

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032789

Facility Name: SHARON HEALTH CARE ELMS

Address: 3611 NORTH ROCHELLE PEORIA 61604
 Number City Zip Code

County: PEORIA

Telephone Number: 309-685-4412 **Fax #** 309-685-4412

HFS ID Number: 363530585001

Date of Initial License for Current Owners: 8/15/87

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Rick Duros **Telephone Number:** 847-441-8200

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>RICK DUROS</u>	
Paid Preparer	(Title) <u>CFO</u>	
	(Signed) _____	(Date) _____
Paid Preparer	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	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	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>29,701</u>	<u>937</u>	<u>429</u>	<u>31,067</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,701</u>	<u>937</u>	<u>429</u>	<u>31,067</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.85%

D. How many bed-hold days during this year were paid by the Department?

28 (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: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	145,616	19,998	7,381	172,995		172,995		172,995		1
2	Food Purchase		167,246		167,246		167,246	(774)	166,472		2
3	Housekeeping	115,342		18,586	133,928		133,928		133,928		3
4	Laundry	57,528	25,067		82,595		82,595		82,595		4
5	Heat and Other Utilities			113,070	113,070		113,070	677	113,747		5
6	Maintenance	64,424		54,950	119,374		119,374	(330)	119,044		6
7	Other (specify):*										7
8	TOTAL General Services	382,910	212,311	193,987	789,208		789,208	(427)	788,781		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,161,032	130,776	14,699	1,306,507		1,306,507		1,306,507		10
10a	Therapy										10a
11	Activities	62,794	1,591	2,652	67,037		67,037		67,037		11
12	Social Services	49,934		5,947	55,881		55,881		55,881		12
13	CNA Training										13
14	Program Transportation			3,949	3,949		3,949		3,949		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,273,760	132,367	33,247	1,439,374		1,439,374		1,439,374		16
	C. General Administration										
17	Administrative	109,185			109,185		109,185	26,738	135,923		17
18	Directors Fees										18
19	Professional Services			11,053	11,053		11,053	(109)	10,944		19
20	Dues, Fees, Subscriptions & Promotions			11,178	11,178		11,178	(420)	10,758		20
21	Clerical & General Office Expenses	64,927		194,453	259,380		259,380	20,733	280,113		21
22	Employee Benefits & Payroll Taxes			297,496	297,496		297,496	9,723	307,219		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,849	1,849		1,849		1,849		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,628	57,628		57,628	45	57,673		26
27	Other (specify):*										27
28	TOTAL General Administration	174,112		573,657	747,769		747,769	56,710	804,479		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,830,782	344,678	800,891	2,976,351		2,976,351	56,283	3,032,634		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHARON HEALTH CARE ELMS

#0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			14,496	14,496		14,496	71,794	86,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							49,419	49,419			32
33	Real Estate Taxes			40,613	40,613		40,613	3,758	44,371			33
34	Rent-Facility & Grounds			106,105	106,105		106,105	(98,949)	7,156			34
35	Rent-Equipment & Vehicles			7,152	7,152		7,152		7,152			35
36	Other (specify):*											36
37	TOTAL Ownership			168,366	168,366		168,366	26,022	194,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6,172	6,172		6,172		6,172			38
39	Ancillary Service Centers		20,654	162,047	182,701		182,701		182,701			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	TOTAL Special Cost Centers		20,654	221,874	242,528		242,528		242,528			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,830,782	365,332	1,191,131	3,387,245		3,387,245	82,305	3,469,550			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: 1/1/06

Ending: 12/31/06

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	11,468	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(774)	2		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	(549)	19		17
18	Fines and Penalties				18
19	Entertainment	(2,193)	21		19
20	Contributions	(4,351)	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	(438)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,383)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,220)		\$	30

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

		1	2	
		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)	92,525		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 92,525		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 82,305		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 SHARON HEALTH CARE ELMS

ID# 0032789

Report Period Beginning: 1/1/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-Allowable Salary	\$ (12,164)	17
2	Deferred Maintenance	(1,219)	6
3			
4			
5			
6			
7			
8			
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			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48	Total	(13,383)	
49			

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(774)	0	0	0	0	0	0	0	0	0	0	(774)	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	677	0	0	0	0	0	0	677	5
6	Maintenance	(1,219)	0	0	0	889	0	0	0	0	0	0	(330)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,993)	0	0	0	1,566	0	0	0	0	0	0	(427)	8
	B. Health Care and Programs													
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	CNA 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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(12,164)	0	0	38,902	0	0	0	0	0	0	0	26,738	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(549)	0	440	0	0	0	0	0	0	0	0	(109)	19
20	Fees, Subscriptions & Promotions	(438)	0	0	0	18	0	0	0	0	0	0	(420)	20
21	Clerical & General Office Expenses	(6,544)	0	73	27,200	4	0	0	0	0	0	0	20,733	21
22	Employee Benefits & Payroll Taxes	0	0	0	7,193	2,530	0	0	0	0	0	0	9,723	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	45	0	0	0	0	0	0	45	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(19,695)	0	513	73,295	2,597	0	0	0	0	0	0	56,710	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,688)	0	513	73,295	4,163	0	0	0	0	0	0	56,283	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	11,468	0	60,326	0	0	0	0	0	0	0	0	71,794	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	49,419	0	0	0	0	0	0	0	0	49,419	32
33	Real Estate Taxes	0	0	1,585	0	2,173	0	0	0	0	0	0	3,758	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(8,364)	0	0	0	0	0	0	(98,949)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,468	0	20,745	0	(6,191)	0	0	0	0	0	0	26,022	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,220)	0	21,258	73,295	(2,028)	0	0	0	0	0	0	82,305	45

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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%	\$ 440	\$ 440	15
16	V	21 Clerical Expense		Peoria Forest Partnership		73	73	16
17	V	30 Depreciation		Peoria Forest Partnership		60,326	60,326	17
18	V	32 Interest		Peoria Forest Partnership		49,419	49,419	18
19	V	33 Real Estate Tax		Peoria Forest Partnership		1,585	1,585	19
20	V							20
21	V							21
22	V	34 Rent	90,585	Peoria Forest Partnership			(90,585)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 90,585			\$ 111,843	\$ * 21,258	39

* 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: **1/1/06**Ending: **12/31/06****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		\$	Redwood Management	100.00%	\$		15
16	V							16
17	V	17 Management Fees						17
18	V							18
19	V	17 Salary-J.Shlofrock				21,622	21,622	19
20	V	22 Payroll Taxes-JS				4,302	4,302	20
21	V							21
22	V							22
23	V							23
24	V	17 Salary-S.Aron				17,280	17,280	24
25	V	22 Payroll Taxes-SA				1,388	1,388	25
26	V							26
27	V	21 Salary-L.Shlofrock				27,200	27,200	27
28	V	22 Payroll Taxes-LS				1,503	1,503	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		\$			\$ 73,295	\$ * 73,295	39

* 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:

1/1/06

Ending:

12/31/06

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%	\$ 677	\$ 677	15
16	V	6 Repairs and Maint		Barton Management, Inc.	100.00%	889	889	16
17	V	20 Dues,Fees,Subscriptions		Barton Management, Inc.	100.00%	18	18	17
18	V	21 Clerical and General		Barton Management, Inc.	100.00%	4	4	18
19	V	26 Insurance		Barton Management, Inc.	100.00%	45	45	19
20	V	22 Emp.Ben.Gen.Admin.		Barton Management, Inc.	100.00%	2,530	2,530	20
21	V	33 Real Estate Tax		Barton Management, Inc.	100.00%	2,173	2,173	21
22	V	34 Rent Office Space		Barton Management, Inc.	100.00%	7,036	7,036	22
23	V							23
24	V							24
25	V							25
26	V	34 Rent	15,400	Barton Management, Inc.	100.00%		(15,400)	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		\$ 15,400			\$ 13,372	\$ * (2,028)	39

* 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: 1/1/06 Ending: 12/31/06

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		See Attached			Alloc Rdwd	\$ 27,200	1
2	John Shlofrock	Owner	Administrative		See Attached			Alloc Rdwd	21,622	2
3	Paul Magit	Owner	Administrative		See Attached					3
4	Elisa Shlofrock-Zusman	Owner	Administrative		See Attached					4
5	Jean Shlofrock	Relative	Secretary		See Attached					5
6	Rick Duros	Owner	Administrative		See Attached			Salary	12,712	17-1
7	Stan Aron	Owner	Administrative		See Attached			Alloc Rdwd	17,280	7
8	Gary Weintraub	Owner	Legal		See Attached			Salary	12,712	17-1
9										9
10										10
11										11
12										12
13								TOTAL	\$ 91,526	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:

1/1/06

Ending: 12/31/06

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending: 12/31/06

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Bed Size	585	4	\$ 2,625	\$ 98	\$ 440	1
2	21	Clerical Expense	Bed Size	585	4	439	98	73	2
3	30	Depreciation	Bed Size	585	4	360,109	98	60,326	3
4	32	Interest	Bed Size	585	4	295,000	98	49,419	4
5	33	Real Estate Tax	Bed Size	585	4	9,460	98	1,585	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					\$ 667,633	\$	\$ 111,843	25

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending: 12/31/06

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	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	Salary-J. Shlofrock	Avg Hours Worked	37	5	100,000	100,000	8	21,622	4
5	Payroll Taxes-JS	Avg Hours Worked	37	5	19,898		8	4,302	5
6									6
7	Salary-S.Aron	Avg Hours Worked	14	4	69,120	69,120	4	17,280	7
8	Payroll Taxes-SA	Avg Hours Worked	14	4	5,551		4	1,388	8
9									9
10									10
11	Salary-L.Shlofrock	Avg Hours Worked	25	5	170,000	170,000	4	27,200	11
12	Payroll Taxes-LS	Avg Hours Worked	25	5	9,396		4	1,503	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				\$ 373,965	\$ 339,120		\$ 73,295	25

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending: 12/31/06

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	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 218,800	8	\$ 9,622	\$	15,400	\$ 677	1
2	6	Repairs and Maint	Rental Income 218,800	8	12,634		15,400	889	2
3	20	Dues,Fees, Subscriptions	Rental Income 218,800	8	250		15,400	18	3
4	21	Clerical and General	Rental Income 218,800	8	50		15,400	4	4
5	26	Insurance	Rental Income 218,800	8	643		15,400	45	5
6	27	Emp.Ben. Gen.Admin.	Rental Income 218,800	8	35,942		15,400	2,530	6
7	33	Real Estate Tax	Rental Income 218,800	8	30,877		15,400	2,173	7
8	34	Rent Office Space	Rental Income 218,800	8	99,973		15,400	7,036	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				\$ 189,991	\$		\$ 13,372	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			
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								49,419	10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		49,419	14										
15	TOTALS (line 9+line14)					\$	\$		49,419	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 _____

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 2005 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 2005.

(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>40,613.00</u>	\$ <u>40,613.00</u>
2. <u>See Attached</u>	<u>Home Office</u>	\$ <u>9,460.00</u>	\$ <u>1,585.00</u>
3. <u>See Attached</u>	<u>Building Co.</u>	\$ <u>30,877.00</u>	\$ <u>2,173.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>80,950.00</u>	\$ <u>44,371.00</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789 Report Period Beginning:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

Sharon Healthcare Willows - Facility - 219 Beds

Sharon Healthcare Woods - Facility - 152 Beds

Sharon Healthcare Pines - Facility - 120 Beds

Peoria 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	<u>Facility</u>			\$ <u>107,214</u>	1
2	<u>Allocation-Peoria Forest</u>			<u>6,024</u>	2
3	TOTALS			\$ 113,238	3

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		1987		5,207	165	20	260	95	3,158	9
10	Various		1988		4,581	124	20	240	116	2,965	10
11	Various		1989		1,877	60	20	94	34	1,035	11
12	Various		1990		6,666	134	20	373	239	4,652	12
13	Various		1991		23,422	742	20	1,189	447	12,057	13
14	Various		1992		19,136	642	20	974	332	9,243	14
15	Various		1994		9,731	250	20	487	237	3,079	15
16	Various		1995		2,723	69	20	136	67	791	16
17	Various		1996		4,103	106	20	206	100	1,113	17
18	Various		1997		19,387	497	20	970	473	4,632	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

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

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

See Page 12A, Line 70 for total

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

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1991		\$ 1,862,634	\$	35	\$ 59,139	\$ 59,139	\$	4
5			1991		39,368		31.5	1,188	1,188		5
6											6
7											7
8											8
	Improvement Type**										
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

*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
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 & Page12ARep)	1,902,001	60,327		60,327		936,691	68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,998,834	\$ 63,116		\$ 65,256	\$ 2,140	\$ 979,416	70

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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		\$ 1,998,834	\$ 63,116		\$ 65,256	\$ 2,140	\$ 979,416	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,183	2
3	Lawn Repair	1998	625	16	20	31	15	138	3
4	Water Softener	1998	1,700	44	20	85	41	374	4
5	Phone Shelf	1998	207	5	20	10	5	45	5
6	Rooftop Unit	1998	1,472	38	20	74	36	320	6
7	Amer II Minuteman	1998	272	7	20	14	7	59	7
8	Patio Ramp	1998	538	14	20	27	13	115	8
9	Roofing	1998	3,187	82	20	159	77	672	9
10	Drapes	1998	5,805	149	20	290	141	1,197	10
11	Heat Condenser	1999	1,203	31	20	60	29	241	11
12	Windows	1999	81	2	20	4	2	16	12
13	Garage Door	1999	142	4	20	7	3	29	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	742	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	516	15
16	Windows	1999	481	12	20	24	12	96	16
17	Concrete Parking Lot	1999	969	25	20	48	23	177	17
18	Roof	1999	996	26	20	50	24	183	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	360	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	289	20
21	Renovation Design	2000	2,561	66	20	128	62	430	21
22	Renovation Design	2000	1,950	50	20	98	48	319	22
23	Garbage Disposal	2000	791	20	20	40	20	127	23
24	Water Heater	2000	345	9	20	17	8	55	24
25	Parking Spaces	2000	89	2	20	4	2	13	25
26	Parking Spaces	2000	3,720	95	20	186	91	592	26
27	Drapery	2000	5,588	143	20	279	136	877	27
28	Nurse Call Station	2000	3,544	91	20	177	86	556	28
29	Renovation Project	2000	398	10	20	20	10	61	29
30	Electrical Work	2001	1,427	37	20	71	34	215	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	3,749	31
32	Exit Door	2001	2,391	61	20	120	59	355	32
33	Renovation Design	2001	2,864	73	20	143	70	425	33
34	TOTAL (lines 1 thru 33)		\$ 2,082,481	\$ 65,260		\$ 69,437	\$ 4,177	\$ 993,942	34

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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		\$ 2,082,481	\$ 65,260		\$ 69,437	\$ 4,177	\$ 993,942	1
2	Garage	2001	965	25	20	48	23	144	2
3	Drapery	2001	6,320	162	20	316	154	911	3
4	Install Drapery	2001	662	17	20	33	16	96	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	175	5
6	Gas Water Heater	2001	2,481	64	20	124	60	347	6
7	Compact Water Booster	2001	1,247	32	20	62	30	175	7
8	Drapery	2001	1,622	42	20	81	39	227	8
9	Install Roof	2001	4,357	112	20	218	106	610	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	133	10
11	Water Heater	2001	4,496	115	20	225	110	610	11
12	Replace Shingles	2001	923	24	20	46	22	125	12
13	Replace Refrig System	2001	1,092	28	20	55	27	146	13
14	Replace Shingles	2001	1,221	31	20	61	30	163	14
15	Flooring	2001	90	2	20	5	3	12	15
16	Parking Posts	2002	281	7	20	14	7	34	16
17	2 Exit Doors	2002	769	20	20	38	18	81	17
18	Roof Repair	2003	961	25	20	48	23	83	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	138	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	160	20
21	Duct Work	2003	2,598	67	20	130	63	203	21
22	Flooring	2003	3,190	82	20	160	78	249	22
23	Roof	2004	4,760	119	20	238	119	342	23
24	Kitchen Floor	2004	994	25	20	50	25	65	24
25	Kitchen Floor	2004	1,133	28	20	57	29	72	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	88	26
27	Rooftop Unit	2004	1,803	46	20	90	44	106	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	153	28
29	Lobby Rehab	2005	4,550	117	20	227	110	190	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	55	30
31	Back Doors	2005	2,310	59	20	116	57	96	31
32	Locks for Lobby	2005	873	22	20	44	22	36	32
33	Bathroom Repairs	2005	979	25	20	49	24	39	33
34	TOTAL (lines 1 thru 33)		\$ 2,144,851	\$ 66,855		\$ 72,556	\$ 5,701	\$ 1,000,006	34

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/06

Ending:

12/31/06

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 12C, Carried Forward		\$ 2,144,851	\$ 66,855		\$ 72,556	\$ 5,701	\$ 1,000,006	1
2	Lobby Rehab	2005	959	25	20	48	23	38	2
3	Remodeling Project-Frnt Bldg	2005	729	19	20	36	17	29	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	86	4
5	Ceiling Tile	2005	2,876	74	20	144	70	108	5
6	Front Lobby Renovation	2005	110	3	20	6	3	4	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	326	7
8	Carpet-Avtivity Room	2005	1,680	43	20	84	41	63	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	80	9
10	Dishroom Work	2005	796	20	20	40	20	26	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	19	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	17	12
13	Water Heater	2005	4,817	124	20	241	117	139	13
14	Ceiling Tiles	2005	604	15	20	30	15	16	14
15	Ceiling Tiles	2006	725	18	20	36	18	18	15
16	Condensing Unit	2006	1,040	10	20	52	42	10	16
17	Replace Ceilings	2006	6,769	36	20	338	302	36	17
18	Closet Wall Work	2006	890	5	20	45	40	54	18
19	Sidewalk	2006	7,888	42	20	394	352	42	19
20	Window Treatments	2006	1,504	5	20	75	70	5	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)		\$ 2,190,932	\$ 67,671		\$ 74,859	\$ 7,188	\$ 1,001,122	34

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

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	\$ 51,598	\$ 3,813	\$ 7,716	\$ 3,903	10	\$ 44,969	71
72	Current Year Purchases	13,360	2,632	2,633	1	10	2,632	72
73	Fully Depreciated Assets	209,441				10	209,441	73
74								74
75	TOTALS	\$ 274,399	\$ 6,445	\$ 10,349	\$ 3,904		\$ 257,042	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 Chevy Van	2001	\$ 2,463	\$ 141	\$ 493	\$ 352	5	\$ 2,463	76
77		2001 Dodge Ram	2004	2,945	565	589	24	5	2,097	77
78										78
79										79
80	TOTALS			\$ 5,408	\$ 706	\$ 1,082	\$ 376		\$ 4,560	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,583,977	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,822	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,290	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,468	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,262,724	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Alloc-Barton Mgmt				7,036			5
6					_____			6
7	TOTAL				\$ 7,036			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 7,152 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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 49,644	\$		\$ 49,644	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,205			4,205	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			51,004			51,004	4
5	Physician Care	39-2	visits				20,654		20,654	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts			57,194			57,194	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	38-3				6,172			6,172	13
14	TOTAL			\$		\$ 168,219	\$ 20,654		\$ 188,873	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHARON HEALTH CARE ELMS# 0032789Report Period Beginning: 1/1/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 645,042	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	643,930		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,397		6
7	Other Prepaid Expenses	4,653		7
8	Accounts Receivable (owners or related parties)	135,000		8
9	Other(specify): <u>Due from Medicare</u>	122,589		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,579,611	\$	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	288,927		15
16	Equipment, at Historical Cost	279,807		16
17	Accumulated Depreciation (book methods)	(325,982)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 242,752	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,822,363	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,451	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,878		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,659		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,849		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	1,504,858		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,705,695	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,705,695	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 116,668	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,822,363	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (227,004)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (227,004)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	343,672	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)	\$ 343,672	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)	\$ 116,668	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SHARON HEALTH CARE ELMS# 0032789Report Period Beginning: 1/1/06Ending: 12/31/06**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	\$ 3,731,353	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,731,353	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	(477)	28
28a	Misc	40	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (437)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,730,916	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	789,208	31
32	Health Care	1,439,374	32
33	General Administration	747,769	33
B. Capital Expense			
34	Ownership	168,365	34
C. Ancillary Expense			
35	Special Cost Centers	188,873	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,387,244	40
41	Income before Income Taxes (line 30 minus line 40)**	343,672	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 343,672	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:

1/1/06

Ending:

12/31/06

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	3,000	3,208	\$ 70,977	\$ 22.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,224	22,197	466,540	21.02	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	53,879	56,764	602,154	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	282	337	2,864	8.50	8
9	Activity Director					9
10	Activity Assistants	6,001	6,380	62,794	9.84	10
11	Social Service Workers	3,856	4,092	49,934	12.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,014	13,877	145,616	10.49	15
16	Dishwashers					16
17	Maintenance Workers	4,831	5,287	64,424	12.19	17
18	Housekeepers	14,520	15,120	115,342	7.63	18
19	Laundry	6,666	7,208	57,528	7.98	19
20	Administrator	2,080	2,080	71,598	34.42	20
21	Assistant Administrator					21
22	Other Administrative	850	850	37,587	44.22	22
23	Office Manager					23
24	Clerical	6,004	6,228	64,927	10.43	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	1,773	1,925	18,497	9.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,980	145,553	\$ 1,830,782 *	\$ 12.58	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	278	\$ 7,381	1-3	35
36	Medical Director	118	6,000	9-3	36
37	Medical Records Consultant	49	1,605	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,600	103	39
40	Physical Therapy Consultant	140	4,884	10-3	40
41	Occupational Therapy Consultant	123	4,296	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	314	10-3	43
44	Activity Consultant	88	2,652	11-3	44
45	Social Service Consultant	39	1,172	12-3	45
46	Other(specify)				46
47	Psychiatric	157	4,775	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,098	\$ 36,679		49

C. CONTRACT NURSES

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

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

0032789

Report Period Beginning: **1/1/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Sherry Ford	Administrator	0	\$ 71,598	Workers' Compensation Insurance	\$ 63,818	IDPH License Fee	\$ 4,854			
Rick Duros	CFO	5.74	22,258	Unemployment Compensation Insurance	34,413	Advertising: Employee Recruitment				
Gary Weintraub	Legal	7.81	15,329	FICA Taxes	147,655	Health Care Worker Background Check				
				Employee Health Insurance	56,669	(Indicate # of checks performed <u>187</u>)	1,867			
				Employee Meals		Patient Background Checks <u>80</u>	800			
				Illinois Municipal Retirement Fund (IMRF)*		License, Fees & Permits	2,854			
				Employee Retirement Plan Contribution	1,695	Dues & Subscriptions	317			
				Employee Benefits	2,969	Promotional Advertising	66			
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 109,185							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$				
							Out-of-State Travel	\$		
							In-State Travel			
							Seminar Expense	1,849		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 307,219	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,758
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
Frost,Ruttenburg&Rothblatt	Accounting	\$ (2,225)				\$	Out-of-State Travel	\$		
Alloc-Barton	Accounting	280								
Alloc-Sharon Complex	Accounting	670								
Alpha Data Services	Data Processing	4,530								
LTC Solutions	Computer	1,320								
Thresholds	Computer	2,356								
Alloc-Sharon Complex	Computer	215								
Ivans	Computer	1,333								
Alloc-Barton	Professional Fees	549								
Personnel Planners	Unemploymt Consult	2,025								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,849
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,053							

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting & Decorating	2003	\$ 505	4	\$ 84	\$ 168	\$ 168	\$ 85	\$	\$	\$	\$	\$
2	Painting & Decorating	2004	98	4		16	33	33	16				
3	Painting & Decorating	2005	0	4			0	0	0	0			
4	Painting & Decorating	2006	1,444	4				241	481	481	241		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,047		\$ 84	\$ 184	\$ 201	\$ 359	\$ 497	\$ 481	\$ 241	\$	\$

Facility Name & ID Number SHARON HEALTH CARE ELMS

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. _____
- (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. \$ 8,621 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 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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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%ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
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 \$5,000, 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.