2017	3,949		20	197	197	625	2
3	2 50-Gallon Water Heaters	2017	3,130		20	157	157	574	3
4	Roof Repairs Over B, F & G Wings	2017	70,391		20	3,520	3,520	14,078	4
5	Fire Protection Updates	2017	2,943		20	147	147	491	5
6	Roomalert Door Controler Bypass Keypad	2018	6,355		20	318	318	794	6
7	Installation Of New Furnace	2018	10,600		20	530	530	1,281	7
8	Design Flooring And New Wall Construction Design	2018	11,648		20	582	582	1,359	8
9	Entire Facility-Sliding Doors/Floors/Paint/Cove Base/Labor	2018	136,906		20	6,845	6,845	17,684	9
10	Repaired & Replaced Coolant Heater	2018	2,900		20	145	145	399	10
11	Repaired Security Fence	2018	2,809		20	140	140	351	11
12	Removal Of Seven Trees	2018	5,075		20	254	254	508	12
13	New Condensor For Outdoor Conditioner Unit	2019	3,700		20	185	185	370	13
14	Roof Replacement - A Wing	2019	14,451		20	723	723	1,024	14
15	Roof Replacement - H Wing	2019	12,693		20	635	635	899	15
16	New 7.5 Ton Hvac Unit	2019	5,999		20	300	300	325	16
17	Replace Corroded Pipe And Unclog Low Point Drain	2019	4,828		20	241	241	483	17
18	Roof Repair Above North Hallway	2019	2,949		20	147	147	295	18
19	Roofing Work - Sheet Over Exixting Sheating	2020	8,676		20	434	434	434	19
20	Hvac - Replace Rooftop Unit	2020	4,394		20	220	220	220	20
21	Compressor Repair - North Side Dining	2020	4,404		20	220	220	220	21
22	Replace Concrete - Handicap Area & Garbage Area	2020	7,197		20	360	360	360	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)		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	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)		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	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)		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	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)		$ 6,282,325	$ 183,870		$ 199,866	$ 15,996	$ 5,238,543	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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									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.

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Allocated from Peoria Forest	1991	87,723	2,680	31.5	2,647	(33)	54,261	4
5	Allocated from Peoria Forest	2019	84,446	3,785	39	2,413	(1,372)	4,222	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)		$ 172,168	$ 6,465		$ 5,059	$ (1,405)	$ 58,483	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 172,168	$ 6,465		$ 5,059	$ (1,405)	$ 58,483	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)		$ 172,168	$ 6,465		$ 5,059	$ (1,405)	$ 58,483	34

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 268,155	$	$ 21,953	$ 21,953	10	$ 167,690	71
72	Current Year Purchases	12,055		1,206	1,206	10	1,206	72
73	Fully Depreciated Assets	1,000,760				10	1,000,760	73
74								74
75	TOTALS	$ 1,280,971	$	$ 23,158	$ 23,158		$ 1,169,656	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 DODGE RAM	1999	$ 12,821	$	$	$	5	$ 12,821	76
77		1998 CHEV VAN	2001	5,449				5	5,449	77
78		2001 DODGE RAM	2004	6,611				5	6,611	78
79		See Attached		81,889		2,052	2,052		79,837	79
80	TOTALS			$ 106,770	$	$ 2,052	$ 2,052		$ 104,718	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)	$ 7,922,394	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 183,870	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 225,077	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,512,916	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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				404			5
6	Allocated from Barton Management				14,883			6
7	TOTAL				$ 15,287 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 6,935 Description: See Attached
(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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 2,601,577	$	1
2	Cash-Patient Deposits	5,850		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	812,281		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,365		6
7	Other Prepaid Expenses	56,625		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,564,698	$	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	1,794,468		15
16	Equipment, at Historical Cost	1,252,393		16
17	Accumulated Depreciation (book methods)	(2,414,088)		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)**	$ 632,773	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,197,471	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 361,689	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	107,671		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,291		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,311		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,599		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,673,855		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,457,416	$	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	See Attached	462,953		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 462,953	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,920,369	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,277,102	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,197,471	$	48

***(See instructions.)**

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,149,520	1
2	Restatements (describe):		2
3	State Replacement Tax	2,640	3
4	Change in Treasury Stock	(16,640)	4
5	Other	10,492	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,146,012	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,090	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	(18,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 131,090	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,277,102	24 *

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,830,686	1
2	Discounts and Allowances for all Levels	(1,143,830)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,686,856	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	8,800	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)**	$ 8,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,669	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,669	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	667,454	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 667,454	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,366,779	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,355,685	31
32	Health Care	3,551,859	32
33	General Administration	2,341,773	33
	B. Capital Expense		
34	Ownership	428,342	34
	C. Ancillary Expense		
35	Special Cost Centers	82,777	35
36	Provider Participation Fee	457,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,217,689	40
41	**Income before Income Taxes (line 30 minus line 40)****	149,090	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 149,090	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,112,914	44
45	Private Pay - Net Inpatient Revenue	153,153	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Medicaid Hospice	120,250	47
48	Other-(specify) Veterans	300,539	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,686,856	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 Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,016	2,080	$ 103,401	$ 49.71	1
2	Assistant Director of Nursing	2,143	2,271	67,028	29.51	2
3	Registered Nurses	12,789	13,678	490,564	35.87	3
4	Licensed Practical Nurses	23,476	24,725	751,566	30.40	4
5	CNAs & Orderlies	55,846	57,951	797,156	13.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,584	12,272	172,693	14.07	8
9	Activity Director					9
10	Activity Assistants	11,176	11,984	150,709	12.58	10
11	Social Service Workers	26,468	28,392	481,128	16.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,275	29,430	419,977	14.27	15
16	Dishwashers					16
17	Maintenance Workers	4,618	4,940	98,504	19.94	17
18	Housekeepers	42,206	45,406	605,983	13.35	18
19	Laundry					19
20	Administrator	1,960	2,080	113,172	54.41	20
21	Assistant Administrator	2,552	2,752	127,252	46.24	21
22	Other Administrative	1,831	1,951	78,783	40.38	22
23	Office Manager					23
24	Clerical	5,626	6,099	174,192	28.56	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	1,907	1,971	30,353	15.40	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,147	2,146	79,136	36.87	33
34	TOTAL (lines 1 - 33)	236,620	250,128	$ 4,741,597 *	$ 18.96	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	Monthly	$ 9,412	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,576	11-03	44
45	Social Service Consultant	45	1,575	12-03	45
46	Other(specify)				46
47	Psychiatric Director	Monthly	7,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	89	$ 45,863		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	910	$ 45,343	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	910	$ 45,343		53

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Stribley	Administrator	0	$ 113,172
April Halverson	Assistant Administrator	0	7,279
Gary Weintraub	Administrative	12.29%	27,090
Anca Zota-Oviedo	Administrative	1.09%	46,265
Tim Lockard	Assistant Administrator	0	87,410
Jamie Spencer	Assistant Administrator	0	32,562
Stan Aaron	Administrative	18.89%	5,428
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 319,207

B. Administrative - Other

Description	Amount
Management Fees - Redwood Management	$ 521,459
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 521,459

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,553
ProPay HR	Payroll Processing	1,086
Paychex	Payroll Processing	11,137
iSolved HCM Midwest	Accounting Fees	3,684
Marcum LLP	Accounting Fees	13,307
Sharon HC Complex	Accounting Fees	2,364
Barton Management	Computer Services	54,290
Information Controls, Inc	Workforce Management	1,200
Sharon HC Complex	Computer Services	2,215
Constant Virtual Solutions	Computer Services	2,460
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 93,297

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,925
Unemployment Compensation Insurance	22,665
FICA Taxes	362,732
Employee Health Insurance	210,450
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	19,829
Employee Benefits - Vaccine	2,667
Christmas Expense	34
Other Employee Benefits	3,082
TOTAL (agree to Schedule V, line 22, col.8)	$ 681,384

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	$ 1,990
Advertising: Employee Recruitment	9,039
Health Care Worker Background Check	
(Indicate # of checks performed 156)	1,560
Patient Background Checks 73	730
Dues & Subscriptions	9,277
Licenses & Fees	3,415
See Supplemental Schedule	72
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,083

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,729
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,729

**See instructions.

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $15,696**

(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. $ **41,570** Line **10**

(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. $ **457,253**
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? **Yes**

(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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.