

		FOR BHF USE				

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

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.

<p>I. IDPH License ID Number: <u>0054163</u></p> <p>Facility Name: <u>Sharon Health Care Woods</u></p> <p>Address: <u>3223 W Richwoods Blv</u> <u>Peoria</u> <u>61604</u> Number City Zip Code</p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 685-5241</u> Fax # <u>(309) 688-5746</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>8/15/1987</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 20%;">Paid Preparer</td> <td>(Signed) _____ <u>04/30/2020</u></td> </tr> <tr> <td>* Subject to the attached Accountants' Consulting Report (Date)</td> </tr> <tr> <td>(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____ <u>04/30/2020</u>	* Subject to the attached Accountants' Consulting Report (Date)	(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number Sharon Health Care Woods

0054163 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,632	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,632	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,521	79		48,600	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,521	79		48,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.36%

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

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

I. On what date did you start providing long term care at this location?
Date started 08/15/1987

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Sharon Health Care Woods # 0054163 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	237,437	55,101	8,162	300,700		300,700		300,700		1
2	Food Purchase		377,533		377,533		377,533	(6)	377,527		2
3	Housekeeping	284,675	54,321		338,996		338,996		338,996		3
4	Laundry	65,362	19,740		85,102		85,102		85,102		4
5	Heat and Other Utilities			175,682	175,682		175,682	(2,216)	173,466		5
6	Maintenance	71,314		182,918	254,232		254,232	5,694	259,926		6
7	Other (specify):*										7
8	TOTAL General Services	658,788	506,695	366,762	1,532,245		1,532,245	3,472	1,535,717		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	936,215	138,099	9,300	1,083,614		1,083,614	(11,681)	1,071,933		10
10a	Therapy										10a
11	Activities	88,434	14,697		103,131		103,131		103,131		11
12	Social Services	755,755			755,755		755,755		755,755		12
13	CNA Training										13
14	Program Transportation			1,557	1,557		1,557		1,557		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,780,404	152,796	28,857	1,962,057		1,962,057	(11,681)	1,950,376		16
	C. General Administration										
17	Administrative	270,113		344,643	614,756		614,756	(280,154)	334,602		17
18	Directors Fees										18
19	Professional Services			71,139	71,139		71,139	802	71,941		19
20	Dues, Fees, Subscriptions & Promotions			89,976	89,976		89,976	(39,759)	50,217		20
21	Clerical & General Office Expenses	321,091	2,366	61,538	384,995		384,995	(17,744)	367,251		21
22	Employee Benefits & Payroll Taxes			473,802	473,802		473,802		473,802		22
23	Inservice Training & Education										23
24	Travel and Seminar			487	487		487		487		24
25	Other Admin. Staff Transportation			4,950	4,950		4,950		4,950		25
26	Insurance-Prop.Liab.Malpractice			142,055	142,055		142,055	170	142,225		26
27	Other (specify):*							2,196	2,196		27
28	TOTAL General Administration	591,204	2,366	1,188,590	1,782,160		1,782,160	(334,490)	1,447,670		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,030,396	661,857	1,584,209	5,276,462		5,276,462	(342,699)	4,933,763		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 Woods

#0054163

Report Period Beginning:

01/01/20

Ending:

12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,214	31,214		31,214	118,402	149,616			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(0)	(0)			32
33	Real Estate Taxes			94,460	94,460		94,460	10,586	105,046			33
34	Rent-Facility & Grounds			583,902	583,902		583,902	(573,243)	10,659			34
35	Rent-Equipment & Vehicles			4,499	4,499		4,499		4,499			35
36	Other (specify):*											36
37	TOTAL Ownership			714,075	714,075		714,075	(444,255)	269,820			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):*	70,967		3,274	74,241		74,241	(74,241)	(0)			43
44	TOTAL Special Cost Centers	70,967		3,274	74,241		74,241	(74,241)	(0)			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,101,363	661,857	2,301,558	6,064,778		6,064,778	(861,196)	5,203,582			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 Woods

0054163

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(3,180)	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	33,227	30		9
10	Interest and Other Investment Income	(39,913)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(189)	21		19
20	Contributions	(27,473)	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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(113,312)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,846)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	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)	(710,350)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (710,350)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (861,196)		37

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

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

		1	2	3	4	
		Yes	No	Amount	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 Woods

ID# 0054163

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (6,000)	21	1
2	Miscellaneous Income	(50)	21	2
3	Non-Allowable Legal	(1,069)	19	3
4	Patient Clothing	(1,200)	10	4
5	Resident Stipend	(10,481)	10	5
6	Marketing Director	(14,855)	43	6
7	Marketing Expense	(3,274)	43	7
8	Meals	(3,401)	21	8
9	Lobbying Expense	(8,109)	21	9
10	Additional R&M	9,268	06	10
11	Capitalized R&M	(5,692)	06	11
12	PAC Dues	(12,336)	20	12
13	Non Allowable Compensation	(56,112)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(113,312)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Woods# 0054163

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(6)											(6)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,180)		964									(2,216)	5
6	Maintenance	3,576		2,118									5,694	6
7	Other (specify):*													7
8	TOTAL General Services	390		3,082									3,472	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,681)											(11,681)	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	(11,681)											(11,681)	16
	C. General Administration													
17	Administrative					(280,154)							(280,154)	17
18	Directors Fees													18
19	Professional Services	(1,069)		209	1,662								802	19
20	Fees, Subscriptions & Promotions	(39,809)		50									(39,759)	20
21	Clerical & General Office Expenses	(17,749)		5									(17,744)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			170									170	26
27	Other (specify):*					2,196							2,196	27
28	TOTAL General Administration	(58,627)		434	1,662	(277,959)							(334,490)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,919)		3,516	1,662	(277,959)							(342,699)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Woods # 0054163 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	33,227			85,175								118,402	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(39,913)			39,913								(0)	32
33	Real Estate Taxes			5,470	5,116								10,586	33
34	Rent-Facility & Grounds			(16,923)	(556,320)								(573,243)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(6,686)		(11,453)	(426,116)								(444,255)	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):*	(74,241)											(74,241)	43
44	TOTAL Special Cost Centers	(74,241)											(74,241)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(150,846)		(7,937)	(424,454)	(277,959)							(861,196)	45

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 NO

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

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

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

Facility Name & ID Number

Sharon Health Care Woods

0054163

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	19.31%	BARTON SENIOR RESIDENCES (SLF)	ZION	BARTON MANAGEMENT	NORTHFIELD	BOOKEEPING	1
2	John Shlofrock	28.17%	CENTRAL PLAZA	CHICAGO	PEORIA FOREST PTNSHP	NORTHFIELD	BUILDING & DIETARY CO.	2
3	Gary Weintraub	13.31%	CLAYTON RESIDENTIAL HOME, INC.	CHICAGO	REDWOOD MANAGEMENT	NORTHFIELD	MANAGEMENT CO.	3
4	Eliza Zusman	21.83%	THORNTON HEIGHTS TERRACE, LTD.	CHICAGO HEIGHTS				4
5	Duros Trust	10.86%	RUSH BARTON (SLF)	CHICAGO				5
6	Enid Kaplan	3.11%	SHARON HEALTH CARE PINES, INC.	PEORIA				6
7	Anca Oviedo	1.09%	SHARON HEALTH CARE WILLOWS, INC.	PEORIA				7
8	Marian Simon	1.09%	SHARON HEALTH CARE ELMS, INC.	PEORIA				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 Woods

0054163

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Barton Management Inc.		\$ 964	\$	964	15
16	V	6 Repairs & Maintenance		Barton Management Inc.		2,118		2,118	16
17	V	19 Professional Fees		Barton Management Inc.		209		209	17
18	V	20 Dues, Licenses, Fees		Barton Management Inc.		50		50	18
19	V	21 Clerical & General		Barton Management Inc.		5		5	19
20	V	26 Insurance		Barton Management Inc.		170		170	20
21	V	33 Real Estate Taxes		Barton Management Inc.		5,470		5,470	21
22	V	34 Rent Office Space		Barton Management Inc.		10,377		10,377	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			\$ 19,363	\$ *	(7,937)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	<u>5</u> Utilities	\$	Peoria Forest Partnership		\$		15
16	V	<u>19</u> Professional Fees		Peoria Forest Partnership		1,662	1,662	16
17	V	<u>30</u> Depreciation		Peoria Forest Partnership		85,175	85,175	17
18	V	<u>32</u> Interest		Peoria Forest Partnership		39,913	39,913	18
19	V	<u>33</u> Real Estate Tax		Peoria Forest Partnership		5,116	5,116	19
20	V	<u>34</u> Rent	556,320	Peoria Forest Partnership			(556,320)	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		\$ 556,320			\$ 131,866	\$ * (424,454)	39

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

Facility Name & ID Number Sharon Health Care Woods

0054163

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	344,643	Redwood Management			\$ (344,643) 15
16	V						
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						
20	V	17 Management Fee - S. Aron		Redwood Management		38,279	38,279 20
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 344,643			\$ 66,684	\$ * (277,959) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Sharon Health Care Woods # 0054163 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Shlofrock	Shareholder	Administrative	28.17%	See attached	6.50	15.48%	Alloc Salary	\$ 26,210	17-7	1
2	Stan Aron	Shareholder	Administrative	19.31%	See attached	4.00	10.81%	Sal. Alloc Mgmt F	42,025	17-1, 17-7	2
3	Gary Weintraub	Shareholder	Legal	13.31%	See attached	5.00	11.90%	Salary	33,427	17-1	3
4	Anca Zota-Oviedo	Shareholder	Administrative	1.09%	See attached	4.00	7.27%	Salary	26,235	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	\$ 127,897		13

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

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Days	501,818	8	\$ 8,697	\$ 55,632	\$ 964	1
2	6	Repairs & Maintenance	Available Days	501,818	8	19,103	55,632	2,118	2
3	19	Professional Fees	Available Days	501,818	8	1,885	55,632	209	3
4	20	Dues, Licenses, Fees	Available Days	501,818	8	450	55,632	50	4
5	21	Clerical & General	Available Days	501,818	8	41	55,632	5	5
6	26	Insurance	Available Days	501,818	8	1,534	55,632	170	6
7	33	Real Estate Taxes	Available Days	501,818	8	49,340	55,632	5,470	7
8	34	Rent Office Space	Available Days	501,818	8	93,608	55,632	10,377	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	\$	\$ 19,363	25

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Peoria Forest Partnership

Street Address

465 Central Ave., Suite 100

City / State / Zip Code

Northfield, IL. 60093

Phone Number

(847) 441-8200

Fax Number

(847) 441-0800

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Bed Size	584	4	\$	\$	152	\$	1
2	19	Professional Fees	Bed Size	584	4	6,386		152	1,662	2
3	30	Depreciation	Bed Size	584	4	327,252		152	85,175	3
4	32	Interest	Bed Size	584	4	153,349		152	39,913	4
5	33	Real Estate Tax	Bed Size	584	4	19,655		152	5,116	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	\$		\$ 131,866	25

Facility Name & ID Number Sharon Health Care Woods

0054163

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 Redwood Management
 Street Address 465 Central Ave., Suite 100
 City / State / Zip Code Northfield, IL. 60093
 Phone Number (847) 441-8200
 Fax Number (847) 441-0800

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salary - J. Shlofrock	Average Hours Worked	31	5	125,000	125,000	6.50	26,210	1
2	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 Woods

0054163

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Woods

0054163

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

Facility Name & ID Number Sharon Health Care Woods

0054163

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

Facility Name & ID Number Sharon Health Care Woods

0054163

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Woods

0054163

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Allocated from Peoria Forest		X							39,913										
7																				
8																				
9	TOTAL Facility Related									39,913										
B. Non-Facility Related*																				
10	Interest Income		X							(39,913)										
11																				
12																				
13																				
14	TOTAL Non-Facility Related									(39,913)										
15	TOTALS (line 9+line14)									(0)										

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.	\$	94,122	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.)	\$	195,138	2
3. Under or (over) accrual (line 2 minus line 1).	\$	101,016	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4,030	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.	\$	105,046	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	87,659	8
	2016	89,499	9
	2017	90,170	10
	2018	90,183	11
	2019	92,276	12

2020 Accrual = \$92,276 x 1.0437 = \$96,306 - \$92,276 prepaid = \$4,030

Allocated from Barton Management = \$5,470

Allocated from Peoria Forest Partnership = \$5,116

***Line 2 includes \$92,276 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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Woods COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0054163

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-25-426-019</u>	<u>Long Term Care Property</u>	\$ <u>92,275.88</u>	\$ <u>92,275.88</u>
2. <u>05-19-112-017-0000</u>	<u>Allocated from Barton Management</u>	\$ <u>98,680.58</u>	\$ <u>5,469.91</u>
3. <u>See Attached</u>	<u>Allocated from Peoria Forest</u>	\$ <u>19,655.42</u>	\$ <u>5,115.79</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>210,611.88</u></u>	\$ <u><u>102,861.58</u></u>

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 Woods COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0054163

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Woods

0054163 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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

[Sharon Health Care Willows - Facility 218 Beds](#)

[Sharon Health Care Elms- Facility 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 NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1991	\$ 166,575	1
2	Allocated from Peoria Forest Partnership		1999	9,360	2
3	TOTALS			\$ 175,935	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152	1991	1972	\$ 2,893,930	\$ 82,536	31.5	\$ 91,871	\$ 9,335	\$ 2,729,658	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1987	18,543		20			13,601	9
10	Various		1988	20,355		20			18,253	10
11	Various		1989	7,490		20			6,972	11
12	Various		1990	39,136		20			36,984	12
13	Various		1991	7,089		20			6,744	13
14	Various		1992	45,962		20			38,876	14
15	Various		1993	19,912		20			19,519	15
16	Various		1994	15,494		20			15,491	16
17	Various		1995	21,826		20			21,824	17
18	Various		1996	23,181		20			23,169	18
19	Various		1997	48,372		20			48,366	19
20	Various		1998	43,929		20			43,924	20
21	Various		1999	72,933		20	4	4	72,933	21
22	Various		2000	39,056		20	918	918	39,056	22
23	Various		2001	16,554		20	828	828	16,204	23
24	Various		2002	4,453		20	163	163	4,239	24
25	Various		2003	14,380		20	75	75	14,211	25
26	Various		2004	9,173		20			9,173	26
27	Various		2005	19,674		20			19,674	27
28	Various		2006	21,334		20			21,334	28
29	Various		2007	52,326		20	1,059	1,059	50,667	29
30	Various		2008	158,927		20			158,927	30
31	Various		2009	125,432		20	5,862	5,862	78,144	31
32	Various		2012	41,437		20	4,035	4,035	35,420	32
33	Various		2013	21,510		20	1,507	1,507	16,409	33
34	Various		2014	182,439		20	9,122	9,122	58,711	34
35	Various		2015	7,469		20	373	373	2,215	35
36	Various		2016	11,539		20	577		2,690	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 Woods

0054163

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		120,044	2,639		3,430	791	40,679	68
69			31,214			(31,214)		69
70		\$ 4,123,898	\$ 116,389		\$ 119,824	\$ 2,858	\$ 3,664,067	70

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,123,898	\$ 116,389		\$ 119,824	\$ 3,435	\$ 3,664,067	1
2	1 100-Gallon Water Heater	2017	3,887		20	194	194	777	2
3	Roof Repair-Sheathing & Ridge Vent On West Side Of D Wing	2017	14,113		20	706	706	2,823	3
4	Rooftop Heat/Cool Unit	2017	9,860		20	493	493	1,808	4
5	Plumbing In D-Wing, Rooms 9 & 11, & B-Wing	2017	2,741		20	137	137	525	5
6	Replaced Roof On East Side A Wing	2018	19,837		20	992	992	2,562	6
7	Replaced Roof On East Side B Wing	2018	19,057		20	953	953	1,985	7
8	Repair Water Leak In B Wing Hallway & Rm #2	2018	2,535		20	127	127	285	8
9	Installation Of New Hvac Rooftop Unit	2019	4,183		20	209	209	227	9
10	Heat Exchanger And Parts	2019	4,289		20	214	214	357	10
11	Replaced Fire Alarm Panel	2019	5,743		20	287	287	455	11
12	Roof Repair And Replacement - B & D Wings	2019	20,393		20	1,020	1,020	1,529	12
13	Dining Room Paneling	2019	5,154		20	258	258	387	13
14	Remove And Replace Concrete Pads	2019	12,408		20	620	620	931	14
15	Flooring - Hallways	2019	44,524		20	2,226	2,226	4,267	15
16	Lumber Supplies	2019	6,882		20	344	344	602	16
17	Lumber Supplies	2019	5,665		20	283	283	496	17
18	Painting & Frp Panels Installation	2019	50,000		20	2,500	2,500	4,167	18
19	Painting & Frp Panels Installation	2019	11,521		20	576	576	912	19
20	Flooring - Rooms	2019	43,328		20	2,166	2,166	3,430	20
21	Engine And Generator Repair	2019	3,954		20	198	198	395	21
22	Reroute Water Lines, Replace Shower Valves In C Wing Shower	2019	4,033		20	202	202	403	22
23	Load Bank Unit Repair	2019	2,831		20	142	142	283	23
24	Replace Sprinkler Heads	2019	4,610		20	231	231	461	24
25	A/C Surging - Actuator And Fuel Pump Repair	2020	5,692		20	285	285	285	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	34

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	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)	\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	34

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	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)	\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	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		\$ 4,431,138	\$ 116,389		\$ 135,186	\$ 18,797	\$ 3,694,419	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4	Allocated from Peoria Forest	1991	61,164		35	1,748		37,735	4
5	Allocated from Peoria Forest	2019	58,880	2,639	39	1,682	(957)	2,944	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)		\$ 120,044	\$ 2,639		\$ 3,430	\$ (957)	\$ 40,679	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 120,044	\$ 2,639		\$ 3,430	\$ 791	\$ 40,679	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)	\$ 120,044	\$ 2,639		\$ 3,430	\$ 791	\$ 40,679	34

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning:

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	\$ 162,142	\$	\$ 10,054	\$ 10,054	10	\$ 114,775	71
72	Current Year Purchases	3,528		353	353	10	353	72
73	Fully Depreciated Assets	624,510				10	624,510	73
74								74
75	TOTALS	\$ 790,180	\$	\$ 10,406	\$ 10,406		\$ 739,638	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CHEV VAN	2001	\$ 3,782	\$	\$	\$	5	\$ 3,782	76
77		1999 FORD E350	2007	9,334				5	9,334	77
78		1989 CHEVY/C1500	2008	2,400				5	2,400	78
79		See Attached		87,157		4,024	4,024		87,157	79
80	TOTALS			\$ 102,673	\$	\$ 4,024	\$ 4,024		\$ 102,673	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,499,926	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,389	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,616	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 33,227	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,536,729	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				282			5
6	Allocated from Barton Management				10,377			6
7	TOTAL				\$ 10,659			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,499 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

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 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 prescripts							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 Woods

0054163

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,983,412	\$	1
2	Cash-Patient Deposits	7,889		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	268,988		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,785		6
7	Other Prepaid Expenses	24,673		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	10,677		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,357,424	\$	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	1,148,979		15
16	Equipment, at Historical Cost	649,588		16
17	Accumulated Depreciation (book methods)	(1,481,784)		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)	\$ 316,783	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,674,207	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 195,102	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,967		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,268		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,380		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,030		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached</u>	981,156		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,501,903	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,501,903	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,172,304	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,674,207	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,455,679	1
2	Restatements (describe):		2
3	State Replacement Tax	(6,961)	3
4	Change in Treasury Stock	(17,505)	4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,431,214	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,090	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	(292,000)	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)	\$ (258,910)	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)	\$ 1,172,304	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sharon Health Care Woods

0054163

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,596,140	1
2	Discounts and Allowances for all Levels	(1,901,863)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,694,277	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49,718	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,718	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	353,873	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 353,873	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,097,868	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,532,245	31
32	Health Care	1,962,057	32
33	General Administration	1,782,160	33
B. Capital Expense			
34	Ownership	714,075	34
C. Ancillary Expense			
35	Special Cost Centers	74,241	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,064,778	40
41	Income before Income Taxes (line 30 minus line 40)**	33,090	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 33,090	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,674,227	44
45	Private Pay - Net Inpatient Revenue	20,050	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,694,277	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 Woods**

0054163

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

Ending: **12/31/20**

12/31/20

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	17,329	468,559	25.81	4
5	CNAs & Orderlies	31,277	436,965	13.37	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	6,514	88,434	13.36	10
11	Social Service Workers	42,320	755,755	17.11	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	16,028	237,437	14.39	15
16	Dishwashers				16
17	Maintenance Workers	3,312	71,314	20.17	17
18	Housekeepers	20,354	284,675	13.39	18
19	Laundry	5,153	65,362	12.19	19
20	Administrator	2,000	125,099	60.14	20
21	Assistant Administrator	2,000	81,606	39.23	21
22	Other Administrative	1,340	63,408	43.43	22
23	Office Manager				23
24	Clerical	10,927	321,091	28.08	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	2,375	30,691	12.85	31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Attached</u>	1,855	70,967	37.66	33
34	TOTAL (lines 1 - 33)	162,784	\$ 3,101,363 *	\$ 18.29	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 8,162	01-03	35
36	Medical Director	Monthly 18,000	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
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychiatric Director	Monthly 7,500	10-03	47
48				48
49	TOTAL (lines 35 - 48)	\$ 35,462		49

C. CONTRACT NURSES

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

Facility Name & ID Number Sharon Health Care Woods

0054163

Report Period Beginning: 01/01/20

Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Bobby Ford	Administrator	0	\$ 125,099	Workers' Compensation Insurance	\$ 38,107	IDPH License Fee	\$ 11,400	
Dennis McGarvey	Assistant Administrator	0	81,606	Unemployment Compensation Insurance	25,405	Advertising: Employee Recruitment	9,560	
Gary Weintraub	Administrative	13.31%	33,427	FICA Taxes	237,254	Health Care Worker Background Check		
Anca Zota-Oviedo	Administrative	1.09%	26,235	Employee Health Insurance	160,193	(Indicate # of checks performed 121)	1,214	
Stan Aaron	Administrative	19.31%	3,746	Employee Meals		Patient Background Checks	44	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	10,516	
				401K Contribution	10,707	Licenses & Fees	17,037	
				Employee Benefit	2,113			
				Christmas Expense	24			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 270,113					
B. Administrative - Other								
Description			Amount					
Management Fee - Redwood Management			\$ 344,643					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 344,643					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached	Legal		\$ 2,079				Out-of-State Travel	\$
Personnel Planners	Unemployment Consulting		1,110					
Sharon HC Complex	Accounting Fees		804					
iSolved HCM Midwest, LLC	Accounting Fees		2,525				In-State Travel	
Marcum LLP	Accounting Fees		12,759					
Paychex	Payroll Processing		7,411					
Barton Management	Computer Expense		28,157				Seminar Expense	487
Information Controls, Inc	Workforce Management		1,200					
Sharon HC Complex	Computer Expense		2,389					
Constant Virtual Solutions	Computer Expense		11,291				Entertainment Expense	()
ProPay HR	Payroll Processing		1,415				(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 71,139				TOTAL	\$ 487

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sharon Health Care Woods

0054163

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. Alliance for Living - \$19,716
- (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. \$ 0 Line N/A
- (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. \$
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.