

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	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	219	Intermediate (ICF)	219	79,935	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	219	TOTALS	219	79,935	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	74,395	1,760		76,155	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,395	1,760		76,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.27%

D. How many bed-hold days during this year were paid by Public Aid? 1244 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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 8/15/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/15/97 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 _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS # 0032797 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	332,726	47,702	13,501	393,929		393,929		393,929		1
2	Food Purchase		344,987		344,987		344,987	(80)	344,907		2
3	Housekeeping	319,856	77,924		397,780		397,780		397,780		3
4	Laundry	96,515	51,707		148,222		148,222		148,222		4
5	Heat and Other Utilities			182,935	182,935		182,935	1,224	184,159		5
6	Maintenance	170,836		99,914	270,750		270,750	4,062	274,812		6
7	Other (specify):*										7
8	TOTAL General Services	919,933	522,320	296,350	1,738,603		1,738,603	5,206	1,743,809		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	1,538,649	44,054	95,168	1,677,871		1,677,871		1,677,871		10
10a	Therapy	161,443		13,426	174,869		174,869		174,869		10a
11	Activities	170,879	21,720	4,805	197,404		197,404		197,404		11
12	Social Services	173,214		18,719	191,933		191,933		191,933		12
13	Nurse Aide Training	8,669	4,162		12,831		12,831		12,831		13
14	Program Transportation			7,949	7,949		7,949		7,949		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,052,854	69,936	160,467	2,283,257		2,283,257		2,283,257		16
	C. General Administration										
17	Administrative	170,481		322,364	492,845		492,845	(269,284)	223,561		17
18	Directors Fees										18
19	Professional Services			37,177	37,177		37,177	(11,369)	25,808		19
20	Dues, Fees, Subscriptions & Promotions			28,797	28,797		28,797	(7,712)	21,085		20
21	Clerical & General Office Expenses	202,595	3,531	46,779	252,905		252,905	(68,224)	184,681		21
22	Employee Benefits & Payroll Taxes			474,184	474,184		474,184		474,184		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,714	5,714		5,714	(892)	4,822		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			85,791	85,791		85,791	95	85,886		26
27	Other (specify):*							3,898	3,898		27
28	TOTAL General Administration	373,076	3,531	1,000,806	1,377,413		1,377,413	(353,488)	1,023,925		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,345,863	595,787	1,457,623	5,399,273		5,399,273	(348,282)	5,050,991		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 HEALTHCARE WILLOWS

#0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			47,251	47,251		47,251	172,133	219,384			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							170,375	170,375			32
33	Real Estate Taxes			82,314	82,314		82,314	7,340	89,654			33
34	Rent-Facility & Grounds			828,540	828,540		828,540	(815,482)	13,058			34
35	Rent-Equipment & Vehicles			20,445	20,445		20,445		20,445			35
36	Other (specify):*											36
37	TOTAL Ownership			978,550	978,550		978,550	(465,634)	512,916			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			119,903	119,903		119,903		119,903			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			119,903	119,903		119,903		119,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,345,863	595,787	2,556,076	6,497,726		6,497,726	(813,916)	5,683,810			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,464	30		9
10	Interest and Other Investment Income	(5,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(80)	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	(892)	24		19
20	Contributions	(1,103)	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	(40,019)	21		24
25	Fund Raising, Advertising and Promotional	(2,265)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,799)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,096)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,107)		\$	30

OHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	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)	(759,809)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (759,809)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (813,916)		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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 RISK MANAGEMENT FEES	\$ (12,000)	19	1
2 PENALTIES	(1,420)	20	2
3 COPE ILCLTC DUES	(4,343)	20	3
4 MISCELLANEOUS INCOME	(1,366)	21	4
5 DEFERRED MAINTENANCE	2,233	6	5
6 NON-ALLOWABLE SALARY	(24,200)	21	6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
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90			90
91			91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTHCARE WILLOWS# 0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(80)											(80)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					1,224							1,224	5
6	Maintenance	2,233				1,829							4,062	6
7	Other (specify):*													7
8	TOTAL General Services	2,153				3,053							5,206	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				(269,284)								(269,284)	17
18	Directors Fees													18
19	Professional Services	(12,000)		380	251								(11,369)	19
20	Fees, Subscriptions & Promotions	(7,712)											(7,712)	20
21	Clerical & General Office Expenses	(68,804)				580							(68,224)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(892)											(892)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					95							95	26
27	Other (specify):*				2,542	1,356							3,898	27
28	TOTAL General Administration	(89,408)		380	(266,491)	2,031							(353,488)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,255)		380	(266,491)	5,084							(348,282)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTHCARE WILLOWS # 0032797 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	38,464		133,669									172,133	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,316)		175,691									170,375	32
33	Real Estate Taxes			3,014		4,326							7,340	33
34	Rent-Facility & Grounds			(801,540)		(13,942)							(815,482)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	33,148		(489,166)		(9,616)							(465,634)	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):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,107)		(488,786)	(266,491)	(4,532)							(813,916)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	PEORIA FOREST PARTNERSHIP	100.00%	\$ 380	\$	380	15
16	V	30 DEPRECIATION		PEORIA FOREST PARTNERSHIP		133,669		133,669	16
17	V	32 INTEREST		PEORIA FOREST PARTNERSHIP		175,691		175,691	17
18	V	33 REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		3,014		3,014	18
19	V								19
20	V	34 RENT	801,540	PEORIA FOREST PARTNERSHIP				(801,540)	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		\$ 801,540			\$ 312,754	\$ *	(488,786)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	REDWOOD MANAGEMENT	100.00%	\$ 251	\$	251	15
16	V								16
17	V	17 MANAGEMENT FEES	322,364	REDWOOD MANAGEMENT				(322,364)	17
18	V								18
19	V	17 SALARY-L.SHLOFROCK		REDWOOD MANAGEMENT		38,080		38,080	19
20	V	27 PAYROLL TAXES-LS		REDWOOD MANAGEMENT		1,367		1,367	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	17 SALARY-S. ARON		REDWOOD MANAGEMENT		15,000		15,000	25
26	V	27 PAYROLL TAXES-SA		REDWOOD MANAGEMENT		1,175		1,175	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		\$ 322,364			\$ 55,873	\$ *	(266,491)	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	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,224	\$	1,224	15
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,829		1,829	16
17	V	21 CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		580		580	17
18	V	26 INSURANCE		BARTON MANAGEMENT INC.		95		95	18
19	V	27 EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		1,356		1,356	19
20	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.		4,326		4,326	20
21	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.		13,058		13,058	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34 RENT	27,000	BARTON MANAGEMENT INC.				(27,000)	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		\$ 27,000			\$ 22,468	\$ *	(4,532)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS # 0032797 Report Period Beginning: 01/01/01 Ending: 12/31/01

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	LEON SHLOFROCK	SHAREHOLDER	Administrative	21.12%	SEE ATTACHED	4	8.00%	Alloc-RDWD	\$ 38,080	17-7	1
2	JOHN SHLOFROCK	SHAREHOLDER	Administrative	9.57%	SEE ATTACHED	8	17.02%				2
3	JOE MAGIT	SHAREHOLDER	Administrative	8.55%	SEE ATTACHED	3	8.57%				3
4	ELISA SHLOFROCK-ZUSMA	SHAREHOLDER	Clerical	2.05%	SEE ATTACHED	5.5	13.75%				4
5	JEAN SHLOFROCK	RELATIVE	Clerical	0.00%	SEE ATTACHED	7	17.50%				5
6	GARY WEINTRAUB	SHAREHOLDER	Legal	2.05%	SEE ATTACHED	5	12.50%	SALARY	11,621	17-1	6
7	STAN ARON	SHAREHOLDER	Administrative	11.65%	SEE ATTACHED	3.5	5.38%	Alloc-RDWD	15,000	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,701		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 HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	\$ 1,025	\$ 219	\$ 380	1
2	30	DEPRECIATION	BED SIZE	590	4	360,112	219	133,669	2
3	32	INTEREST	BED SIZE	590	4	473,322	219	175,691	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	8,119	219	3,014	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					\$ 842,578	\$	\$ 312,754	25

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending: 12/31/01

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	19	PROFESSIONAL FEES	BED SIZE	590	4	\$ 675	\$ 219	\$ 251	1
2									2
3									3
4									4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	238,000	238,000	4.00	38,080
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	8,546	4.00	1,367	6
7									7
8									8
9									9
10									10
11	17	SALARY-S. ARON	AVG HOURS WORKED	14	4	60,000	60,000	3.50	15,000
12	27	PAYROLL TAXES-SA	AVG HOURS WORKED	14	4	4,700	3.50	1,175	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					\$ 311,921	\$ 298,000	\$ 55,873	25

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,800	8	\$ 8,512	\$ 27,000	\$ 1,224	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	187,800	8	12,724	27,000	1,829	2
3	21	CLERICAL AND GENERAL	RENTAL INCOME	187,800	8	4,037	27,000	580	3
4	26	INSURANCE	RENTAL INCOME	187,800	8	662	27,000	95	4
5	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	187,800	8	9,429	27,000	1,356	5
6	33	REAL ESTATE TAXES	RENTAL INCOME	187,800	8	30,092	27,000	4,326	6
7	34	RENT OFFICE SPACE	RENTAL INCOME	187,800	8	90,828	27,000	13,058	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					\$ 156,284	\$	\$ 22,468	25

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending: 12/31/01

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 HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$	9									
B. Non-Facility Related*																				
10	See Supplemental Schedule										170,375	10								
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	170,375	14								
15	TOTALS (line 9+line14)					\$	\$			\$	170,375	15								

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

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

Facility Name & ID Number

SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
1	INTEREST INCOME						\$	\$				\$ (5,316) 1					
2	ALLOC-PEORIA FOREST	X										175,691 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							\$	\$				\$ 170,375 21					

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHARON HEALTHCARE WILLOWS COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0032797

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. <u>13-25-427-009</u>	<u>Long Term Care Property</u>	\$ <u>35,559.88</u>	\$ <u>35,559.88</u>
2. <u>13-25-427-012</u>	<u>Long Term Care Property</u>	\$ <u>42,535.68</u>	\$ <u>42,535.68</u>
3. <u>SEE ATTACHED</u>	<u>HOME OFFICE</u>	\$ <u>60,183.77</u>	\$ <u>4,326.00</u>
4. <u>SEE ATTACHED</u>	<u>BUILDING COMPANY</u>	\$ <u>8,125.10</u>	\$ <u>3,016.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>146,404.43</u>	\$ <u>85,437.56</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? YES NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

SHARON HEALTHCARE PINES-FACILITY-120 BEDS
SHARON HEALTHCARE WOODS-FACILITY-152 BEDS
SHARON HEALTHCARE ELMS-FACILITY-99 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: N/A 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>237,559</u>	<u>1</u>
2	<u>ALLOC-PEORIA FOREST</u>			<u>13,348</u>	<u>2</u>
3	TOTALS			\$ 250,907	3

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1988		12,982		20	767	767	9,639	9
10	Various		1990		15,966		20	849	849	8,645	10
11	Various		1991		1,595		20	80	80	743	11
12	Various		1992		13,429		20	691	(691)	5,928	12
13	Various		1993		5,656		20	283	283	2,237	13
14	Various		1994		3,579		20	179	179	1,265	14
15	Various		1995		29,692		20	1,484	1,484	9,751	15
16	Various		1996		13,113		20	656	656	3,653	16
17	Various		1997		189,520		20	9,475	9,475	45,907	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
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30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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
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54					-		-	54
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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		4,307,318	136,700		136,700		1,439,379	68
69			11,683			(11,683)		69
70		\$ 4,592,850	\$ 148,383		\$ 151,164	\$ 1,399	\$ 1,527,147	70

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 4,592,850	\$ 148,383		\$ 151,164	\$ 2,781	\$ 1,527,147	1
2	4 NEW OFFICES	1998	21,517		20	1,076	1,076	3,856	2
3	PHONE SHELF	1998	458		20	23	23	82	3
4	FIRE STA COVER	1998	1,165		20	58	58	203	4
5	LAWN COMPRESSOR	1998	572		20	29	29	102	5
6	A/C COMPRESSORS	1998	3,172		20	159	159	543	6
7	AMER II MINUTEMAN	1998	602		20	30	30	103	7
8	PAVE LOT	1998	1,500		20	75	75	250	8
9	LANDSCAPING	1998	4,700		20	235	235	764	9
10	ROOFING	1998	4,351		20	218	218	709	10
11	COOLER CONDENSOR	1998	1,331		20	67	67	218	11
12	ROOFTOP UNIT	1998	6,245		20	312	312	962	12
13	WINDOWS	1999	1,020		20	51	51	145	13
14	FREEZER CONDENSOR	1999	2,662		20	133	133	377	14
15	WINDOWS	1999	179		20	9	9	26	15
16	GARAGE DOOR	1999	315		20	16	16	45	16
17	A/C COMPRESSOR	1999	869		20	43	43	111	17
18	ROOF	1999	3,868		20	193	193	483	18
19	DOORS	1999	741		20	37	37	93	19
20	LOBBY DECORATIONS	1999	987		20	49	49	118	20
21	CUBICAL CURTAINS	1999	1,164		20	58	58	131	21
22	WINDOWS (3)	1999	722		20	36	36	81	22
23	ROOF	1999	6,769		20	338	338	732	23
24	CONCRETE PARKING LOT	1999	2,144		20	107	107	232	24
25	DOORGUARD SYSTEM	1999	3,120		20	156	156	325	25
26	WINDOWS (3)	2000	722		20	36	36	66	26
27	WATER HEATER	2000	2,274		20	114	114	209	27
28	DOORS	2000	1,063		20	53	53	97	28
29	TILE	2000	691		20	35	35	53	29
30	DOOR PART	2000	811		20	41	41	62	30
31	A/C COMPRESSOR	2000	1,291		20	65	65	98	31
32	RELOCATE CABLE	2000	16,400		20	820	820	1,162	32
33	LIGHTS	2000	1,792		20	90	90	120	33
34	TOTAL (lines 1 thru 33)		\$ 4,688,067	\$ 148,383		\$ 155,926	\$ 7,543	\$ 1,539,705	34

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12B, Carried Forward		\$ 4,688,067	\$ 148,383		\$ 155,926	\$ 7,543	\$ 1,539,705	1
2	LINK-IDPH COORD	2000	2,252		20	113	113	151	2
3	WATER HEATER	2000	763		20	38	38	48	3
4	PARKING SPACES	2000	198		20	10	10	13	4
5	PARKING SPACES	2000	3,100		20	155	155	194	5
6	FLOORING	2000	1,558		20	78	78	91	6
7	WINDOWS (3)	2000	890		20	45	45	53	7
8	WINDOW	2001	509		20	12	12	12	8
9	LINK IMPROVEMENTS	2001	229		20	5	5	5	9
10	GARAGE	2001	2,134		20	44	44	44	10
11	ROOF	2001	3,810		20	78	78	78	11
12	ROOF	2001	2,596		20	53	53	53	12
13	CUBICLE CURTAIN	2001	790		20	14	14	14	13
14	VCT	2001	1,533		20	24	24	24	14
15	FLOORING INSTALLED	2001	1,331		20	18	18	18	15
16	DOOR	2001	918		20	13	13	13	16
17	DRAWINGS-LINK (IHDA)	2001	1,836		20	22	22	22	17
18	CCTV SYSTEM	2001	827		20	10	10	10	18
19	INSTALL WALL PACKS	2001	1,939		20	23	23	23	19
20	PVC SIDEWALK LIGHTS	2001	465		20	6	6	6	20
21	WG MONITOR	2001	1,030		20	12	12	12	21
22	LANDSCAPING WORK	2001	3,421		20	40	40	40	22
23	DRAWINGS-LINK (IHDA)	2001	53		20				23
24	INSTALL ROOF	2001	2,200		20	26	26	26	24
25	SEER CONDENSER	2001	791		20	8	8	8	25
26	CONCRETE WORK	2001	15,300		20	147	147	147	26
27	FLOOR TILE	2001	1,232		20	12	12	12	27
28	CUBICLE CURTAINS	2001	1,025		20	8	8	8	28
29	CONDENSING UNIT-REFR	2001	2,042		20	15	15	15	29
30	DRYWALL & PAINT	2001	5,939		20	44	44	44	30
31	CONCRETE WORK	2001	1,085		20	8	8	8	31
32	LUMBER	2001	663		20	5	5	5	32
33	WINDOW TREATMENTS	2001	1,576		20	12	12	12	33
34	TOTAL (lines 1 thru 33)		\$ 4,752,102	\$ 148,383		\$ 157,024	\$ 8,641	\$ 1,540,914	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,752,102	\$ 148,383		\$ 157,024	\$ 8,641	\$ 1,540,914	1
2	REPLACE REFRIG SYSTM	2001	2,227		20	12	12	12	2
3	REPLACE SHINGLES	2001	188		20	1	1	1	3
4	HEAT/COOL UNIT	2001	884		20	5	5	5	4
5	PLUMBING WORK	2001	1,979		20	11	11	11	5
6	PLUMBING WORK	2001	2,018		20	7	7	7	6
7	FLOORING	2001	200		20				7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12D, Carried Forward		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12E, Carried Forward		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	1
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33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12F, Carried Forward		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	1
2									2
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12G, Carried Forward		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	1
2									2
3									3
4									4
5									5
6									6
7									7
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33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	1
2									2
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4									4
5									5
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7									7
8									8
9									9
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11									11
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,759,598	\$ 148,383		\$ 157,060	\$ 8,677	\$ 1,540,950	34

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1991		\$ 4,127,141	\$ 131,037	31.5	\$ 131,037	\$	\$ 1,403,187	4
5		1991		87,229	2,632	31.5	2,632		3,948	5
6										6
7										7
8										8
Improvement Type**										
9	SHARON OAKS BUILDING IMPROVEMENTS	1987		3,274	104	20	104		1,469	9
10	SHARON OAKS BUILDING IMPROVEMENTS	1988		32,193	1,023	20	1,023		13,721	10
11	SHARON OAKS BUILDING IMPROVEMENTS	1989		2,460	79	20	79		997	11
12	SHARON OAKS BUILDING IMPROVEMENTS	1990		5,647	179	20	179		2,005	12
13	SHARON OAKS BUILDING IMPROVEMENTS	1991		7,588	242	20	242		2,476	13
14	SHARON OAKS BUILDING IMPROVEMENTS	1992		23,754	849	20	849		7,362	14
15	SHARON OAKS BUILDING IMPROVEMENTS	1993		7,628	217	20	217		1,855	15
16	SHARON OAKS BUILDING IMPROVEMENTS	1994		5,330	208	20	208		1,514	16
17	SHARON OAKS BUILDING IMPROVEMENTS	1995		5,074	130	20	130		845	17
18										18
19										19
20										20
21										21
22										22
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24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 576,842	\$ 22,110	\$ 57,286	\$ 35,176	10	\$ 468,851	71
72	Current Year Purchases	6,414	6,414	1,025	(5,389)	10	1,025	72
73	Fully Depreciated Assets	245,672				10	86,057	73
74								74
75	TOTALS	\$ 828,928	\$ 28,524	\$ 58,311	\$ 29,787		\$ 555,933	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 DODGE RAM	1999	\$ 12,821	\$ 2,923	\$ 2,923	\$	5	\$ 8,436	76
77		1998 CHEV VAN	2001	5,449	1,090	1,090		5	1,090	77
78										78
79										79
80	TOTALS			\$ 18,270	\$ 4,013	\$ 4,013	\$		\$ 9,526	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)	\$ 5,857,703	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,920	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,384	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,464	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,106,409	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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>ALLOC-BARTON</u>				<u>13,058</u>			5
6								6
7	TOTAL				\$ <u>13,058</u>			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: \$ 18,156 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	<u>FACILITY</u>	<u>VAN</u>	\$ <u>184</u>	\$ <u>2,214</u>	17
18	<u>FACILITY</u>	<u>TRUCK RENTAL</u>	<u>74</u>	<u>74</u>	18
19					19
20					20
21	TOTAL		\$ <u>258</u>	\$ <u>2,288</u>	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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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

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

Facility Name & ID Number SHARON HEALTHCARE WILLOWS # 0032797 Report Period Beginning: 01/01/01 Ending: 12/31/01
 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	407	2,499		2,906
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	1,214	7,455		8,669
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	176	1,080		1,256
9	TOTALS	\$ 1,797	\$ 11,034	\$	\$ 12,831
10	SUM OF line 9, col. 1 and 2 (e)	\$ 12,831			

C. CONTRACTUAL INCOME

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

\$ 18,688

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	14

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			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	Exceptional Care Program												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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(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	\$ 64,735	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,490,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,014		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	286		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,597,148	\$	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	545,225		15
16	Equipment, at Historical Cost	434,121		16
17	Accumulated Depreciation (book methods)	(485,428)		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): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 493,918	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,091,066	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 105,639	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,648		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,858		31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,438		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	148		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	475,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 756,731	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 756,731	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,334,335	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,091,066	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,339,021	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,339,021	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,686)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,686)	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)	\$ 1,334,335	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,465,143	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,465,143	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	Nurses Aide Training Reimbursements	18,687	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)	\$ 18,687	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,316	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	3,894	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,894	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,493,040	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,738,603	31
32	Health Care	2,283,257	32
33	General Administration	1,377,413	33
B. Capital Expense			
34	Ownership	978,550	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	119,903	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,497,726	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,686)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,686)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis 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 HEALTHCARE WILLOWS

0032797

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,025	2,193	\$ 48,130	\$ 21.95	1
2	Assistant Director of Nursing	2,000	2,467	52,933	21.46	2
3	Registered Nurses	31,226	34,181	682,613	19.97	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	73,666	79,415	712,816	8.98	5
6	Nurse Aide Trainees	619	619	8,669	14.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,017	15,393	161,443	10.49	8
9	Activity Director					9
10	Activity Assistants	17,014	18,343	170,879	9.32	10
11	Social Service Workers	13,468	14,483	173,214	11.96	11
12	Dietician					12
13	Food Service Supervisor	10,802	11,416	100,463	8.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,975	26,394	232,263	8.80	15
16	Dishwashers					16
17	Maintenance Workers	17,779	18,704	170,836	9.13	17
18	Housekeepers	45,013	46,576	319,856	6.87	18
19	Laundry	12,303	13,569	96,515	7.11	19
20	Administrator	4,160	4,160	80,545	19.36	20
21	Assistant Administrator	2,080	2,250	35,411	15.74	21
22	Other Administrative	2,303	2,303	54,525	23.68	22
23	Office Manager					23
24	Clerical	7,752	8,264	202,595	24.52	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	4,208	4,547	42,157	9.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	285,410	305,277	\$ 3,345,863 *	\$ 10.96	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	365	\$ 13,501	01-03	35
36	Medical Director	137	20,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,920	10-03	39
40	Physical Therapy Consultant	287	8,700	10a-03	40
41	Occupational Therapy Consultant	88	3,938	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	788	10a-03	43
44	Activity Consultant	137	4,805	11-03	44
45	Social Service Consultant	535	18,719	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,663	\$ 72,771		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	666	\$ 23,312	10-03	50
51	Licensed Practical Nurses	932	27,974	10-03	51
52	Nurse Aides	2,468	41,962	10-03	52
53	TOTAL (lines 50 - 52)	4,066	\$ 93,248		53

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

** See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING AND DECO	1994	\$ 1,988	3	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINTING AND DECO	1995	29,856	3	4,976							
3	PAINTING AND DECO	1998	9,630	3	1,605	3,210	3,210	1,605				
4	PAINTING AND DECO	1999	1,009	3		168	336	336	168			
5	PAINTING AND DECO	2000	877	3			146	292	292	147		
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 43,360		\$ 6,581	\$ 3,378	\$ 3,692	\$ 2,233	\$ 460	\$ 147	\$	\$

Facility Name & ID Number SHARON HEALTHCARE WILLOWS

0032797

Report Period Beginning: 01/01/01

Ending: 12/31/01

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. ILCLTC \$3,781
- (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. \$ 7,813 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 119,903
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? NO
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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%ln14
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees