

Facility Name & ID Number Sharon Health Care Elms

0032789 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	2,586			2,586	8	
9	SNF/PED					9	
10	ICF	26,173	540	240	26,953	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	28,759	540	240	29,539	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.58%

D. How many bed-hold days during this year were paid by the Department? 10 (Do not include bed-hold days in Section B.)

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/15/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 2,586

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Sharon Health Care Elms # 0032789 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	168,335	21,149	7,722	197,206		197,206		197,206		1
2	Food Purchase		186,301		186,301		186,301	(1,822)	184,479		2
3	Housekeeping	134,753		23,563	158,316		158,316		158,316		3
4	Laundry	91,823	20,876		112,699		112,699		112,699		4
5	Heat and Other Utilities			100,846	100,846		100,846	636	101,482		5
6	Maintenance	99,950		77,906	177,856		177,856	799	178,655		6
7	Other (specify):*										7
8	TOTAL General Services	494,861	228,326	210,037	933,224		933,224	(387)	932,837		8
	B. Health Care and Programs										
9	Medical Director			14,793	14,793		14,793		14,793		9
10	Nursing and Medical Records	1,366,062	128,773	11,915	1,506,750		1,506,750		1,506,750		10
10a	Therapy										10a
11	Activities	53,647	2,895	1,023	57,565		57,565		57,565		11
12	Social Services	86,816	17,624		104,440		104,440		104,440		12
13	CNA Training										13
14	Program Transportation			4,871	4,871		4,871	(4,871)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,506,525	149,292	32,602	1,688,419		1,688,419	(4,871)	1,683,548		16
	C. General Administration										
17	Administrative	124,249		250,000	374,249		374,249	31,943	406,192		17
18	Directors Fees										18
19	Professional Services			34,625	34,625		34,625	820	35,445		19
20	Dues, Fees, Subscriptions & Promotions			7,751	7,751		7,751	(3,198)	4,553		20
21	Clerical & General Office Expenses	102,095		137,638	239,733		239,733	(92,359)	147,374		21
22	Employee Benefits & Payroll Taxes			345,437	345,437		345,437	9,412	354,849		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,893	4,893		4,893		4,893		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			66,549	66,549		66,549	102	66,651		26
27	Other (specify):*							5,278	5,278		27
28	TOTAL General Administration	226,344		846,893	1,073,237		1,073,237	(48,002)	1,025,235		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,227,730	377,618	1,089,532	3,694,880		3,694,880	(53,260)	3,641,620		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:

1/1/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			103,021	103,021		103,021	11,555	114,576			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							64,683	64,683			32
33	Real Estate Taxes			47,589	47,589		47,589	3,986	51,575			33
34	Rent-Facility & Grounds			105,226	105,226		105,226	(102,172)	3,054			34
35	Rent-Equipment & Vehicles			34,830	34,830		34,830		34,830			35
36	Other (specify):*											36
37	TOTAL Ownership			290,666	290,666		290,666	(21,948)	268,718			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,232	420,925	429,157		429,157		429,157			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		8,232	474,580	482,812		482,812		482,812			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,227,730	385,850	1,854,778	4,468,358		4,468,358	(75,208)	4,393,150			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(48,771)	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	(1,822)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,871)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,594)	21		19
20	Contributions	(2,327)	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	(84,438)	21		24
25	Fund Raising, Advertising and Promotional	(3,213)	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	(16,544)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,580)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	92,372		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 92,372		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (75,208)		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: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Salary	\$ (16,231)	17	1
2	Deferred Maintenance	(313)	6	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				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	(16,544)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Elms# 0032789

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(1,822)	0	0	0	0	0	0	0	0	0	0	(1,822)	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	636	0	0	0	0	0	0	636	5
6	Maintenance	(313)	0	0	0	1,112	0	0	0	0	0	0	799	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,135)	0	0	0	1,748	0	0	0	0	0	0	(387)	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	(4,871)	0	0	0	0	0	0	0	0	0	0	(4,871)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,871)	0	0	0	0	0	0	0	0	0	0	(4,871)	16
	C. General Administration													
17	Administrative	(16,231)	0	0	48,174	0	0	0	0	0	0	0	31,943	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	820	0	0	0	0	0	0	0	0	820	19
20	Fees, Subscriptions & Promotions	(3,213)	0	0	0	15	0	0	0	0	0	0	(3,198)	20
21	Clerical & General Office Expenses	(92,359)	0	0	0	0	0	0	0	0	0	0	(92,359)	21
22	Employee Benefits & Payroll Taxes	0	0	0	9,412	0	0	0	0	0	0	0	9,412	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	102	0	0	0	0	0	0	102	26
27	Other (specify):*	0	0	0	0	5,278	0	0	0	0	0	0	5,278	27
28	TOTAL General Administration	(111,803)	0	820	57,586	5,395	0	0	0	0	0	0	(48,002)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,809)	0	820	57,586	7,143	0	0	0	0	0	0	(53,260)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Elms# 0032789

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(48,771)	0	60,326	0	0	0	0	0	0	0	0	11,555	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	64,683	0	0	0	0	0	0	0	0	64,683	32
33	Real Estate Taxes	0	0	1,816	0	2,170	0	0	0	0	0	0	3,986	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(11,587)	0	0	0	0	0	0	(102,172)	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	(48,771)	0	36,240	0	(9,417)	0	0	0	0	0	0	(21,948)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(167,580)	0	37,060	57,586	(2,274)	0	0	0	0	0	0	(75,208)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Fees	\$	Peoria Forest Partnership	100.00%	\$ 820	\$ 820	15
16	V							16
17	V	30 Depreciation		Peoria Forest Partnership		60,326	60,326	17
18	V	32 Interest		Peoria Forest Partnership		64,683	64,683	18
19	V	33 Real Estate Tax		Peoria Forest Partnership		1,816	1,816	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			\$ 127,645	\$ * 37,060	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$	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				7,348	7,348	20
21	V							21
22	V							22
23	V							23
24	V	17 Salary-S. Aron				26,552	26,552	24
25	V	22 Payroll Taxes-SA				2,064	2,064	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V	17 Management Fees						31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 57,586	\$ * 57,586	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Barton Management	100.00%	\$ 636	\$	636	15
16	V	6 Repairs and Maint		Barton Management		1,112		1,112	16
17	V	20 Dues, Fees Subscriptions		Barton Management		15		15	17
18	V	26 Insurance		Barton Management		102		102	18
19	V	27 Emp. Ben. Gen. Admin		Barton Management		5,278		5,278	19
20	V	33 Real Estate Taxes		Barton Management		2,170		2,170	20
21	V	34 Rent Office Space		Barton Management		5,313		5,313	21
22	V								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			\$ 14,626	\$ *	(2,274)	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:

1/1/09

Ending:

12/31/09

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	8	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	14,580	17-1
6	Stan Aron	Owner	Administrative	15.28	See Attached	3	5.00	Alloc Rdwd	26,552	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	\$ 77,335	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:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Bed Size	585	4	\$ 4,895	\$ 98	\$ 820	1
2									2
3	30	Depreciation	Bed Size	585	4	360,112	98	60,326	3
4	32	Interest	Bed Size	585	4	386,115	98	64,683	4
5	33	Real Estate Tax	Bed Size	585	4	10,841	98	1,816	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					\$ 761,963	\$	\$ 127,645	25

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/09

Ending: 12/31/09

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	33,985		8	7,348	5
6									6
7	Salary-S. Aron	Avg Hours Worked	14	4	106,208	106,208	4	26,552	7
8	Payroll Taxes-SA	Avg Hours Worked	14	4	8,255		4	2,064	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				\$ 248,448	\$ 206,208		\$ 57,586	25

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/09

Ending: 12/31/09

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, 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	5	Utilities	Rental Income	284,800	8	\$ 10,723	\$ 16,900	\$ 636	1
2	6	Repairs ans Maint	Rental Income	284,800	8	18,733	16,900	1,112	2
3	20	Dues,Fees,Subscriptions	Rental Income	284,800	8	250	16,900	15	3
4	26	Insurance	Rental Income	284,800	8	1,721	16,900	102	4
5	27	Emp.Ben.Gen.Admin.	Rental Income	284,800	8	88,949	16,900	5,278	5
6	33	Real Estate Tax	Rental Income	284,800	8	36,568	16,900	2,170	6
7	34	Rent Office Space	Rental Income	284,800	8	89,537	16,900	5,313	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					\$ 246,481	\$	\$ 14,626	25

Facility Name & ID Number

Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/09

Ending:

12/31/09

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		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								64,683	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ 64,683	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 64,683	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	43,093	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.)		\$	48,657	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,564	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	46,011	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.		\$	51,575	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	38,448	8	
	2005	40,737	9	
	2006	44,371	10	
	2007	44,379	11	
	2008	45,566	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1987	5,207	165	20		(165)	3,653	9
10	Various		1988	4,581	124	20	229	105	3,337	10
11	Various		1989	1,877	60	20	94	34	1,214	11
12	Various		1990	6,666	134	20	333	199	5,054	12
13	Various		1991	23,422	713	20	1,171	458	14,196	13
14	Various		1992	19,136	575	20	957	382	10,999	14
15	Various		1994	9,731	250	20	487	237	3,827	15
16	Various		1995	2,723	69	20	136	67	1,001	16
17	Various		1996	4,103	106	20	206	100	1,428	17
18	Various		1997	19,387	497	20	970	473	6,122	18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	98	1991		\$ 1,862,634	\$	35	\$ 53,218	\$ 53,218	\$
5		1991		39,368		31.5	1,250	1,250	
6									
7									
8									
Improvement Type**									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	60,326		60,327	1	1,117,670	68
69								69
70		\$ 1,998,834	\$ 63,019		\$ 64,910	\$ 1,891	\$ 1,168,501	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:

1/1/09

Ending:

12/31/09

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	\$ 63,019		\$ 64,910	\$ 1,891	\$ 1,168,501	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,579	2
3	Lawn Repair	1998	625	16	20	31	15	186	3
4	Water Softener	1998	1,700	44	20	85	41	505	4
5	Phone Shelf	1998	207	5	20	10	5	60	5
6	Rooftop Unit	1998	1,472	38	20	74	36	433	6
7	Amer II Minuteman	1998	272	7	20	14	7	80	7
8	Patio Ramp	1998	538	14	20	27	13	157	8
9	Roofing	1998	3,187	82	20	159	77	917	9
10	Drapes	1998	5,805	149	20	290	141	1,644	10
11	Heat Condenser	1999	1,203	31	20	60	29	334	11
12	Windows	1999	81	2	20	4	2	23	12
13	Garage Door	1999	142	4	20	7	3	40	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	1,028	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	714	15
16	Windows	1999	481	12	20	24	12	132	16
17	Concrete Parking Lot	1999	969	25	20	48	23	252	17
18	Roof	1999	996	26	20	50	24	260	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	513	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	412	20
21	Renovation Design	2000	2,561	66	20	128	62	628	21
22	Renovation Design	2000	1,950	50	20	98	48	469	22
23	Garbage Disposal	2000	791	20	20	40	20	188	23
24	Water Heater	2000	345	9	20	17	8	82	24
25	Parking Spaces	2000	89	2	20	4	2	20	25
26	Parking Spaces	2000	3,720	95	20	186	91	878	26
27	Drapery	2000	5,588	143	20	279	136	1,307	27
28	Nurse Call Station	2000	3,544	91	20	177	86	829	28
29	Renovation Project	2000	398	10	20	20	10	92	29
30	Electrical Work	2001	1,427	37	20	71	34	325	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	5,692	31
32	Exit Door	2001	2,391	61	20	120	59	538	32
33	Renovation Design	2001	2,864	73	20	143	70	646	33
34	TOTAL (lines 1 thru 33)		\$ 2,082,481	\$ 65,163		\$ 69,091	\$ 3,928	\$ 1,189,464	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:

1/1/09

Ending:

12/31/09

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	\$ 65,163		\$ 69,091	\$ 3,928	\$ 1,189,464	1
2	Garage	2001	965	25	20	48	23	218	2
3	Drapery	2001	6,320	162	20	316	154	1,397	3
4	Install Drapery	2001	662	17	20	33	16	147	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	269	5
6	Gas Water Heater	2001	2,481	64	20	124	60	538	6
7	Compact Water Booster	2001	1,247	32	20	62	30	271	7
8	Drapery	2001	1,622	42	20	81	39	352	8
9	Install Roof	2001	4,357	112	20	218	106	945	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	207	10
11	Water Heater	2001	4,496	115	20	225	110	956	11
12	Replace Shingles	2001	923	24	20	46	22	196	12
13	Replace Refrig System	2001	1,092	28	20	55	27	230	13
14	Replace Shingles	2001	1,221	31	20	61	30	257	14
15	Flooring	2001	90	2	20	5	3	19	15
16	Parking Posts	2002	281	7	20	14	7	56	16
17	2 Exit Doors	2002	769	20	20	38	18	141	17
18	Roof Repair	2003	961	25	20	48	23	157	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	266	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	309	20
21	Duct Work	2003	2,598	67	20	130	63	402	21
22	Flooring	2003	3,190	82	20	160	78	494	22
23	Roof	2004	4,760	119	20	238	119	699	23
24	Kitchen Floor	2004	994	25	20	50	25	140	24
25	Kitchen Floor	2004	1,133	28	20	57	29	157	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	192	26
27	Rooftop Unit	2004	1,803	46	20	90	44	245	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	397	28
29	Lobby Rehab	2005	4,550	117	20	227	110	540	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	157	30
31	Back Doors	2005	2,310	59	20	116	57	274	31
32	Locks for Lobby	2005	873	22	20	44	22	104	32
33	Bathroom Repairs	2005	979	25	20	49	24	114	33
34	TOTAL (lines 1 thru 33)		\$ 2,144,851	\$ 66,758		\$ 72,210	\$ 5,452	\$ 1,200,310	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:

1/1/09

Ending:

12/31/09

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	\$ 66,758		\$ 72,210	\$ 5,452	\$ 1,200,310	1
2	Lobby Rehab	2005	959	25	20	48	23	112	2
3	Remodeling Project-Frt Bldg	2005	729	19	20	36	17	85	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	263	4
5	Ceiling Tile	2005	2,876	74	20	144	70	329	5
6	Front Lobby Renovation	2005	110	3	20	6	3	13	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	997	7
8	Carpet-Activity Room	2005	1,680	43	20	84	41	192	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	265	9
10	Dishroom Work	2005	796	20	20	40	20	87	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	70	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	63	12
13	Water Heater	2005	4,817	124	20	241	117	510	13
14	Ceiling Tiles	2005	604	15	20	30	15	62	14
15	Ceiling Tiles	2006	725	19	20	36	17	74	15
16	Condensing Unit	2006	1,040	27	20	52	25	90	16
17	Replace Ceilings	2006	6,769	174	20	338	164	557	17
18	Closet Wall Work	2006	890	23	20	45	22	73	18
19	Sidewalk	2006	7,888	202	20	394	192	649	19
20	Window Treatments	2006	1,504	39	20	75	36	121	20
21	Plumbing Services	2007	3,235	83	20	161	78	239	21
22	Picnic Pad	2007	2,123	54	20	106	52	157	22
23	Drapery, Valances	2007	600	51	20	30	(21)	138	23
24	Replace Water Heater	2007	1,184	227	20	59	(168)	843	24
25	Add Rock to Drive	2007	4,949	127	20	247	120	333	25
26	Water Booster	2007	215	18	20	11	(7)	50	26
27	Sidewalk	2007	1,298	249	20	65	(184)	924	27
28	RTU-Roof Top Unit	2007	444	38	20	22	(16)	102	28
29	Wall Pks/Emergency Lighting	2007	7,700	197	20	385	188	485	29
30	Cubicle Curtains	2007	5,848	150	20	292	142	369	30
31	Windows	2007	2,044	392	20	102	(290)	1,455	31
32	Kitchen Exhaust Duckwork	2007	2,218	57	20	111	54	135	32
33	Dining Room Flooring	2007	6,950	178	20	347	169	394	33
34	TOTAL (lines 1 thru 33)		\$ 2,229,740	\$ 69,763		\$ 76,451	\$ 6,688	\$ 1,210,546	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:

1/1/09

Ending:

12/31/09

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	\$ 69,763		\$ 76,451	\$ 6,688	\$ 1,210,546	1
2	Electrical Worl Alarm	2007	2,779	534	20	139	(395)	1,979	2
3	Alarm	2007	1,547	297	20	77	(220)	1,101	3
4	Landscaping Work	2007	2,050	175	20	103	(72)	473	4
5	Roof Top Units	2007	12,870	330	20	643	313	674	5
6	Generator Study	2007	1,776	46	20	89	43	93	6
7	Water Softener Maintenance	2007	3,750	96	20	187	91	196	7
8	Remodel Halls	2008	1,956	50	20	98	48	98	8
9	Nursing Station	2008	6,800	174	20	340	166	313	9
10	Cabinets	2008	3,190	510	20	159	(351)	2,424	10
11	Renovate Hallways	2008	2,368	61	20	118	57	104	11
12	Fence	2008	8,542	406	20	427	21	4,890	12
13	Landscaping Work	2008	718	34	20	36	2	411	13
14	Landscaping Work	2008	942	45	20	47	2	540	14
15	Landscaping Work	2008	735	35	20	37	2	421	15
16	Alarm System	2008	801	21	20	40	19	27	16
17	Borders	2008	1,361	35	20	68	33	42	17
18	New Walk	2008	1,268	33	20	63	30	37	18
19	Shower Room	2008	2,201	56	20	110	54	59	19
20	Shower Room	2008	1,633	42	20	82	40	44	20
21	Shower Room Door	2008	1,429	37	20	71	34	38	21
22	Dining Room Flooring	2007	37,289	956	20	1,864	908	2,032	22
23	Drywall Removal	2009	6,200	153	20	310	157	153	23
24	Roof Deck-Insulation	2009	23,682	532	20	1,184	652	532	24
25	Picnic Shelter Fence	2009	5,300	2,783	20	265	(2,518)	2,783	25
26	Generator	2009	84,443	1,897	20	4,222	2,325	1,897	26
27	Remodel Shower Room	2009	1,522	21	20	76	55	21	27
28	Exhaust Fan	2009	4,700	4,700	20	235	(4,465)	4,700	28
29	Parking Lot-Swale	2009	750	394	20	37	(357)	394	29
30	Regrade Trenches	2009	834	438	20	42	(396)	438	30
31	Vinyl Fence	2009	2,777	1,458	20	139	(1,319)	1,458	31
32	Concrete-Parking Lot	2009	14,238	7,475	20	712	(6,763)	7,475	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,470,191	\$ 93,587		\$ 88,471	\$ (5,116)	\$ 1,246,393	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,470,191	\$ 93,587		\$ 88,471	\$ (5,116)	\$ 1,246,393	1
2	Concrete-Patio,Walkway	2009	7,037	3,691	20	352	(3,339)	3,691	2
3	Shower Room-Remodel	2009	788	9	20	39	30	9	3
4	Regrade, Seed Around Shelter	2009	1,200	630	20	60	(570)	630	4
5	Tile-Downspouts	2009	1,356	712	20	68	(644)	712	5
6	Replace Cable Lighting	2009	1,202	12	20	60	48	12	6
7	Roof Top Unit w/ Gas Heat	2009	8,600	46	20	430	384	46	7
8	Roof Repair	2009	751	1	20	38	37	1	8
9	Park Bench Canopy	2008	7,488	1,198	20	374	(824)	5,691	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	TOTAL (lines 1 thru 33)		\$ 2,498,613	\$ 99,886		\$ 89,892	\$ (9,994)	\$ 1,257,185	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:

1/1/09

Ending:

12/31/09

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	\$ 76,523	\$ 12,665	\$ 14,022	\$ 1,357	10	\$ 57,060	71
72	Current Year Purchases	38,538	38,538	7,655	(30,883)	10	38,538	72
73	Fully Depreciated Assets	440,247				10	440,247	73
74								74
75	TOTALS	\$ 555,308	\$ 51,203	\$ 21,677	\$ (29,526)		\$ 535,845	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	170	589	419	5	2,945	77
78		2008 Chevy Express	2009	10,244	10,244	2,049	(8,195)	5	10,244	78
79		Tractor	2009	1,844	1,844	369	(1,475)	5	1,844	79
80	TOTALS			\$ 17,496	\$ 12,258	\$ 3,007	\$ (9,251)		\$ 17,496	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)	\$ 3,184,655	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,347	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,576	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (48,771)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,810,526	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				5,313			5
6								6
7	TOTAL				\$ 5,313			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 34,830 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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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

0032789

Report Period Beginning: 1/1/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 294,419	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>300,000</u>)	692,809		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,339		6
7	Other Prepaid Expenses	1,375		7
8	Accounts Receivable (owners or related parties)	575,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,596,942	\$	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	596,608		15
16	Equipment, at Historical Cost	386,432		16
17	Accumulated Depreciation (book methods)	(507,234)		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)	\$ 475,806	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,072,748	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 87,059	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,731		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,575		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,011		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>	1,195,918		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,379,294	\$	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)	\$ 1,379,294	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 693,454	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,072,748	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 869,383	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 869,383	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,929)	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)	\$ (175,929)	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)	\$ 693,454	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 4,273,138	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,273,138	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***	15,459	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,459	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	145	28
28a	Vending Income	(349)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (204)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,288,393	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	933,224	31
32	Health Care	1,688,419	32
33	General Administration	1,073,237	33
B. Capital Expense			
34	Ownership	290,666	34
C. Ancillary Expense			
35	Special Cost Centers	429,157	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)*	\$ 4,468,358	40
41	Income before Income Taxes (line 30 minus line 40)**	(179,965)	41
42	Income Taxes	4,036	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (175,929)	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:

1/1/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,046	2,182	\$ 56,639	\$ 25.96	1
2	Assistant Director of Nursing	1,768	2,040	44,559	21.84	2
3	Registered Nurses					3
4	Licensed Practical Nurses	23,298	24,719	512,273	20.72	4
5	CNAs & Orderlies	62,045	65,738	677,456	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,663	6,060	53,647	8.85	10
11	Social Service Workers	5,693	6,141	86,816	14.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,233	12,347	168,335	13.63	15
16	Dishwashers					16
17	Maintenance Workers	4,748	5,024	99,950	19.89	17
18	Housekeepers	14,435	15,420	134,753	8.74	18
19	Laundry	10,165	11,085	91,823	8.28	19
20	Administrator	2,080	2,080	78,856	37.91	20
21	Assistant Administrator					21
22	Other Administrative	1,248	1,248	66,754	53.49	22
23	Office Manager					23
24	Clerical	6,144	6,488	132,222	20.38	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	2,063	2,295	23,647	10.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,629	162,867	\$ 2,227,730 *	\$ 13.68	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	140	\$ 7,722	1-3	35
36	Medical Director	228	14,793	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	97	4,385	10-3	40
41	Occupational Therapy Consultant	102	4,601	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,129	10-3	43
44	Activity Consultant	23	1,023	11-3	44
45	Social Service Consultant	162	4,043	12-3	45
46	Other(specify)				46
47	Psychiatric Director	156	13,581	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,029	\$ 53,077		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

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	\$ 78,856	Workers' Compensation Insurance	\$ 68,925	IDPH License Fee	\$	
Rick Duros	COO	7.91	24,039	Unemployment Compensation Insurance	16,844	Advertising: Employee Recruitment	2,327	
Gary Weintraub	Legal	3.07	21,354	FICA Taxes	178,733	Health Care Worker Background Check		
				Employee Health Insurance	75,886	(Indicate # of checks performed 49)	490	
				Employee Meals		Patient Background Checks	44	
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees & Permits	937	
				Employee Retirement Plan Contribution	1,132	Dues & Subscriptions	359	
				Employee Benefits	13,329			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 124,249					
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			\$ 250,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 250,000				Seminar Expense	4,893
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Frost,Ruttenberg&Rothblatt	Accounting		\$ 9,175				line 24, col. 8)	
Alloc-Sharon Complex	Accounting		755					
Barton Managemt-alloc	Accounting		347					
Honkamp Krueger & Co	Accounting		1,746					
Diversified Digital Tech	Computer		335					
Ivans	Computer		862					
Alloc-Sharon Complex	Computer		4,794					
Alloc-Barton Management	Computer		5,720					
Alpha Data Services	Data Processing		5,666					
Personnel Planners	Unemploymt Consult		1,860					
Barton Managemt	Professional Fee		3,254					
Barton Managemt	Legal Fee		111					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 34,625					

* 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	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting & Decorating	2003	\$ 505	4	\$ 85	\$	\$	\$	\$	\$	\$	\$												
2	Painting & Decorating	2004	98	4	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		\$ 359	\$ 716	\$ 949	\$ 741	\$ 282	\$ 31	\$	\$												

Facility Name & ID Number Sharon Health Care Elms

0032789

Report Period Beginning:

1/1/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes, only CNA's
- (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. \$ 24,873 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. \$ 53,655
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: _____
- (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.