



Facility Name & ID Number SHARON HEALTH CARE ELMS

# 0032789 Report Period Beginning: 01/01/02 Ending: 12/31/02

**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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	31,582	1,795		33,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,582	1,795		33,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.31%

D. How many bed-hold days during this year were paid by Public Aid? 387 (Do not include bed-hold days in Section B.)

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/15/87 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: 12/31/02 Fiscal Year: 12/31/02

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

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number **SHARON HEALTH CARE ELMS** # **0032789** Report Period Beginning: **01/01/02** Ending: **12/31/02****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
	<b>A. General Services</b>										
1	Dietary	167,448	18,634	10,907	196,989		196,989		196,989		1
2	Food Purchase		140,039		140,039	(670)	139,369	(752)	138,617		2
3	Housekeeping	112,345		19,282	131,627		131,627		131,627		3
4	Laundry	71,213	19,190		90,403		90,403		90,403		4
5	Heat and Other Utilities			81,000	81,000		81,000	685	81,685		5
6	Maintenance	62,822		38,189	101,011		101,011	10,156	111,167		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	413,828	177,863	149,378	741,069	(670)	740,399	10,089	750,488		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,281,079	111,062	44,429	1,436,570		1,436,570		1,436,570		10
10a	Therapy										10a
11	Activities	43,469	2,515	2,596	48,580		48,580		48,580		11
12	Social Services	59,135		5,421	64,556		64,556		64,556		12
13	Nurse Aide Training	1,790	1,825		3,615		3,615		3,615		13
14	Program Transportation			4,344	4,344		4,344		4,344		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,385,473	115,402	62,790	1,563,665		1,563,665		1,563,665		16
	<b>C. General Administration</b>										
17	Administrative	90,453			90,453		90,453	44,840	135,293		17
18	Directors Fees										18
19	Professional Services			17,223	17,223		17,223	238	17,461		19
20	Dues, Fees, Subscriptions & Promotions			10,585	10,585		10,585	(2,815)	7,770		20
21	Clerical & General Office Expenses	81,717		25,071	106,788		106,788	(17,278)	89,510		21
22	Employee Benefits & Payroll Taxes			258,645	258,645	670	259,315		259,315		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,528	1,528		1,528		1,528		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,486	29,486		29,486	63	29,549		26
27	Other (specify):*							5,241	5,241		27
28	<b>TOTAL General Administration</b>	172,170		342,538	514,708	670	515,378	30,289	545,667		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,971,471	293,265	554,706	2,819,442		2,819,442	40,378	2,859,820		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 &amp; ID Number

SHARON HEALTH CARE ELMS

#0032789

Report Period Beginning:

01/01/02

Ending:

12/31/02

## 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	
	<b>D. Ownership</b>											
30	Depreciation			18,914	18,914		18,914	85,781	104,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,557	14,557		14,557	71,421	85,978			32
33	Real Estate Taxes			37,810	37,810		37,810	3,527	41,337			33
34	Rent-Facility & Grounds			14,466	14,466		14,466	(6,965)	7,501			34
35	Rent-Equipment & Vehicles			18,896	18,897		18,897		18,897			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			104,643	104,644		104,644	153,764	258,408			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			53,655	53,655		53,655		53,655			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,971,471	293,265	713,004	2,977,741		2,977,741	194,142	3,171,883			45

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning: 01/01/02

Ending: 12/31/02

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	25,455	30		9
10	Interest and Other Investment Income	(1,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(752)	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	(914)	21		19
20	Contributions	(587)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,269)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,494)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 12,213		\$	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)	181,929		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 181,929		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 194,142		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SHARON HEALTH CARE ELMS

ID# 0032789  
 Report Period Beginning: 01/01/02  
 Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-allowable Salary	\$ (15,967)	21	1
2	Deferred Maintenance	9,023	6	2
3	COPE Dues	(1,550)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(8,494)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning:

01/01/02

Ending:

12/31/02

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(752)	0	0	0	0	0	0	0	0	0	0	(752)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	685	0	0	0	0	0	0	685	5
6	Maintenance	9,023	0	0	0	1,133	0	0	0	0	0	0	10,156	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>8,271</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,818</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,089</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	44,840	0	0	0	0	0	0	0	44,840	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	238	0	0	0	0	0	0	0	0	238	19
20	Fees, Subscriptions & Promotions	(2,819)	0	0	0	4	0	0	0	0	0	0	(2,815)	20
21	Clerical & General Office Expenses	(17,468)	0	27	0	163	0	0	0	0	0	0	(17,278)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	63	0	0	0	0	0	0	63	26
27	Other (specify):*	0	0	0	4,371	870	0	0	0	0	0	0	5,241	27
28	<b>TOTAL General Administration</b>	<b>(20,287)</b>	<b>0</b>	<b>265</b>	<b>49,211</b>	<b>1,100</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>30,289</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(12,016)</b>	<b>0</b>	<b>265</b>	<b>49,211</b>	<b>2,918</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>40,378</b>	<b>29</b>



**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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name 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: 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	19 Professional Fees	\$	Peoria Forest Partnership	100.00%	\$ 238	\$ 238
16	V	21 Clerical		Peoria Forest Partnership		27	27
17	V	30 Depreciation		Peoria Forest Partnership		60,326	60,326
18	V	32 Interest		Peoria Forest Partnership		87,204	87,204
19	V	33 Real Estate Tax		Peoria Forest Partnership		1,416	1,416
20	V	34 Rent		Peoria Forest Partnership			
21	V						
22	V	32 Interest	14,557	Peoria Forest Partnership			(14,557)
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		\$ 14,557			\$ 149,211	\$ * 134,654

\* 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		\$	Redwood Management	100.00%	\$	\$	15
16	V							16
17	V	17 Management Fees						17
18	V							18
19	V	17 Salary-L.Shlofrock				27,200	27,200	19
20	V	27 Payroll Taxes-LS				2,994	2,994	20
21	V							21
22	V							22
23	V							23
24	V	17 Salary-S.Aron				17,640	17,640	24
25	V	27 Payroll Taxes-SA				1,377	1,377	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		\$			\$ 49,211	\$ * 49,211	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	5 Utilities	\$	Barton Management Inc.	100.00%	\$ 685	\$ 685
16	V	6 Repairs and Maint		Barton Management Inc.	100.00%	1,133	1,133
17	V	20 Dues, Fees, Subscriptions		Barton Management Inc.	100.00%	4	4
18	V	21 Clerical and General		Barton Management Inc.	100.00%	163	163
19	V	26 Insurance		Barton Management Inc.	100.00%	63	63
20	V	27 Emp. Be. Gen. Admin.		Barton Management Inc.	100.00%	870	870
21	V	33 Real Estate Tax		Barton Management Inc.	100.00%	2,111	2,111
22	V	34 Rent Office Space		Barton Management Inc.	100.00%	7,435	7,435
23	V						
24	V						
25	V						
26	V	34 Rent	14,400	Barton Management Inc.	100.00%		(14,400)
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		\$ 14,400			\$ 12,464	\$ * (1,936)

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

Facility Name & ID Number      SHARON HEALTH CARE ELMS      #      0032789      Report Period Beginning:      01/01/02      Ending:      12/31/02

## 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	Owner	Administrative	21.12	See Attached	4	8.00	Alloc Rdwd	\$ 27,200	17-7	1
2	John Shlofrock	Owner	Administrative	9.57	See Attached	8	17.02				2
3	Joe Magit	Owner	Administrative	8.55	See Attached	3	8.57				3
4	Elisa Shlofrock-Zusman	Owner	Administrative	2.05	See Attached	5.5	13.75				4
5	Jean Shlofrock	Relative	Secretary		See Attached	3	7.50				5
6	Rick Duros	Owner	Administrative	2.14	See Attached	6	12.00	Salary	12,711	17-1	6
7	Gary Weintraub	Owner	Legal	4.18	See Attached	6	12.50	Salary	12,674	17-1	7
8	Stan Aron	Owner	Administrative	11.66	See Attached	3.5	5.38	Alloc Rdwd	17,640	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,225		13

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

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

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/02 Ending: 12/31/02

**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

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

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

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

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19 Professional Fees	Bed Size	585	4	\$ 1,420	\$	98	\$ 238	1
2	21 Clerical	Bed Size	585	4	163		98	27	2
3	30 Depreciation	Bed Size	585	4	360,112		98	60,326	3
4	32 Interest	Bed Size	585	4	520,557		98	87,204	4
5	33 Real Estate Tax	Bed Size	585	4	8,453		98	1,416	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				\$ 890,705	\$		\$ 149,211	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1					\$	\$			1	
2									2	
3									3	
4	17	Salary-L.Shlofrock	Avg Hours Worked	25	5	170,000	170,000	4	27,200	4
5	27	Payroll Taxes-LS	Avg Hours Worked	25	5	18,714		4	2,994	5
6										6
7										7
8										8
9										9
10										10
11	17	Salary-S.Aron	Avg Hours Worked	14	4	70,560	70,560	4	17,640	11
12	27	Payroll Taxes-SA	Avg Hours Worked	14	4	5,508		4	1,377	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					\$ 264,782	\$ 240,560		\$ 49,211	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	5	Utilities	Rental Income	194,550	8	\$ 9,250	\$ 14,400	\$ 685	1
2	6	Repairs and Mainten	Rental Income	194,550	8	15,313	14,400	1,133	2
3	20	Dues, Fees, Subscriptions	Rental Income	194,550	8	48	14,400	4	3
4	21	Clerical and General	Rental Income	194,550	8	2,205	14,400	163	4
5	26	Insurance	Rental Income	194,550	8	847	14,400	63	5
6	27	Emp. Ben Gen. Admin	Rental Income	194,550	8	11,760	14,400	870	6
7	33	Real Estate Taxes	Rental Income	194,550	8	28,523	14,400	2,111	7
8	34	Rent Office Space	Rental Income	194,550	8	100,446	14,400	7,435	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					\$ 168,392	\$	\$ 12,464	25

**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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1						\$	\$				\$	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>					\$	\$			\$		9								
	<b>B. Non-Facility Related*</b>																			
10	<a href="#">See Supplemental Schedule</a>										85,978	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	85,978	14								
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	85,978	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

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

Facility Name & ID Number **SHARON HEALTH CARE ELMS**# **0032789** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2001 report.			\$	35,934	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.)			\$	39,854	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3,920	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	37,417	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	41,337	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	28,731	8		
		1998	30,021	9		
		1999	30,232	10		
		2000	34,887	11		
		2001	38,556	12		
<b>2002 Accrual=36,327(amount paid in 2002)*1.03=\$37,417</b>						
<b>Allocated from Peoria Forest=\$1,416</b>						
<b>Allocated from Barton=\$2,111</b>						
					<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 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 2002 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.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SHARON HEALTH CARE ELMS COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0032789

CONTACT PERSON REGARDING THIS REPORT Rick Duros

TELEPHONE (847)441-8200 FAX #: (847)441-0800

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

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(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>13-25-426-016</u>	<u>Nursing Home Property</u>	\$ <u>36,327.00</u>	\$ <u>36,327.00</u>
2. <u>SeeAttached</u>	<u>Home Office</u>	\$ <u>8,453.00</u>	\$ <u>1,416.00</u>
3. <u>SeeAttached</u>	<u>Building Co.</u>	\$ <u>57,046.00</u>	\$ <u>2,111.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>101,826.00</u>	\$ <u>39,854.00</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 & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name &amp; ID Number SHARON HEALTH CARE ELMS

# 0032789 Report Period Beginning:

01/01/02 Ending:

12/31/02

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1C. 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 Willows- Facility - 219 bedsSharon Healthcare Woods- Facility - 152 bedsSharon Healthcare Pines- Facility - 120 bedsPeoria Forest - Central Dietary (Formerly Unit Six Partnership)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			\$ 107,390	1
2	Allocation - Peoria Forest			6,034	2
3	TOTALS			\$ 113,424	3

Facility Name & ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning:

01/01/02

Ending:

12/31/02

**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
FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated
Beds*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation
			\$	\$		\$	\$	\$
4								
5								
6								
7								
8								
<b>Improvement Type**</b>								
9	Various	1987	5,207		20	260	260	3,256
10	Various	1988	4,581		20	240	240	3,034
11	Various	1989	1,877		20	94	94	1,069
12	Various	1990	6,666		20	373	373	4,316
13	Various	1991	23,422		20	1,189	1,189	12,280
14	Various	1992	19,136		20	974	974	9,329
15	Various	1994	9,731		20	487	487	3,977
16	Various	1995	2,723		20	136	136	1,015
17	Various	1996	4,103		20	206	206	1,352
18	Various	1997	19,387		20	970	970	5,195
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
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	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	98	1991		\$ 1,862,634	\$ 59,139	35	\$ 59,139		\$ 633,277
5		1991		39,368	1,187	31.5	1,188	1	1,782
6									
7									
8									
	<b>Improvement Type**</b>								
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									
35									
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	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		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68	Related Party Allocations(Page12-Rep & Page 12A-Rep)		1,902,002	60,326		60,327		635,059		68
69	Financial Statement Depreciation			5,894			(5,894)			69
70	TOTAL (lines 4 thru 69)		\$ 1,902,002	\$ 66,220		\$ 60,327	\$ (5,894)	\$ 635,059		70

\*\*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		
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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,902,002	\$ 60,326		\$ 60,327	\$	\$ 635,059		70

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning:

01/01/02

Ending:

Page 12B

12/31/02

## 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		\$ 1,902,002	\$ 66,220		\$ 60,327	\$ (5,893)	\$ 635,059	1
2	Rooftop Heat/Cool	1998	5,147		20	257	257	1,285	2
3	Lawn Repair	1998	625		20	31	31	145	3
4	Water Softener	1998	1,700		20	85	85	390	4
5	Phone Shelf	1998	207		20	10	10	46	5
6	Rooftop Unit	1998	1,472		20	74	74	333	6
7	Amer II Minuteman	1998	272		20	14	14	62	7
8	Patio Ramp	1998	538		20	27	27	117	8
9	Roofing	1998	3,187		20	159	159	676	9
10	Drapes	1998	5,805		20	290	290	1,184	10
11	Heat Condensor	1999	1,203		20	60	60	230	11
12	Windows	1999	81		20	4	4	15	12
13	Garage Door	1999	142		20	7	7	27	13
14	Cubicle Tracking	1999	3,724		20	186	186	713	14
15	Cubicle Curtains	1999	2,586		20	129	129	495	15
16	Windows	1999	481		20	24	24	92	16
17	Concrete Parking Lot	1999	969		20	48	48	152	17
18	Roof	1999	996		20	50	50	158	18
19	Replace Drain Lines	1999	1,993		20	100	100	308	19
20	Repipe Water Lines	1999	1,601		20	80	80	247	20
21	Renovation Design	2000	2,561		20	128	128	331	21
22	Renovation Design	2000	1,950		20	98	98	237	22
23	Garbage Disposal	2000	791		20	40	40	93	23
24	Water Heater	2000	345		20	17	17	38	24
25	Parking Spaces	2000	89		20	4	4	9	25
26	Parking Spaces	2000	3,720		20	186	186	419	26
27	Drapery	2000	5,588		20	279	279	605	27
28	Nurse Call Station	2000	3,544		20	177	177	384	28
29	Renovation Project	2000	398		20	10	10	20	29
30	Electrical Work	2001	1,427		20	32	32	64	30
31	Handicap Bathrooms	2001	25,250		20	512	512	1,024	31
32	Exit Door	2001	2,391		20	48	48	96	32
33	Renovation Design	2001	2,864		20	58	58	116	33
34	TOTAL (lines 1 thru 33)		\$ 1,985,649	\$ 66,220		\$ 63,551	\$ (2,669)	\$ 645,170	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 12B, Carried Forward	\$ 1,985,649	\$ 66,220		\$ 63,551	\$ (2,669)	\$ 645,170		1
2	Garage	2001 965		20	48	48	68		2
3	Drapery	2001 6,320		20	316	316	417		3
4	Install Drapery	2001 662		20	33	33	44		4
5	Garage/Rework Trsh C	2001 1,219		20	61	61	80		5
6	Gas Water Heater	2001 2,481		20	124	124	153		6
7	Compact Water Booster	2001 1,247		20	62	62	77		7
8	Drapery	2001 1,622		20	81	81	100		8
9	Install Roof	2001 4,357		20	218	218	269		9
10	Repair-A/C Compressor	2001 966		20	48	48	57		10
11	Water Heater	2001 4,496		20	225	225	259		11
12	Condensing Unit-Refrig	2001 923		20	46	46	53		12
13	Replace Refrig System	2001 1,092		20	55	55	61		13
14	Replace Shingles	2001 1,221		20	61	61	67		14
15	Flooring	2001 90		20	5	5	5		15
16	Parking Posts	2002 281		20					16
17	2 Exit Doors	2002 769		20					17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,014,360	\$ 66,220		\$ 64,934	\$ (1,286)	\$ 646,880		34

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

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	\$ 277,080	\$ 10,833	\$ 35,503	\$ 24,670	10	\$ 256,060	71
72	Current Year Purchases	3,455	1,399	3,470	2,071	10	1,399	72
73	Fully Depreciated Assets	66,502				10	66,502	73
74								74
75	TOTALS	\$ 347,037	\$ 12,232	\$ 38,973	\$ 26,741		\$ 323,961	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 Chev Van	2001	\$ 2,463	\$ 788	\$ 788	\$	5	\$ 1,281	76
77										77
78										78
79										79
80	TOTALS			\$ 2,463	\$ 788	\$ 788	\$		\$ 1,281	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)	\$ 2,477,284	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,240	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,695	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,455	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 972,122	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: \_\_\_\_\_  
 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	Alloc. - Barton Mgmt				7,435			5
6								6
7	<b>TOTAL</b>				\$ 7,435			7

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.	/2003	\$ _____
13.	/2004	\$ _____
14.	/2005	\$ _____

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: \$ 17,900 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Dodge Ram	\$ 83.00	\$ 997	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 83.00	\$ 997	21

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

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

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	210	1,263		1,473
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	322	1,468		1,790
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	63	289		352
9	<b>TOTALS</b>	\$ 595	\$ 3,020	\$	\$ 3,615
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,615			

**C. CONTRACTUAL INCOME**

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

\$ 7,175

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>7</b>

- (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	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	\$			\$			1	
2	Licensed Speech and Language Development Therapist		hrs										2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs										4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescrpts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	<b>TOTAL</b>			\$		\$	\$		\$		\$		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.**

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning: 01/01/02

Ending:

12/31/02

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 43,222	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	616,716		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	15,700		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	50,000		8
9 Other(specify): See supplemental schedule	184		9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 725,822	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	209,187		15
16 Equipment, at Historical Cost	214,777		16
17 Accumulated Depreciation (book methods)	(234,648)		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 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 189,316	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 915,138	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 66,201	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	58,304		30
31 Accrued Taxes Payable (excluding real estate taxes)	6,474		31
32 Accrued Real Estate Taxes(Sch.IX-B)	37,417		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See supplemental schedule	470,190		36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 638,586	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 638,586	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 276,552	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 915,138	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 214,299	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 214,299	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	62,253	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)	\$ 62,253	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 276,552	24 *

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

Facility Name &amp; ID Number SHARON HEALTH CARE ELMS

# 0032789

Report Period Beginning: 01/01/02

Ending: 12/31/02

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,979,184	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,979,184	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,175	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	52,255	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 59,430	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,226	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,226	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	154	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 154	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,039,994	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	741,069	31
32	Health Care	1,563,665	32
33	General Administration	514,708	33
<b>B. Capital Expense</b>			
34	Ownership	104,644	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,977,741	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	62,253	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 62,253	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number **SHARON HEALTH CARE ELMS**

# 0032789

Report Period Beginning: 01/01/02

Ending:

12/31/02

## 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	2,080	2,240	\$ 54,005	\$ 24.11	1
2	Assistant Director of Nursing	16	20	336	16.80	2
3	Registered Nurses					3
4	Licensed Practical Nurses	24,940	26,355	503,730	19.11	4
5	Nurse Aides & Orderlies	59,737	63,114	696,985	11.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,002	1,079	18,219	16.89	8
9	Activity Director					9
10	Activity Assistants	5,521	5,693	43,469	7.64	10
11	Social Service Workers	5,032	5,353	59,136	11.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,792	18,462	167,448	9.07	15
16	Dishwashers					16
17	Maintenance Workers	5,882	6,115	62,822	10.27	17
18	Housekeepers	13,052	14,117	112,345	7.96	18
19	Laundry	8,114	8,788	71,213	8.10	19
20	Administrator	2,080	2,080	65,068	31.28	20
21	Assistant Administrator					21
22	Other Administrative	1,104	1,104	41,352	37.46	22
23	Office Manager					23
24	Clerical	4,108	4,379	55,177	12.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,884	2,026	20,166	9.95	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,344	160,925	\$ 1,971,471 *	\$ 12.25	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	108	\$ 10,907	1-3	35
36	Medical Director	113	6,000	9-3	36
37	Medical Records Consultant	25	760	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,340	10-3	39
40	Physical Therapy Consultant	315	14,194	10-3	40
41	Occupational Therapy Consultant	319	13,406	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	74	2,596	11-3	44
45	Social Service Consultant	92	3,221	12-3	45
46	Other(specify)				46
47	Speech Therapy Consultant	77	3,243	10-3	47
48	Psychiatric	49	2,200	12-3	48
49	TOTAL (lines 35 - 48)	1,269	\$ 59,867		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	95	2,561	10-3	51
52	Nurse Aides	486	6,925	10-3	52
53	TOTAL (lines 50 - 52)	581	\$ 9,486		53



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	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	2000	\$ 29,580	4	\$	\$ 4,930	\$ 9,860	\$ 9,860	\$ 4,930	\$	\$	\$
2	Painting & Decorating	2002	1,005	4			168	335	335	168		
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 30,585		\$	\$ 4,930	\$ 9,860	\$ 10,028	\$ 5,265	\$ 335	\$ 168	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes Cna only
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. II Council of Long Term Care \$5,079
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,348 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,665  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ 670 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%In14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (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.