

Facility Name & ID Number Sharon Health Care Willows

0032797 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	219	Intermediate (ICF)	219	79,935	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	219	TOTALS	219	79,935	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					8
9	SNF/PED					9
10	ICF	68,879	372	731	69,982	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,879	372	731	69,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.55%

D. How many bed-hold days during this year were paid by the Department? N/A (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 08/15/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/15/1987 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Sharon Health Care Willows # 0032797 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	353,296	51,456	11,222	415,974		415,974		415,974		1
2	Food Purchase		474,482		474,482		474,482	(25)	474,457		2
3	Housekeeping	432,288	54,906		487,194		487,194		487,194		3
4	Laundry	133,022	28,197		161,219		161,219		161,219		4
5	Heat and Other Utilities			223,517	223,517		223,517	897	224,414		5
6	Maintenance	84,046	45,193	123,773	253,012		253,012	47,447	300,459		6
7	Other (specify):*										7
8	TOTAL General Services	1,002,652	654,234	358,512	2,015,398		2,015,398	48,319	2,063,717		8
	B. Health Care and Programs										
9	Medical Director			28,800	28,800		28,800		28,800		9
10	Nursing and Medical Records	1,731,104	123,210	22,454	1,876,768		1,876,768	(23,865)	1,852,903		10
10a	Therapy	189,031			189,031		189,031		189,031		10a
11	Activities	168,177	6,871	3,782	178,830		178,830		178,830		11
12	Social Services	278,418		8,665	287,083		287,083		287,083		12
13	CNA Training										13
14	Program Transportation			12,470	12,470		12,470		12,470		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,366,730	130,081	76,171	2,572,982		2,572,982	(23,865)	2,549,117		16
	C. General Administration										
17	Administrative	169,821		276,373	446,194		446,194	(249,333)	196,861		17
18	Directors Fees										18
19	Professional Services			50,555	50,555		50,555	217	50,772		19
20	Dues, Fees, Subscriptions & Promotions			10,133	10,133		10,133	(2,871)	7,262		20
21	Clerical & General Office Expenses	227,391	3,798	56,852	288,041		288,041	(11,361)	276,680		21
22	Employee Benefits & Payroll Taxes			614,248	614,248		614,248		614,248		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,723	4,723		4,723		4,723		24
25	Other Admin. Staff Transportation			3,172	3,172		3,172		3,172		25
26	Insurance-Prop.Liab.Malpractice			138,254	138,254		138,254	175	138,429		26
27	Other (specify):*							2,325	2,325		27
28	TOTAL General Administration	397,212	3,798	1,154,310	1,555,320		1,555,320	(260,848)	1,294,472		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,766,594	788,113	1,588,993	6,143,700		6,143,700	(236,394)	5,907,306		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			126,728	126,728		126,728	151,065	277,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							131,602	131,602			32
33	Real Estate Taxes			119,398	119,398		119,398	9,789	129,187			33
34	Rent-Facility & Grounds			829,577	829,577		829,577	(818,497)	11,080			34
35	Rent-Equipment & Vehicles			31,338	31,338		31,338		31,338			35
36	Other (specify):*											36
37	TOTAL Ownership			1,107,041	1,107,041		1,107,041	(526,041)	581,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,686	5,686		5,686	(5,686)	0			41
42	Provider Participation Fee			119,903	119,903		119,903		119,903			42
43	Other (specify):*			2,318	2,318		2,318	(2,318)	(0)			43
44	TOTAL Special Cost Centers			127,907	127,907		127,907	(8,004)	119,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,766,594	788,113	2,823,941	7,378,648		7,378,648	(770,439)	6,608,209			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(777)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,254	30		9
10	Interest and Other Investment Income	(9,102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(9,219)	21		19
20	Contributions	(3,455)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,092)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(333)	20		28
29	Other-Attach Schedule	11,876			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 3,126		\$	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)	(773,565)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (773,565)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (770,439)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Sharon Health Care Willows

ID# 0032797

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (50)	21	1
2	Vending Expense	(5,686)	41	2
3	Veterans Pharmacy	(22,714)	10	3
4	Veterans Doctors Visits	(1,026)	10	4
5	Marketing	(2,318)	43	5
6	Additional Repairs and Maintenance	50,398	06	6
7	Veterans Lab Fees	(100)	10	7
8	Deferred Maintenance	604	06	8
9	Resident Clothing	(25)	10	9
10	Capitalized R & M	(6,375)	06	10
11	Barton Management Fees	(833)	19	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	11,876		49

Sharon Health Care Willows

ID# 0032797

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Willows# 0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(25)											(25)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(777)				1,674							897	5
6	Maintenance	44,627				2,820							47,447	6
7	Other (specify):*													7
8	TOTAL General Services	43,825				4,494							48,319	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23,865)											(23,865)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(23,865)											(23,865)	16
	C. General Administration													
17	Administrative				(249,333)								(249,333)	17
18	Directors Fees													18
19	Professional Services	(833)		1,050									217	19
20	Fees, Subscriptions & Promotions	(3,788)		917									(2,871)	20
21	Clerical & General Office Expenses	(11,361)											(11,361)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					175							175	26
27	Other (specify):*				2,220	105							2,325	27
28	TOTAL General Administration	(15,982)		1,967	(247,113)	280							(260,848)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	3,978		1,967	(247,113)	4,774							(236,394)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Willows# 0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	16,254		134,811									151,065	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,102)		140,704									131,602	32
33	Real Estate Taxes			4,021		5,768							9,789	33
34	Rent-Facility & Grounds			(801,540)		(16,957)							(818,497)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	7,152		(522,004)		(11,189)							(526,041)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(5,686)											(5,686)	41
42	Provider Participation Fee													42
43	Other (specify):*	(2,318)											(2,318)	43
44	TOTAL Special Cost Centers	(8,004)											(8,004)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	3,126		(520,037)	(247,113)	(6,415)							(770,439)	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%	\$ 1,050	\$ 1,050
16	V	20 DUES, FEES, SUBS.		PEORIA FOREST PARTNERSHIP		917	917
17	V	30 DEPRECIATION		PEORIA FOREST PARTNERSHIP		134,811	134,811
18	V	32 INTEREST		PEORIA FOREST PARTNERSHIP		140,704	140,704
19	V	33 REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		4,021	4,021
20	V	34 RENT	801,540	PEORIA FOREST PARTNERSHIP			(801,540)
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 801,540			\$ 281,503	\$ * (520,037)

* 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				18,056	18,056	19
20	V	27 PAYROLL TAXES-JS				1,483	1,483	20
21	V							21
22	V	17 SALARY-S. ARON				8,974	8,974	22
23	V	27 PAYROLL TAXES-SA				737	737	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	17 MANAGEMENT FEES	276,363				(276,363)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 276,363			\$ 29,250	\$ * (247,113)	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 INC.	100.00%	\$ 1,674	\$ 1,674
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		2,820	2,820
17	V	26 INSURANCE		BARTON MANAGEMENT INC.		175	175
18	V	27 EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		105	105
19	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.		5,768	5,768
20	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.		10,043	10,043
21	V	0					
22	V	0					
23	V						
24	V						
25	V						
26	V						
27	V	34 RENT	27,000	BARTON MANAGEMENT INC.			(27,000)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 27,000			\$ 20,585	\$ * (6,415)

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

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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	Shareholder	Administrative	17.49	See Attached	6.5	13.83%	Allocated	\$ 18,056	17-7	1
2	Rick Duros	Shareholder	Administrative	9.03	See Attached	5	10.00%				2
3	Gary Weintraub	Shareholder	Legal	11.23	See Attached	4	9.76%				3
4	Elisa Shlofrock-Zusman	Shareholder	Clerical	13.66	See Attached	5	11.90%				4
5	Stan Aron	Shareholder	Administrative	17.43	See Attached	3.5	6.36%	Allocated	8,974	17-7	5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										10
11	the Il. Dept. of HFS.										11
12											12
13								TOTAL	\$ 27,030		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	\$ 2,805	\$ 219	\$ 1,050	1
2	20	DUES, FEES, SUBS.	BED SIZE	585	4	2,450	219	917	2
3	30	DEPRECIATION	BED SIZE	585	4	360,112	219	134,811	3
4	32	INTEREST	BED SIZE	585	4	375,852	219	140,704	4
5	33	REAL ESTATE TAX	BED SIZE	585	4	10,741	219	4,021	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					\$ 751,960	\$	\$ 281,503	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	36	6	100,000	100,000	6.50	18,056	5
6	27	PAYROLL TAXES-JS	AVG HOURS WORKED	36	6	8,211		6.50	1,483	6
7									7	
8	17	SALARY-S. ARON	AVG HOURS WORKED	39	5	100,000	100,000	3.50	8,974	8
9	27	PAYROLL TAXES-SA	AVG HOURS WORKED	39	5	8,217		3.50	737	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					\$ 216,428	\$ 200,000	\$	29,250	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BARTON MANAGEMENT INC.
 Street Address 465 CENTRAL AVE.
 City / State / Zip Code NORTHFIELD, IL 60093
 Phone Number (847) 441-8200
 Fax Number (847) 441-0800

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAILABLE DAYS	562,164	9	\$ 11,770	\$ 79,935	\$ 1,674	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	562,164	9	19,835	79,935	2,820	2
3	26	INSURANCE	AVAILABLE DAYS	562,164	9	1,231	79,935	175	3
4	27	EMP. BEN. GEN. ADMIN	AVAILABLE DAYS	562,164	9	739	79,935	105	4
5	33	REAL ESTATE TAXES	AVAILABLE DAYS	562,164	9	40,562	79,935	5,768	5
6	34	RENT OFFICE SPACE	AVAILABLE DAYS	562,164	9	70,633	79,935	10,043	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					\$ 144,770	\$	\$ 20,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

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Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

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Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

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Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	See Supplemental Schedule										5							
Working Capital																		
6											6							
7											7							
8	See Supplemental Schedule										8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10	Interest Income		X							(9,102)	10							
11	Allocated from Peorie		X							140,704	11							
12											12							
13	See Supplemental Schedule										13							
14	TOTAL Non-Facility Related					\$	\$			\$ 131,602	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 131,602	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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										
6										6										
7	TOTAL Long-Term																			
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	100,867	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.)		\$	118,294	2
3. Under or (over) accrual (line 2 minus line 1).		\$	17,427	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,760	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.		\$	129,187	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	84,742	8	
	2006	88,248	9	
	2007	91,720	10	
	2008	97,929	11	
	2009	108,505	12	
2010 Accrual = \$108,505 x 1.03 = \$111,760				
Allocated from Peoria Forest Partnership - \$4,021				
Allocated from Barton Management - \$5,768				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Willows COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032797

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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>13-25-427-012</u>	<u>Long Term Care Facility</u>	\$ <u>52,344.32</u>	\$ <u>52,344.32</u>
2.	<u>13-25-427-009</u>	<u>Long Term Care Facility</u>	\$ <u>56,160.56</u>	\$ <u>56,160.56</u>
3.	<u>See Attached</u>	<u>Peoria Forest Allocation</u>	\$ <u>10,741.34</u>	\$ <u>4,021.12</u>
4.	<u>See Attached</u>	<u>Barton Management Allocation</u>	\$ <u>40,561.52</u>	\$ <u>5,767.50</u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>159,807.74</u></u>	\$ <u><u>118,293.50</u></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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ 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 Pines - Facility 116 Beds

Sharon Healthcare Woods - Facility 152 Beds

Sharon Healthcare Elms - Facility - 98 Beds

Peoria Forest Partnership - Dietary Building

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>239,590</u>	<u>1</u>
2	<u>Allocated from Peoria Forest Partnership</u>			<u>13,462</u>	<u>2</u>
3	TOTALS			\$ <u>253,052</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1988	12,982		20			12,276
10	Various		1990	15,966		20	385	385	14,906
11	Various		1991	1,595		20	80	80	1,461
12	Various		1992	13,429		20	621	621	11,861
13	Various		1993	5,656		20	283	283	4,782
14	Various		1994	3,579		20	179	179	2,876
15	Various		1995	29,692		20	1,485	1,485	23,112
16	Various		1996	13,113		20	656	656	9,554
17	Various		1997	189,520		20	9,476	9,476	131,191
18	Various		1998	45,613		20	2,281	2,281	28,318
19	Various		1999	24,560		20	1,228	1,228	13,951
20	Various		2000	33,805		20	1,690	1,690	17,629
21	Various		2001	62,770		20	3,139	3,139	29,597
22	Various		2002	11,323		20	641	641	5,425
23	Various		2003	30,154		20	2,887	2,887	21,144
24	Various		2004	5,317		20	452	452	3,742
25	Various		2005	34,104		20	3,410	3,410	18,735
26	Various		2006	56,980		20	5,698	5,698	25,046
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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
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59							
60							
61							
62							
63							
64							
65							
66							
67	Related Building Company (Pages 12F & 12G)	4,250,390	134,811		134,812	1	2,632,464
68	Related Party Allocations (Pages 12H & 12I)						
69	Financial Statement Depreciation		126,728			(126,728)	
70	TOTAL (lines 4 thru 69)	\$ 4,840,548	\$ 261,539		\$ 169,403	\$ (92,136)	\$ 3,008,070

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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		\$ 4,840,548	\$ 261,539		\$ 169,403	\$ (92,136)	\$ 3,008,070	1
2	Kick Plates	2007	2,705		20	541	541	2,164	2
3	Dining Room Paint	2007	886		20	177	177	694	3
4	Doors	2007	573		20	57	57	224	4
5	Ceilings-Bathroom	2007	702		20	70	70	263	5
6	Add Rock To Drive	2007	480		20	32	32	117	6
7	Tile Bathrooms	2007	1,203		20	120	120	431	7
8	Water Heater	2007	4,754		20	475	475	1,704	8
9	Wall Pcks/ Emergency Lighting	2007	8,808		20	1,762	1,762	6,312	9
10	Roof Top Heating/Cooling Unit	2007	17,800		20	1,780	1,780	6,378	10
11	Sidewalk	2007	992		20	66	66	237	11
12	Door Guard System	2007	2,401		20	240	240	840	12
13	Door	2007	589		20	59	59	201	13
14	Drain-Ice Machine	2007	1,463		20	293	293	975	14
15	Windows	2007	645		20	65	65	215	15
16	Roof Repair	2007	4,873		20	487	487	1,624	16
17	Roof Repair	2007	3,349		20	335	335	1,116	17
18	New Pavement	2007	23,630		20	1,575	1,575	5,120	18
19	Flooring-South	2007	53,133		20	5,313	5,313	16,825	19
20	Flooring-North	2007	40,077		20	4,008	4,008	12,691	20
21	Remodel Shower, Salon	2007	1,043		20	104	104	322	21
22	Plumbing-Shower	2007	1,244		20	124	124	384	22
23	Wall Unit With Housing	2007	776		20	78	78	239	23
24	Furnace	2008	4,634		20	927	927	2,780	24
25	Sprinkler Replcmt	2008	4,832		20	483	483	1,409	25
26	Hall Ceilings	2008	3,349		20	335	335	977	26
27	Tile-Shwr Rm	2008	1,302		20	130	130	380	27
28	Tape Textures-Ceilings	2008	5,120		20	512	512	1,493	28
29	Dining Rm-Carpet	2008	(1,825)		20	(183)	(183)	(532)	29
30	Water Heater	2008	661		20	66	66	182	30
31	Curtains	2008	8,203		20	820	820	2,188	31
32	Nurse St Work	2008	578		20	58	58	145	32
33	Kitchen Cabinets	2008	1,023		20	102	102	256	33
34	TOTAL (lines 1 thru 33)		\$ 5,040,552	\$ 261,539		\$ 190,416	\$ (71,123)	\$ 3,076,426	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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		\$ 5,040,552	\$ 261,539		\$ 190,416	\$ (71,123)	\$ 3,076,426	1
2	Formica	2008	1,491		20	149	149	373	2
3	Bathrm Painting	2008	968		20	97	97	242	3
4	Water Heater	2008	559		20	56	56	135	4
5	Wallpaper-4 Lg Walls	2008	848		20	85	85	205	5
6	Tiles	2008	570		20	57	57	138	6
7	Chair Rails, Dng Rm, Hall	2008	2,172		20	217	217	525	7
8	Alarm System	2008	1,791		20	179	179	418	8
9	Wallpaper	2008	848		20	170	170	396	9
10	Doors	2008	1,186		20	119	119	267	10
11	Doors	2008	633		20	127	127	285	11
12	Doors	2008	2,650		20	530	530	1,193	12
13	Res Rm Flooring	2008	867		20	87	87	195	13
14	Controls-Fire Alarm	2008	3,069		20	307	307	665	14
15	Nursing Station	2008	8,300		20	830	830	1,798	15
16	Handrails	2008	2,011		20	201	201	436	16
17	New Phone System	2008	14,390		20	2,878	2,878	6,236	17
18	Water Heater	2008	3,976		20	398	398	828	18
19	Install Cctv System	2009	9,892		20	1,413	1,413	2,237	19
20	Roof Repairs	2009	5,527		20	553	553	875	20
21	Condenser & Coil	2009	4,260		20	426	426	639	21
22	Handrails	2009	4,830		20	483	483	724	22
23	Nurse Call Station	2009	84,495		20	8,450	8,450	12,674	23
24	Parking Area Repair	2009	22,735		20	1,137	1,137	1,705	24
25	Replace Cable-Lighting	2009	2,687		20	269	269	381	25
26	Hallway Fixtures	2009	3,508		20	351	351	468	26
27	Wall- Hallway	2009	3,577		20	358	358	477	27
28	Dry Wall	2009	3,540		20	354	354	443	28
29	Fire Walls & Tape Fire Closts	2009	4,270		20	427	427	534	29
30	Gas Furnace	2009	5,680		20	473	473	552	30
31	Piping - Downspouts	2009	13,595		20	1,359	1,359	1,473	31
32	Fire Alarm System Repairs	2009	4,061		20	406	406	812	32
33	Doors	2010	2,556		20	256	256	256	33
34	TOTAL (lines 1 thru 33)		\$ 5,262,093	\$ 261,539		\$ 213,615	\$ (47,924)	\$ 3,115,009	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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 12C, Carried Forward		\$ 5,262,093	\$ 261,539		\$ 213,615	\$ (47,924)	\$ 3,115,009	1
2	New Water Pipe Overhead	2010	6,809		20	624	624	624	2
3	Flooring	2010	3,799		20	232	232	232	3
4	Condensing Unit & Install	2010	2,516		20	168	168	168	4
5	Condensing Unit & Install	2010	3,279		20	219	219	219	5
6	Roof Repair	2010	3,115		20	208	208	208	6
7	Delayed Egress Modific	2010	3,183		20	133	133	133	7
8	Med Rm, Front Offices-Cabinets, Countertops	2010	3,173		20				8
9	Bathroom Flooring	2010	3,202		20				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)		\$ 5,291,169	\$ 261,539		\$ 215,198	\$ (46,341)	\$ 3,116,592	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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		\$ 5,291,169	\$ 261,539		\$ 215,198	\$ (46,341)	\$ 3,116,592
2							
3							
4							
5							
6							
7							
8							
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28							
29							
30							
31							
32							
33							
34		\$ 5,291,169	\$ 261,539		\$ 215,198	\$ (46,341)	\$ 3,116,592

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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							
2							
3	1971	4,162,416	132,157	31.5	132,157		2,604,590
4	1991	87,974	2,654	31.5	2,655	1	27,874
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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26							
27							
28							
29							
30							
31							
32							
33							
34							

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 4,250,390	\$ 134,811		\$ 134,812	\$ 1	\$ 2,632,464

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 378,354	\$	\$ 57,193	\$ 57,193	10	\$ 227,510	71
72	Current Year Purchases	38,954		2,043	2,043	10	2,043	72
73	Fully Depreciated Assets	202,292				10	202,292	73
74								74
75	TOTALS	\$ 619,600	\$	\$ 59,236	\$ 59,236		\$ 431,844	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		See Attached	2010	\$ 39,246	\$	\$ 3,359	\$ 3,359	5	\$ 28,265	76
77										77
78										78
79										79
80	TOTALS			\$ 39,246	\$	\$ 3,359	\$ 3,359		\$ 28,265	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)	\$ 6,203,067	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,539	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 277,793	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,254	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,576,702	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: N/A

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	Storage			1,037			5
6	Allocated from Barton Management			10,043			6
7	TOTAL			\$ 11,080			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: \$ 31,338 Description: See Attached Schedule

(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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A	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): See Supplemental									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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows# 0032797Report Period Beginning: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 938,108	\$	1
2	Cash-Patient Deposits	1,876		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,759		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,592		6
7	Other Prepaid Expenses	11,537		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	13,383		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,041,255	\$	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			15
16	Equipment, at Historical Cost	2,020,695		16
17	Accumulated Depreciation (book methods)	(1,191,446)		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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 829,249	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,870,504	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 145,233	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,706		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,248		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,045		31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,760		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,391,440		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,768,432	\$	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	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,768,432	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 102,072	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,870,504	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (60,660)	1
2	Restatements (describe):		2
3	Rounding Error	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (60,659)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,181	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) Treasury Stock	(1,450)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 162,731	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)	\$ 102,072	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	\$ 7,064,749	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,064,749	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***	9,102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,102	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	468,978	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 468,978	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,542,829	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,015,398	31
32	Health Care	2,572,982	32
33	General Administration	1,555,320	33
B. Capital Expense			
34	Ownership	1,107,041	34
C. Ancillary Expense			
35	Special Cost Centers	8,004	35
36	Provider Participation Fee	119,903	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,378,648	40
41	Income before Income Taxes (line 30 minus line 40)**	164,181	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 164,181	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	1,912	2,080	\$ 73,974	\$ 35.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,386	39,376	870,070	22.10	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	74,005	80,530	760,311	9.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,286	13,961	189,031	13.54	8
9	Activity Director					9
10	Activity Assistants	15,045	16,019	168,177	10.50	10
11	Social Service Workers	19,781	21,650	278,418	12.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,396	30,204	353,296	11.70	15
16	Dishwashers					16
17	Maintenance Workers	14,423	3,789	84,046	22.18	17
18	Housekeepers	38,871	42,798	432,288	10.10	18
19	Laundry	12,854	13,982	133,022	9.51	19
20	Administrator	2,080	2,200	95,577	43.44	20
21	Assistant Administrator	2,080	2,200	74,244	33.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,480	19,799	227,391	11.48	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	1,845	2,061	26,749	12.98	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	276,444	290,649	\$ 3,766,594 *	\$ 12.96	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	312	\$ 11,222	01-03	35
36	Medical Director	384	28,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	3,782	11-03	44
45	Social Service Consultant	98	5,409	12-03	45
46	Other(specify)				46
47	Psychiatric Medical Director	413	20,654	10-3	47
48	Psychological Consultant	65	3,256	12-3	48
49	TOTAL (lines 35 - 48)	1,438	\$ 74,923		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Cindy Jones	Administrator	0	\$ 95,577	Workers' Compensation Insurance	\$ 139,510	IDPH License Fee	\$ 40	
April Davis	Assist. Admin.	0	74,244	Unemployment Compensation Insurance	32,680	Advertising: Employee Recruitment	2,309	
				FICA Taxes	269,734	Health Care Worker Background Check		
				Employee Health Insurance	116,006	(Indicate # of checks performed 28)	420	
				Employee Meals		Patient Background Checks	43	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	893	
				401K Contribution	44,087	Licenses & Fees	2,043	
				Other Employee Benefits	12,229	Allocated from Peoria Forest	917	
						Yellow Page Advertising	333	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 169,821					
B. Administrative - Other								
Description			Amount					
Management Fees - Barton Management			\$ 276,373					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 276,373					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 9,685				Out-of-State Travel	\$
Honkamp Krueger & Co., P.C.	Accounting		2,763					
LTC Solutions	Computer Services		1,800				In-State Travel	
Allocated from SH Complex	Computer Services		5,512					
Allocated from Barton Mgmt.	Computer Services		15,557					
Alpha Data Service	Payroll Processing		7,914					
Personnel Planners	Unemployment Tax Cons.		3,439					
Barton Management	Adjusted Out On Page 5A		833				Seminar Expense	4,723
Sharon Healthcare Complex	Accounting		1,832					
Health Data	Computer Services		609					
Barton Management	Accounting		611					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 50,554				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,723

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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							
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	Painting & Decorating	2004	\$ 2,803		\$ 468	\$	\$	\$	\$	\$	\$	\$	\$											
2	Painting & Decorating	2005	4,748		1,582	792																		
3	Painting & Decorating	2006	3,608		1,203	1,203	601																	
4	Painting & Decorating	2007	3,624		604	1,208	1,208	604																
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 14,783		\$ 3,857	\$ 3,203	\$ 1,809	\$ 604	\$	\$	\$	\$	\$											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Willows

0032797

Report Period Beginning:

01/01/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,574 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 119,903
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? Yes
- (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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
- d. Have vehicle usage logs been maintained? Yes
- 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? Yes
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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.