

Facility Name & ID Number Sharon Health Care Elms# 0032789 Report Period Beginning: 1/1/08 Ending: 12/31/08

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>35,868</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>35,868</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>31,307</u>	<u>804</u>	<u>67</u>	<u>32,178</u>	10
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>31,307</u>	<u>804</u>	<u>67</u>	<u>32,178</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.71%

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

99 (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 98 and days of care provided 3,973Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	206,675	19,078	8,083	233,836		233,836		233,836		1
2	Food Purchase		205,496		205,496		205,496	(1,931)	203,565		2
3	Housekeeping	133,328		20,600	153,928		153,928		153,928		3
4	Laundry	79,746	24,563		104,309		104,309		104,309		4
5	Heat and Other Utilities			120,691	120,691		120,691	704	121,395		5
6	Maintenance	80,391		82,439	162,830		162,830	269	163,099		6
7	Other (specify):*										7
8	TOTAL General Services	500,140	249,137	231,813	981,090		981,090	(958)	980,132		8
	B. Health Care and Programs										
9	Medical Director			7,469	7,469		7,469		7,469		9
10	Nursing and Medical Records	1,230,165	122,554	4,589	1,357,308		1,357,308		1,357,308		10
10a	Therapy										10a
11	Activities	57,669	1,790	2,215	61,674		61,674		61,674		11
12	Social Services	63,537		13,558	77,095		77,095		77,095		12
13	CNA Training										13
14	Program Transportation			3,334	3,334		3,334	(3,334)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,351,371	124,344	31,165	1,506,880		1,506,880	(3,334)	1,503,546		16
	C. General Administration										
17	Administrative	120,588		150,000	270,588		270,588	(125,476)	145,112		17
18	Directors Fees										18
19	Professional Services			37,377	37,377		37,377	645	38,022		19
20	Dues, Fees, Subscriptions & Promotions			12,650	12,650		12,650	(1,048)	11,602		20
21	Clerical & General Office Expenses	91,300		292,347	383,647		383,647	(257,740)	125,907		21
22	Employee Benefits & Payroll Taxes			309,812	309,812		309,812	12,330	322,142		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,609	1,609		1,609		1,609		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,819	63,819		63,819	81	63,900		26
27	Other (specify):*										27
28	TOTAL General Administration	211,888		867,614	1,079,502		1,079,502	(371,208)	708,294		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,063,399	373,481	1,130,592	3,567,472		3,567,472	(375,500)	3,191,972		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: 1/1/08 Ending: 12/31/08

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			55,227	55,227	55,227	46,968	102,195				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						80,534	80,534				32
33	Real Estate Taxes			43,433	43,433	43,433	3,728	47,161				33
34	Rent-Facility & Grounds			107,684	107,684	107,684	(98,710)	8,974				34
35	Rent-Equipment & Vehicles			37,971	37,971	37,971		37,971				35
36	Other (specify):*											36
37	TOTAL Ownership			244,315	244,315	244,315	32,520	276,835				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,187	272,083	282,270	282,270		282,270				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802	53,802		53,802				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10,187	325,885	336,072	336,072		336,072				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,063,399	383,668	1,700,792	4,147,859	4,147,859	(342,980)	3,804,879				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: 1/1/08

Ending: 12/31/08

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	(13,357)	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	(1,931)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,334)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,326)	21		19
20	Contributions	(987)	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	(250,000)	21		24
25	Fund Raising, Advertising and Promotional	(1,048)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,436)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,432)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (292,851)		\$	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)	(50,129)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,129)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (342,980)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Sharon Health Care Elms

ID# 0032789

Report Period Beginning: 1/1/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-Allowable Salary	\$ (14,378)	17
2	Deferred Maintenance	(1,054)	6
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(15,432)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	(1,931)	0	0	0	0	0	0	0	0	0	0	(1,931)	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	704	0	0	0	0	0	0	704	5
6	Maintenance	(1,054)	0	0	0	1,323	0	0	0	0	0	0	269	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,985)	0	0	0	2,027	0	0	0	0	0	0	(958)	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	(3,334)	0	0	0	0	0	0	0	0	0	0	(3,334)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,334)	0	0	0	0	0	0	0	0	0	0	(3,334)	16
	C. General Administration													
17	Administrative	(14,378)	0	0	(111,098)	0	0	0	0	0	0	0	(125,476)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	645	0	0	0	0	0	0	0	0	645	19
20	Fees, Subscriptions & Promotions	(1,048)	0	0	0	0	0	0	0	0	0	0	(1,048)	20
21	Clerical & General Office Expenses	(257,749)	0	0	0	9	0	0	0	0	0	0	(257,740)	21
22	Employee Benefits & Payroll Taxes	0	0	0	6,808	5,522	0	0	0	0	0	0	12,330	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	81	0	0	0	0	0	0	81	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(273,175)	0	645	(104,290)	5,612	0	0	0	0	0	0	(371,208)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(279,494)	0	645	(104,290)	7,639	0	0	0	0	0	0	(375,500)	29

STATE OF ILLINOIS

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/08

Ending:

Summary B

12/31/08

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	(13,357)	0	60,325	0	0	0	0	0	0	0	0	46,968	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	80,534	0	0	0	0	0	0	0	0	80,534	32
33	Real Estate Taxes	0	0	1,703	0	2,025	0	0	0	0	0	0	3,728	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(8,125)	0	0	0	0	0	0	(98,710)	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	(13,357)	0	51,977	0	(6,100)	0	0	0	0	0	0	32,520	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)	(292,851)	0	52,622	(104,290)	1,539	0	0	0	0	0	0	(342,980)	45

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/08

Ending:

12/31/08

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%	\$ 645	\$ 645	15
16	V							16
17	V	30 Depreciation		Peoria Forest Partnership		60,325	60,325	17
18	V	32 Interest		Peoria Forest Partnership		80,534	80,534	18
19	V	33 Real Estate Tax		Peoria Forest Partnership		1,703	1,703	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			\$ 143,207	\$ * 52,622	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: 1/1/08

Ending: 12/31/08

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
18	V							18
19	V	17 Salary-J. Shlofrock				21,622	21,622	19
20	V	22 Payroll Taxes-JS				5,448	5,448	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				1,360	1,360	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V	17 Management Fees	150,000				(150,000)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 150,000			\$ 45,710	\$ * (104,290)	39

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

Facility Name & ID Number Sharon Health Care Elms# 0032789Report Period Beginning: 1/1/08Ending: 12/31/08

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	100.00%	\$ 704	\$ 704	15	
16	V	6	Repairs and Maint		Barton Management		1,323	1,323	16	
17	V	20	Dues, Fees Subscriptions		Barton Management				17	
18	V	21	Clerical and General		Barton Management		9	9	18	
19	V	26	Insurance		Barton Management		81	81	19	
20	V	22	Emp. Ben. Gen. Admin		Barton Management		5,522	5,522	20	
21	V	33	Real Estate Taxes		Barton Management		2,025	2,025	21	
22	V	34	Rent Office Space		Barton Management		8,775	8,775	22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V	34	Rent	16,900	Barton Management				(16,900)	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			\$ 16,900			\$ 18,439	\$ *	1,539	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: 1/1/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	John Shlofrock	Owner	Administrative	15.30	See Attached		0.17	Alloc Rdwd	\$ 21,622	1
2										2
3	Elisa Shlofrock-Zusman	Owner	Administrative	12.08	See Attached		0.12			3
4	Jean Shlofrock	Owner	Secretary	21.12	See Attached					4
5	Rick Duros	Owner	Administrative	7.91	See Attached	6	0.12	Salary	14,581	17-1
6	Stan Aron	Owner	Administrative	15.28	See Attached	3	5.00	Alloc Rdwd	17,280	6
7	Gary Weintraub	Owner	Legal	9.95	See Attached	5	0.12	Salary	14,581	17-1
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 68,064	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: 1/1/08

Ending: 12/31/08

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: 1/1/08

Ending: 12/31/08

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	\$ 3,850	\$	98	\$ 645	1
2									2
3	30	Depreciation	585	4	360,103		98	60,325	3
4	32	Interest	585	4	480,740		98	80,534	4
5	33	Real Estate Tax	585	4	10,164		98	1,703	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				\$ 854,857	\$		\$ 143,207	25

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning: 1/1/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	25,195		8	5,448	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	5,440		4	1,360	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				\$ 199,755	\$ 169,120		\$ 45,710	25

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning: 1/1/08

Ending: 12/31/08

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, 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	5	Utilities	Rental Income 284,800	8	\$ 11,870	\$	16,900	\$ 704	1
2	6	Repairs ans Maint	Rental Income 284,800	8	22,301		16,900	1,323	2
3	20	Dues,Fees,Subscriptions	Rental Income 284,800	8			16,900		3
4	21	Clerical and General	Rental Income 284,800	8	150		16,900	9	4
5	26	Insurance	Rental Income 284,800	8	1,372		16,900	81	5
6	27	Emp.Ben.Gen.Admin.	Rental Income 284,800	8	93,049		16,900	5,522	6
7	33	Real Estate Tax	Rental Income 284,800	8	34,119		16,900	2,025	7
8	34	Rent Office Space	Rental Income 284,800	8	147,875		16,900	8,775	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				\$ 310,736	\$		\$ 18,439	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	Allocated from Peoria Forest	x								80,534	10									
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									80,534	14									
15	TOTALS (line 9+line14)									80,534	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 41,498	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 45,566	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 4,068	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 43,093	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 47,161	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	41,295	8
	2004	38,448	9
	2005	40,737	10
	2006	44,371	11
	2007	44,379	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>41,838.00</u>	\$ <u>41,838.00</u>
2. <u>See Attached</u>	<u>Home Office</u>	\$ <u>10,164.00</u>	\$ <u>1,703.00</u>
3. <u>See Attached</u>	<u>Building Co.</u>	\$ <u>34,119.00</u>	\$ <u>2,025.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>86,121.00</u>	\$ <u>45,566.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

1/1/08

Ending:

12/31/08

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 - 116 Beds

Peoria Forest 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

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		(165)	3,488	9
10	Various			1988	4,581	124	20	229	105	3,213	10
11	Various			1989	1,877	60	20	94	34	1,154	11
12	Various			1990	6,666	134	20	333	199	4,920	12
13	Various			1991	23,422	713	20	1,171	458	13,483	13
14	Various			1992	19,136	575	20	957	382	10,424	14
15	Various			1994	9,731	250	20	487	237	3,577	15
16	Various			1995	2,723	69	20	136	67	932	16
17	Various			1996	4,103	106	20	206	100	1,322	17
18	Various			1997	19,387	497	20	970	473	5,625	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:

1/1/08

Ending:

12/31/08

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	\$ 53,218	\$ 53,218	\$	4
5			1991		39,368		31.5	1,250	1,250		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:

1/1/08

Ending:

12/31/08

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	60,325		60,327	2	1,057,345	68
69								69
70		\$ 1,998,834	\$ 63,018		\$ 64,910	\$ 1,892	\$ 1,105,483	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:

1/1/08

Ending:

12/31/08

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	\$ 63,018		\$ 64,910	\$ 1,892	\$ 1,105,483	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,447	2
3	Lawn Repair	1998	625	16	20	31	15	170	3
4	Water Softener	1998	1,700	44	20	85	41	461	4
5	Phone Shelf	1998	207	5	20	10	5	55	5
6	Rooftop Unit	1998	1,472	38	20	74	36	395	6
7	Amer II Minuteman	1998	272	7	20	14	7	73	7
8	Patio Ramp	1998	538	14	20	27	13	143	8
9	Roofing	1998	3,187	82	20	159	77	835	9
10	Drapes	1998	5,805	149	20	290	141	1,495	10
11	Heat Condenser	1999	1,203	31	20	60	29	303	11
12	Windows	1999	81	2	20	4	2	21	12
13	Garage Door	1999	142	4	20	7	3	36	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	933	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	648	15
16	Windows	1999	481	12	20	24	12	120	16
17	Concrete Parking Lot	1999	969	25	20	48	23	227	17
18	Roof	1999	996	26	20	50	24	234	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	462	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	371	20
21	Renovation Design	2000	2,561	66	20	128	62	562	21
22	Renovation Design	2000	1,950	50	20	98	48	419	22
23	Garbage Disposal	2000	791	20	20	40	20	168	23
24	Water Heater	2000	345	9	20	17	8	73	24
25	Parking Spaces	2000	89	2	20	4	2	18	25
26	Parking Spaces	2000	3,720	95	20	186	91	783	26
27	Drapery	2000	5,588	143	20	279	136	1,164	27
28	Nurse Call Station	2000	3,544	91	20	177	86	738	28
29	Renovation Project	2000	398	10	20	20	10	81	29
30	Electrical Work	2001	1,427	37	20	71	34	288	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	5,044	31
32	Exit Door	2001	2,391	61	20	120	59	477	32
33	Renovation Design	2001	2,864	73	20	143	70	572	33
34	TOTAL (lines 1 thru 33)		\$ 2,082,481	\$ 65,162		\$ 69,091	\$ 3,929	\$ 1,124,299	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:

1/1/08

Ending:

12/31/08

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	\$ 65,162		\$ 69,091	\$ 3,929	\$ 1,124,299	1
2	Garage	2001	965	25	20	48	23	193	2
3	Drapery	2001	6,320	162	20	316	154	1,235	3
4	Install Drapery	2001	662	17	20	33	16	130	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	238	5
6	Gas Water Heater	2001	2,481	64	20	124	60	474	6
7	Compact Water Booster	2001	1,247	32	20	62	30	239	7
8	Drapery	2001	1,622	42	20	81	39	310	8
9	Install Roof	2001	4,357	112	20	218	106	833	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	182	10
11	Water Heater	2001	4,496	115	20	225	110	841	11
12	Replace Shingles	2001	923	24	20	46	22	173	12
13	Replace Refrig System	2001	1,092	28	20	55	27	202	13
14	Replace Shingles	2001	1,221	31	20	61	30	226	14
15	Flooring	2001	90	2	20	5	3	16	15
16	Parking Posts	2002	281	7	20	14	7	48	16
17	2 Exit Doors	2002	769	20	20	38	18	121	17
18	Roof Repair	2003	961	25	20	48	23	132	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	223	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	260	20
21	Duct Work	2003	2,598	67	20	130	63	336	21
22	Flooring	2003	3,190	82	20	160	78	412	22
23	Roof	2004	4,760	119	20	238	119	580	23
24	Kitchen Floor	2004	994	25	20	50	25	115	24
25	Kitchen Floor	2004	1,133	28	20	57	29	129	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	158	26
27	Rooftop Unit	2004	1,803	46	20	90	44	198	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	316	28
29	Lobby Rehab	2005	4,550	117	20	227	110	423	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	123	30
31	Back Doors	2005	2,310	59	20	116	57	215	31
32	Locks for Lobby	2005	873	22	20	44	22	81	32
33	Bathroom Repairs	2005	979	25	20	49	24	89	33
34	TOTAL (lines 1 thru 33)		\$ 2,144,851	\$ 66,757		\$ 72,210	\$ 5,453	\$ 1,133,550	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:

1/1/08

Ending:

12/31/08

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	\$ 66,757		\$ 72,210	\$ 5,453	\$ 1,133,550	1
2	Lobby Rehab	2005	959	25	20	48	23	87	2
3	Remodeling Project-Frt Bldg	2005	729	19	20	36	17	66	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	204	4
5	Ceiling Tile	2005	2,876	74	20	144	70	255	5
6	Front Lobby Renovation	2005	110	3	20	6	3	10	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	773	7
8	Carpet-Activity Room	2005	1,680	43	20	84	41	149	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	203	9
10	Dishroom Work	2005	796	20	20	40	20	67	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	53	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	48	12
13	Water Heater	2005	4,817	124	20	241	117	386	13
14	Ceiling Tiles	2005	604	15	20	30	15	47	14
15	Ceiling Tiles	2006	725	19	20	36	17	55	15
16	Condensing Unit	2006	1,040	27	20	52	25	63	16
17	Replace Ceilings	2006	6,769	174	20	338	164	383	17
18	Closet Wall Work	2006	890	23	20	45	22	50	18
19	Sidewalk	2006	7,888	202	20	394	192	447	19
20	Window Treatments	2006	1,504	39	20	75	36	82	20
21	Plumbing Services	2007	3,235	83	20	161	78	156	21
22	Picnic Pad	2007	2,123	54	20	106	52	102	22
23	Drapery, Valances	2007	600	57	20	30	(27)	87	23
24	Replace Water Heater	2007	1,184	379	20	59	(320)	616	24
25	Add Rock to Drive	2007	4,949	127	20	247	120	206	25
26	Water Booster	2007	215	20	20	11	(9)	31	26
27	Sidewalk	2007	1,298	415	20	65	(350)	675	27
28	RTU-Roof Top Unit	2007	444	42	20	22	(20)	64	28
29	Wall Pks/Emergency Lighting	2007	7,700	197	20	385	188	288	29
30	Cubicle Curtains	2007	5,848	150	20	292	142	219	30
31	Windows	2007	2,044	654	20	102	(552)	1,063	31
32	Kitchen Exhaust Duckwork	2007	2,218	57	20	111	54	78	32
33	Dining Room Flooring	2007	6,950	178	20	347	169	215	33
34	TOTAL (lines 1 thru 33)		\$ 2,229,740	\$ 70,354		\$ 76,451	\$ 6,097	\$ 1,140,778	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:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,229,740	\$ 70,354		\$ 76,451	\$ 6,097	\$ 1,140,778	1
2	Electrical Worl Alarm	2007	2,779	889	20	139	(750)	1,445	2
3	Alarm	2007	1,547	495	20	77	(418)	804	3
4	Landscaping Work	2007	2,050	195	20	103	(92)	297	4
5	Roof Top Units	2007	12,870	330	20	643	313	344	5
6	Generator Study	2007	1,776	46	20	89	43	47	6
7	Water Softener Maintenance	2007	3,750	96	20	187	91	100	7
8	Remodel Halls	2008	1,956	48	20	98	50	48	8
9	Nursing Station	2008	6,800	138	20	340	202	138	9
10	Cabinets	2008	3,190	1,914	20	159	(1,755)	1,914	10
11	Renovate Hallways	2008	2,368	43	20	118	75	43	11
12	Fence	2008	8,542	4,485	20	427	(4,058)	4,485	12
13	Landscaping Work	2008	718	377	20	36	(341)	377	13
14	Landscaping Work	2008	942	495	20	47	(448)	495	14
15	Landscaping Work	2008	735	386	20	37	(349)	386	15
16									16
17	Alarm System	2008	801	6	20	40	34	6	17
18	Borders	2008	1,361	7	20	68	61	7	18
19									19
20	New Walk	2008	1,268	4	20	63	59	4	20
21	Shower Room	2008	2,201	2	20	110	108	2	21
22	Shower Room	2008	1,633	2	20	82	80	2	22
23	Shower Room Door	2008	1,429	2	20	71	69	2	23
24	Dining Room Flooring	2007	37,289	956	20	1,864	908	1,076	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)		\$ 2,325,745	\$ 81,270		\$ 81,249	\$ (21)	\$ 1,152,800	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: 1/1/08 Ending: 12/31/08

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	\$ 88,425	\$ 14,424	\$ 14,814	\$ 390	10	\$ 70,973	71
72	Current Year Purchases	32,941	19,519	5,543	(13,976)	10	14,514	72
73	Fully Depreciated Assets	402,401				10	402,401	73
74								74
75	TOTALS	\$ 523,767	\$ 33,943	\$ 20,357	\$ (13,586)		\$ 487,888	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	2,775	77
78										78
79										79
80	TOTALS			\$ 5,408	\$ 339	\$ 589	\$ 250		\$ 5,238	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)		\$ 2,968,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 115,552	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 102,195	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (13,357)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,645,926	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				8,775			5
6					_____			6
7	TOTAL				\$ 8,775			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 37,971 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.

Facility Name & ID Number Sharon Health Care Elms# 0032789

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Sharon Health Care Elms# 0032789Report Period Beginning: 1/1/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 117,292	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>250,000</u>)	1,413,925		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,704		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	845,000		8
9	Other(specify): <u>Due From Medicare</u>	29,400		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,437,321	\$	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	423,743		15
16	Equipment, at Historical Cost	343,291		16
17	Accumulated Depreciation (book methods)	(404,213)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 362,821	\$	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,800,142	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,521	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,692		30
	Accrued Taxes Payable (excluding real estate taxes)	25,407		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,093		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,436		35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	1,668,610		36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,930,759	\$	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
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,930,759	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 869,383	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,800,142	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 650,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 650,195	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	219,188	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)	\$ 219,188	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)	\$ 869,383	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning: 1/1/08

Ending: 12/31/08

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	\$ 4,365,821	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,365,821	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***	37	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	1,149	28
28a	Misc Income	40	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,189	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,367,047	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	981,090	31
32	Health Care	1,506,880	32
33	General Administration	1,079,502	33
B. Capital Expense			
34	Ownership	244,315	34
C. Ancillary Expense			
35	Special Cost Centers	282,270	35
36	Provider Participation Fee	53,802	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,147,859	40
41	Income before Income Taxes (line 30 minus line 40)**	219,188	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 219,188	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: 1/1/08

Ending:

12/31/08

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	1,048	1,204	\$ 33,409	\$ 27.75	1
2	Assistant Director of Nursing	1,704	1,960	43,143	22.01	2
3	Registered Nurses					3
4	Licensed Practical Nurses	21,665	22,976	507,488	22.09	4
5	CNAs & Orderlies	54,225	57,325	624,035	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,596	6,174	57,669	9.34	10
11	Social Service Workers	3,888	4,160	63,537	15.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,358	15,448	206,675	13.38	15
16	Dishwashers					16
17	Maintenance Workers	2,556	2,758	80,391	29.15	17
18	Housekeepers	14,742	15,519	133,328	8.59	18
19	Laundry	8,436	8,997	79,746	8.86	19
20	Administrator	2,080	2,080	77,048	37.04	20
21	Assistant Administrator					21
22	Other Administrative	1,275	1,275	43,540	34.15	22
23	Office Manager					23
24	Clerical	5,584	5,798	91,300	15.75	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	1,941	2,173	22,090	10.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,098	147,847	\$ 2,063,399 *	\$ 13.96	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	148	\$ 8,083	1-3	35
36	Medical Director	116	7,469	9-3	36
37	Medical Records Consultant	14	405	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	40	1,799	10-3	40
41	Occupational Therapy Consultant	11	385	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	200	10-3	43
44	Activity Consultant	49	2,215	11-3	44
45	Social Service Consultant	56	2,519	12-3	45
46	Other(specify)				46
47	Psychiatric Director	128	11,039	12-3	47
48					48
49	TOTAL (lines 35 - 48)	662	\$ 35,914		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: 1/1/08

Ending: 12/31/08

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	\$ 77,048	Workers' Compensation Insurance	\$ 71,640	IDPH License Fee	\$	
Rick Duros	CFO	0	22,977	Unemployment Compensation Insurance	22,805	Advertising: Employee Recruitment	6,967	
Gary Weintraub	Legal	0	20,563	FICA Taxes	164,791	Health Care Worker Background Check		
				Employee Health Insurance	52,041	(Indicate # of checks performed <u>77</u>)	770	
				Employee Meals		Patient Background Checks <u>52</u>	520	
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees & Permits	2,894	
				Employee Retirement Plan Contribution	878	Dues & Subscriptions	451	
				Employee Benefits	4,465			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 120,588					
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
Redwood Management			\$ 150,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 150,000				Seminar Expense	1,609
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Frost,Ruttenberg&Rothblatt	Accounting		\$ 15,320				\$ 1,609	
Bisys	Accounting		355					
Pension Performance	Accounting		623					
Honkamp Krueger & Co	Accounting		932					
LTC Solutions	Computer		1,500					
Ivans	Computer		1,551					
Alloc-Sharon Complex	Computer		2,868					
Threshold Technologies	Computer		6,377					
Alpha Data Services	Data Processing		5,332					
Personnel Planners	Unemploymt Consult		1,680					
Count Me In	Computer		91					
Barton Managemt	Professional Fee		748					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 37,377					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sharon Health Care Elms

Report Period Beginning: 1/1/08 Ending:

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Painting & Decorating	2003	\$ 505	4	\$ 168	\$ 85							
2	Painting & Decorating	2004	98	4	33	33	16						
3	Painting & Decorating	2005	0	4	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	Painting & Decorating	2008	188	4				31	63	63	31		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,547		\$ 201	\$ 359	\$ 716	\$ 949	\$ 741	\$ 282	\$ 31	\$	\$

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? no
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. \$ 22,695 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. \$ 53,802
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? n/a
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. \$ 0
- (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.