

		FOR BHF USE				

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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 1/1/07 to 12/31/07 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: 1/1/07 Ending: 12/31/07

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>31,137</u>	<u>653</u>	<u>512</u>	<u>32,302</u>	10
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>31,137</u>	<u>653</u>	<u>512</u>	<u>32,302</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.30%

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

14 (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)

noneF. 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: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,847	20,253	7,065	188,165		188,165		188,165		1
2	Food Purchase		195,699		195,699		195,699	(1,441)	194,258		2
3	Housekeeping	126,457		18,894	145,351		145,351		145,351		3
4	Laundry	70,382	26,733		97,115		97,115		97,115		4
5	Heat and Other Utilities			110,934	110,934		110,934	664	111,598		5
6	Maintenance	69,060		68,285	137,345		137,345	(316)	137,029		6
7	Other (specify):*										7
8	TOTAL General Services	426,746	242,685	205,178	874,609		874,609	(1,093)	873,516		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,181,925	121,952	12,507	1,316,384		1,316,384		1,316,384		10
10a	Therapy										10a
11	Activities	55,716	1,899	3,165	60,780		60,780		60,780		11
12	Social Services	57,356		10,537	67,893		67,893		67,893		12
13	CNA Training										13
14	Program Transportation			6,879	6,879		6,879		6,879		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,294,997	123,851	33,088	1,451,936		1,451,936		1,451,936		16
	C. General Administration										
17	Administrative	114,915			114,915		114,915	24,509	139,424		17
18	Directors Fees										18
19	Professional Services			29,986	29,986		29,986	281	30,267		19
20	Dues, Fees, Subscriptions & Promotions			5,471	5,471		5,471	(266)	5,205		20
21	Clerical & General Office Expenses	84,641		35,332	119,973		119,973	4,841	124,814		21
22	Employee Benefits & Payroll Taxes			286,614	286,614		286,614	9,830	296,444		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,189	2,189		2,189		2,189		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,362	60,362		60,362	107	60,469		26
27	Other (specify):*										27
28	TOTAL General Administration	199,556		419,954	619,510		619,510	39,302	658,812		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,921,299	366,536	658,220	2,946,055		2,946,055	38,209	2,984,264		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:

1/1/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			19,869	19,869		19,869	73,071	92,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							71,569	71,569			32
33	Real Estate Taxes			41,939	41,939		41,939	4,089	46,028			33
34	Rent-Facility & Grounds			105,108	105,108		105,108	(98,242)	6,866			34
35	Rent-Equipment & Vehicles			7,869	7,869		7,869		7,869			35
36	Other (specify):*											36
37	TOTAL Ownership			174,785	174,785		174,785	50,487	225,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,176	218,929	222,105		222,105		222,105			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		3,176	272,584	275,760		275,760		275,760			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,921,299	369,712	1,105,589	3,396,600		3,396,600	88,696	3,485,296			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: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,745	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	(1,441)	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				17
18	Fines and Penalties				18
19	Entertainment	(3,563)	21		19
20	Contributions	(1,208)	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	(94)	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	(16,208)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,769)		\$	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)	98,465		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 98,465		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 88,696		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: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-Allowable Salary	\$ (14,393)	17
2	Deferred Maintenance	(1,815)	6
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49	Total	(16,208)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(1,441)	0	0	0	0	0	0	0	0	0	0	(1,441)	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	664	0	0	0	0	0	0	664	5
6	Maintenance	(1,815)	0	0	0	1,499	0	0	0	0	0	0	(316)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,256)	0	0	0	2,163	0	0	0	0	0	0	(1,093)	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	(14,393)	0	0	38,902	0	0	0	0	0	0	0	24,509	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	281	0	0	0	0	0	0	0	0	281	19
20	Fees, Subscriptions & Promotions	(94)	0	0	0	(172)	0	0	0	0	0	0	(266)	20
21	Clerical & General Office Expenses	(4,771)	0	0	9,600	12	0	0	0	0	0	0	4,841	21
22	Employee Benefits & Payroll Taxes	0	0	0	6,433	3,397	0	0	0	0	0	0	9,830	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	107	0	0	0	0	0	0	107	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(19,258)	0	281	54,935	3,344	0	0	0	0	0	0	39,302	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,514)	0	281	54,935	5,507	0	0	0	0	0	0	38,209	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	12,745	0	60,326	0	0	0	0	0	0	0	0	73,071	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	71,569	0	0	0	0	0	0	0	0	71,569	32
33	Real Estate Taxes	0	0	1,649	0	2,440	0	0	0	0	0	0	4,089	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(7,657)	0	0	0	0	0	0	(98,242)	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	12,745	0	42,959	0	(5,217)	0	0	0	0	0	0	50,487	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)	(9,769)	0	43,240	54,935	290	0	0	0	0	0	0	88,696	45

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

* 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: **1/1/07**Ending: **12/31/07****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%	\$ 281	\$ 281	15
16	V							16
17	V	30 Depreciation		Peoria Forest Partnership		60,326	60,326	17
18	V	32 Interest		Peoria Forest Partnership		71,569	71,569	18
19	V	33 Real Estate Tax		Peoria Forest Partnership		1,649	1,649	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			\$ 133,825	\$ * 43,240	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: **1/1/07**Ending: **12/31/07****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				4,308	4,308	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				1,364	1,364	25
26	V							26
27	V	21 Salary-L.Shlofrock				9,600	9,600	27
28	V	22 Payroll Taxes-LS				761	761	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		\$			\$ 54,935	\$ * 54,935	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: **1/1/07**Ending: **12/31/07****VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	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			Name of Related Organization					
15	V	5	Utilities	\$		Barton Management, Inc.	100.00%	\$ 664	\$ 664	15
16	V	6	Repairs and Maint			Barton Management, Inc.	100.00%	1,499	1,499	16
17	V	20	Dues,Fees,Subscriptions			Barton Management, Inc.	100.00%	(172)	(172)	17
18	V	21	Clerical and General			Barton Management, Inc.	100.00%	12	12	18
19	V	26	Insurance			Barton Management, Inc.	100.00%	107	107	19
20	V	22	Emp.Ben.Gen.Admin.			Barton Management, Inc.	100.00%	3,397	3,397	20
21	V	33	Real Estate Tax			Barton Management, Inc.	100.00%	2,440	2,440	21
22	V	34	Rent Office Space			Barton Management, Inc.	100.00%	6,743	6,743	22
23	V									23
24	V									24
25	V									25
26	V	34	Rent	14,400		Barton Management, Inc.	100.00%		(14,400)	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			\$ 14,400				\$ 14,690	\$ * 290	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: 1/1/07 Ending: 12/31/07

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	\$ 9,600	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	13,459	17-1
7	Stan Aron	Owner	Administrative		See Attached			Alloc Rdwd	17,280	7
8	Gary Weintraub	Owner	Legal		See Attached			Salary	13,459	17-1
9										9
10										10
11										11
12										12
13								TOTAL	\$ 75,420	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: 1/1/07

Ending: 12/31/07

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: 1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Peoria Forest Partnership
 Street Address 465 Central Ave., Suite 100
 City / State / Zip Code Northfield, IL 60093
 Phone Number (847-441-8200
 Fax Number (847-441-0800

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	585	4	\$ 1,675	\$	98	\$ 281	1
2									2
3	30	Depreciation	585	4	360,112		98	60,326	3
4	32	Interest	585	4	427,222		98	71,569	4
5	33	Real Estate Tax	585	4	9,844		98	1,649	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				\$ 798,853	\$		\$ 133,825	25

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	19,925		8	4,308	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	5,455		4	1,364	8
9									9
10									10
11	Salary-L.Shlofrock	Avg Hours Worked	25	5	60,000	60,000	4	9,600	11
12	Payroll Taxes-LS	Avg Hours Worked	25	5	4,758		4	761	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				\$ 259,258	\$ 229,120		\$ 54,935	25

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning: 1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Barton Management, Inc.
 Street Address 465 Central Ave.
 City / State / Zip Code Northfield, IL 60093
 Phone Number (847-441-8200
 Fax Number (847-441-0800

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Rental Income 184,800	8	\$ 8,523	\$	14,400	\$ 664	1
2	6	Repairs and Maint	Rental Income 184,800	8	19,242		14,400	1,499	2
3	20	Dues,Fees, Subscriptions	Rental Income 184,800	8	(2,210)		14,400	(172)	3
4	21	Clerical and General	Rental Income 184,800	8	150		14,400	12	4
5	26	Insurance	Rental Income 184,800	8	1,367		14,400	107	5
6	27	Emp.Ben. Gen.Admin.	Rental Income 184,800	8	43,594		14,400	3,397	6
7	33	Real Estate Tax	Rental Income 184,800	8	31,308		14,400	2,440	7
8	34	Rent Office Space	Rental Income 184,800	8	86,534		14,400	6,743	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				\$ 188,508	\$		\$ 14,690	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									71,569 10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									71,569 14										
15	TOTALS (line 9+line14)									71,569 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 847-441-82500 FAX #: 847-441-2800

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>40,290.00</u>	\$ <u>40,290.00</u>
2. <u>See Attached</u>	<u>Home Office</u>	\$ <u>9,844.00</u>	\$ <u>1,649.00</u>
3. <u>See Attached</u>	<u>Building Co.</u>	\$ <u>31,308.00</u>	\$ <u>2,440.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>81,442.00</u>	\$ <u>44,379.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

1/1/07 Ending:

12/31/07

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:

1/1/07

Ending:

12/31/07

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	3,323	9
10	Various			1988	4,581	124	20	240	116	3,089	10
11	Various			1989	1,877	60	20	94	34	1,095	11
12	Various			1990	6,666	194	20	373	179	4,785	12
13	Various			1991	23,422	713	20	1,189	476	12,772	13
14	Various			1992	19,136	606	20	974	368	9,850	14
15	Various			1994	9,731	250	20	487	237	3,329	15
16	Various			1995	2,723	69	20	136	67	862	16
17	Various			1996	4,103	106	20	206	100	1,217	17
18	Various			1997	19,387	497	20	970	473	5,126	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:

1/1/07

Ending:

12/31/07

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning:

1/1/07

Ending:

12/31/07

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		1,902,001	60,327		60,327		997,018	68
69								69
70		\$ 1,998,834	\$ 63,111		\$ 65,256	\$ 2,145	\$ 1,042,466	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:

1/1/07

Ending:

12/31/07

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	\$ 63,111		\$ 65,256	\$ 2,145	\$ 1,042,466	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,315	2
3	Lawn Repair	1998	625	16	20	31	15	154	3
4	Water Softener	1998	1,700	44	20	85	41	418	4
5	Phone Shelf	1998	207	5	20	10	5	50	5
6	Rooftop Unit	1998	1,472	38	20	74	36	357	6
7	Amer II Minuteman	1998	272	7	20	14	7	66	7
8	Patio Ramp	1998	538	14	20	27	13	129	8
9	Roofing	1998	3,187	82	20	159	77	753	9
10	Drapes	1998	5,805	149	20	290	141	1,346	10
11	Heat Condenser	1999	1,203	31	20	60	29	272	11
12	Windows	1999	81	2	20	4	2	18	12
13	Garage Door	1999	142	4	20	7	3	33	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	838	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	582	15
16	Windows	1999	481	12	20	24	12	108	16
17	Concrete Parking Lot	1999	969	25	20	48	23	202	17
18	Roof	1999	996	26	20	50	24	208	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	411	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	330	20
21	Renovation Design	2000	2,561	66	20	128	62	496	21
22	Renovation Design	2000	1,950	50	20	98	48	369	22
23	Garbage Disposal	2000	791	20	20	40	20	148	23
24	Water Heater	2000	345	9	20	17	8	64	24
25	Parking Spaces	2000	89	2	20	4	2	16	25
26	Parking Spaces	2000	3,720	95	20	186	91	687	26
27	Drapery	2000	5,588	143	20	279	136	1,021	27
28	Nurse Call Station	2000	3,544	91	20	177	86	647	28
29	Renovation Project	2000	398	10	20	20	10	71	29
30	Electrical Work	2001	1,427	37	20	71	34	252	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	4,397	31
32	Exit Door	2001	2,391	61	20	120	59	416	32
33	Renovation Design	2001	2,864	73	20	143	70	499	33
34	TOTAL (lines 1 thru 33)		\$ 2,082,481	\$ 65,255		\$ 69,437	\$ 4,182	\$ 1,059,139	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:

1/1/07

Ending:

12/31/07

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	\$ 65,255		\$ 69,437	\$ 4,182	\$ 1,059,139	1
2	Garage	2001	965	25	20	48	23	168	2
3	Drapery	2001	6,320	162	20	316	154	1,073	3
4	Install Drapery	2001	662	17	20	33	16	113	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	207	5
6	Gas Water Heater	2001	2,481	64	20	124	60	411	6
7	Compact Water Booster	2001	1,247	32	20	62	30	207	7
8	Drapery	2001	1,622	42	20	81	39	269	8
9	Install Roof	2001	4,357	112	20	218	106	721	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	158	10
11	Water Heater	2001	4,496	115	20	225	110	725	11
12	Replace Shingles	2001	923	24	20	46	22	149	12
13	Replace Refrig System	2001	1,092	28	20	55	27	174	13
14	Replace Shingles	2001	1,221	31	20	61	30	194	14
15	Flooring	2001	90	2	20	5	3	14	15
16	Parking Posts	2002	281	7	20	14	7	41	16
17	2 Exit Doors	2002	769	20	20	38	18	101	17
18	Roof Repair	2003	961	25	20	48	23	108	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	180	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	210	20
21	Duct Work	2003	2,598	67	20	130	63	269	21
22	Flooring	2003	3,190	82	20	160	78	331	22
23	Roof	2004	4,760	119	20	238	119	461	23
24	Kitchen Floor	2004	994	25	20	50	25	90	24
25	Kitchen Floor	2004	1,133	28	20	57	29	100	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	123	26
27	Rooftop Unit	2004	1,803	46	20	90	44	152	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	234	28
29	Lobby Rehab	2005	4,550	117	20	227	110	306	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	89	30
31	Back Doors	2005	2,310	59	20	116	57	156	31
32	Locks for Lobby	2005	873	22	20	44	22	59	32
33	Bathroom Repairs	2005	979	25	20	49	24	64	33
34	TOTAL (lines 1 thru 33)		\$ 2,144,851	\$ 66,850		\$ 72,556	\$ 5,706	\$ 1,066,796	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:

1/1/07

Ending:

12/31/07

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	\$ 66,850		\$ 72,556	\$ 5,706	\$ 1,066,796	1
2	Lobby Rehab	2005	959	25	20	48	23	63	2
3	Remodeling Project-Frnt Bldg	2005	729	19	20	36	17	48	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	145	4
5	Ceiling Tile	2005	2,876	74	20	144	70	181	5
6	Front Lobby Renovation	2005	110	3	20	6	3	7	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	550	7
8	Carpet-Activity Room	2005	1,680	43	20	84	41	106	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	141	9
10	Dishroom Work	2005	796	20	20	40	20	47	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	36	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	33	12
13	Water Heater	2005	4,817	124	20	241	117	262	13
14	Ceiling Tiles	2005	604	15	20	30	15	32	14
15	Ceiling Tiles	2006	725	19	20	36	17	36	15
16	Condensing Unit	2006	1,040	10	20	52	42	37	16
17	Replace Ceilings	2006	6,769	36	20	338	302	210	17
18	Closet Wall Work	2006	890	5	20	45	40	28	18
19	Sidewalk	2006	7,888	42	20	394	352	244	19
20	Window Treatments	2006	1,504	5	20	75	70	43	20
21	Plumbing Services	2007	3,235	73	20	161	88	73	21
22	Picnic Pad	2007	2,123	48	20	106	58	48	22
23	Drapery, Valances	2007	600	30	20	30		30	23
24	Replace Water Heater	2007	1,184	22	20	59	37	22	24
25	Add Rock To Drive	2007	4,949	79	20	247	168	79	25
26	Water Booster	2007	215	11	20	11		11	26
27	Sidewalk	2007	1,298	18	20	65	47	18	27
28	RTU-Roof Top Unit	2007	444	22	20	22		22	28
29	Wall Pks/Emergency Lighting	2007	7,700	91	20	385	294	91	29
30	Cubicle Curtains	2007	5,848	69	20	292	223	69	30
31	Windows	2007	2,044	292	20	102	(190)	292	31
32	Kitchen Exhaust Duckwork	2007	2,218	21	20	111	90	21	32
33	Dining Room Flooring	2007	6,950	37	20	347	310	37	33
34	TOTAL (lines 1 thru 33)		\$ 2,229,740	\$ 68,480		\$ 76,797	\$ 8,317	\$ 1,069,858	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:

1/1/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,229,740	\$ 68,480		\$ 76,797	\$ 8,317	\$ 1,069,858	1
2	Electrical Work Alarm	2007	2,779	9	20	139	130	9	2
3	Alarm	2007	1,547	5	20	77	72	5	3
4	Landscaping Work	2007	2,050	103	20	103		103	4
5	Roof Top units	2007	12,870	14	20	643	629	14	5
6	Generator Study	2007	1,776	2	20	89	87	2	6
7	Water Softener Maintenance	2007	3,750	4	20	187	183	4	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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)		\$ 2,254,512	\$ 68,617		\$ 78,035	\$ 9,418	\$ 1,069,995	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: 1/1/07 Ending: 12/31/07

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	\$ 58,435	\$ 6,423	\$ 9,920	\$ 3,497	10	\$ 52,596	71
72	Current Year Purchases	30,545	4,396	4,396		10	4,396	72
73	Fully Depreciated Assets	215,964				10	215,964	73
74								74
75	TOTALS	\$ 304,944	\$ 10,819	\$ 14,316	\$ 3,497		\$ 272,956	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	\$	\$	\$	5	\$ 2,463	76
77		2001 Dodge Van	2004	2,945	339	589	250	5	2,436	77
78										78
79										79
80	TOTALS			\$ 5,408	\$ 339	\$ 589	\$ 250		\$ 4,899	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)		\$ 2,678,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 79,775	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 92,940	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 13,165	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,347,850	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				6,743			5
6					_____			6
7	TOTAL				\$ 6,743			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 7,869 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?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$			\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															12
13	Other (specify):															13
14	TOTAL			\$		\$	\$		\$		\$		\$			14

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

Facility Name & ID Number SHARON HEALTH CARE ELMS

0032789

Report Period Beginning: 1/1/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 80,838	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	876,614		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,998		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	685,000		8
9	Other(specify): <u>Due From Medicare</u>	182,537		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,853,987	\$	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	389,796		15
16	Equipment, at Historical Cost	310,353		16
17	Accumulated Depreciation (book methods)	(345,851)		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)	\$ 354,298	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,208,285	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,683	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,170		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,343		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,498		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>	1,311,421		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,542,115	\$	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)	\$ 1,542,115	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 666,170	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,208,285	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 111,435	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 111,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 554,735	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)	\$ 554,735	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)	\$ 666,170	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SHARON HEALTH CARE ELMS# 0032789Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 3,945,113	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,945,113	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***	7,358	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,358	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Inc	211	28
28a	Vending Income	(1,347)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,136)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,951,335	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	874,609	31
32	Health Care	1,451,936	32
33	General Administration	619,510	33
B. Capital Expense			
34	Ownership	174,785	34
C. Ancillary Expense			
35	Special Cost Centers	222,105	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)*	\$ 3,396,600	40
41	Income before Income Taxes (line 30 minus line 40)**	554,735	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 554,735	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

1/1/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,008	1,048	\$ 32,017	\$ 30.55	1
2	Assistant Director of Nursing	1,912	2,080	43,566	20.95	2
3	Registered Nurses					3
4	Licensed Practical Nurses	20,515	21,636	459,490	21.24	4
5	CNAs & Orderlies	53,942	56,982	623,895	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,611	6,104	55,716	9.13	10
11	Social Service Workers	3,852	4,191	57,356	13.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,034	15,064	160,847	10.68	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,201	69,060	31.38	17
18	Housekeepers	14,253	15,148	126,457	8.35	18
19	Laundry	7,586	8,202	70,382	8.58	19
20	Administrator	2,080	2,080	73,604	35.39	20
21	Assistant Administrator					21
22	Other Administrative	1,275	1,275	41,311	32.40	22
23	Office Manager					23
24	Clerical	5,522	5,750	84,641	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,128	2,304	22,957	9.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,703	144,065	\$ 1,921,299 *	\$ 13.34	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	144	\$ 7,065	1-3	35
36	Medical Director	112	3,867	10-3	36
37	Medical Records Consultant	46	1,620	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,400	10-3	39
40	Physical Therapy Consultant	50	2,240	10-3	40
41	Occupational Therapy Consultant	43	1,934	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	446	10-3	43
44	Activity Consultant	90	3,165	11-3	44
45	Social Service Consultant	35	1,385	12-3	45
46	Other(specify)				46
47	Psychiatric Director	114	9,152	12-3	47
48					48
49	TOTAL (lines 35 - 48)	740	\$ 33,274		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: **1/1/07**

Ending: **12/31/07**

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	\$ 73,604	Workers' Compensation Insurance	\$ 67,763	IDPH License Fee	\$		
Rick Duros	CFO	0	22,258	Unemployment Compensation Insurance	33,571	Advertising: Employee Recruitment	3,851		
Gary Weintraub	Legal	0	19,053	FICA Taxes	147,294	Health Care Worker Background Check			
				Employee Health Insurance	36,289	(Indicate # of checks performed <u>43</u>)	427		
				Employee Meals		Patient Background Checks <u>18</u>	183		
				Illinois Municipal Retirement Fund (IMRF)*		License, Fees & Permits	576		
				Employee Retirement Plan Contribution	625	Dues & Subscriptions	74		
				Employee Benefits	1,072	Promotional Advertising	94		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 114,915						
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	2,189	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 286,614	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Frost,Ruttenburg&Rothblatt	Accounting	\$ 11,660				\$	Out-of-State Travel	\$	
Alloc-Barton	Accounting	417							
Alloc-Sharon Complex	Accounting	682							
Alpha Data Services	Data Processing	4,907					In-State Travel		
LTC Solutions	Computer	1,320							
Thresholds	Computer	3,143							
Alloc-Sharon Complex	Computer	196							
Ivans	Computer	1,528					Seminar Expense	2,189	
Alloc-Barton	Computer	2,198							
Personnel Planners	Unemploymt Consult	3,252							
Honkamp Krueger & Co.	Accounting	683							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 29,986					\$ 2,189	

* 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Painting & Decorating	2003	\$ 505	4	\$ 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	Painting & Decorating	2007	1,312	4				219	437	437	219		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,359		\$ 184	\$ 201	\$ 359	\$ 716	\$ 918	\$ 678	\$ 219	\$	\$

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. \$ 10,561 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.