

Facility Name & ID Number Sharon Health Care Pines

0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	<u>116</u>	Intermediate (ICF)	<u>116</u>	<u>42,340</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>116</u>	TOTALS	<u>116</u>	<u>42,340</u>	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 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>32,587</u>	<u>240</u>		<u>32,827</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,587</u>	<u>240</u>		<u>32,827</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.53%

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 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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	203,731	18,365	6,698	228,794		228,794		228,794		1
2	Food Purchase		242,358		242,358		242,358	(18)	242,340		2
3	Housekeeping	178,024	26,143		204,167		204,167		204,167		3
4	Laundry	67,221	16,555		83,776		83,776		83,776		4
5	Heat and Other Utilities			102,916	102,916		102,916	343	103,259		5
6	Maintenance	52,406	402	71,847	124,655		124,655	16,172	140,827		6
7	Other (specify):*										7
8	TOTAL General Services	501,382	303,823	181,461	986,666		986,666	16,497	1,003,163		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,183,111	38,963	14,702	1,236,776		1,236,776	(199)	1,236,577		10
10a	Therapy										10a
11	Activities	66,339	12,595	2,857	81,791		81,791		81,791		11
12	Social Services	186,537		4,836	191,373		191,373		191,373		12
13	CNA Training										13
14	Program Transportation			31,266	31,266		31,266		31,266		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,435,987	51,558	68,061	1,555,606		1,555,606	(199)	1,555,407		16
	C. General Administration										
17	Administrative	118,278			118,278		118,278	24,011	142,289		17
18	Directors Fees										18
19	Professional Services			37,547	37,547		37,547	(10,347)	27,200		19
20	Dues, Fees, Subscriptions & Promotions			18,040	18,040		18,040	(11,621)	6,419		20
21	Clerical & General Office Expenses	93,085	1,875	139,620	234,580		234,580	(30,426)	204,154		21
22	Employee Benefits & Payroll Taxes			397,865	397,865		397,865	(2,873)	394,992		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,577	3,577		3,577		3,577		24
25	Other Admin. Staff Transportation			2,464	2,464		2,464		2,464		25
26	Insurance-Prop.Liab.Malpractice			72,318	72,318		72,318	111	72,429		26
27	Other (specify):*							1,952	1,952		27
28	TOTAL General Administration	211,363	1,875	671,431	884,669		884,669	(29,193)	855,476		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,148,732	357,256	920,953	3,426,941		3,426,941	(12,895)	3,414,046		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.

Facility Name & ID Number

Sharon Health Care Pines

#0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

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			45,992	45,992		45,992	104,264	150,256			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,824	3,824		3,824	70,401	74,225			32
33	Real Estate Taxes			59,231	59,231		59,231	4,555	63,786			33
34	Rent-Facility & Grounds			124,487	124,487		124,487	(117,334)	7,153			34
35	Rent-Equipment & Vehicles			18,089	18,089		18,089		18,089			35
36	Other (specify):*											36
37	TOTAL Ownership			251,623	251,623		251,623	61,886	313,509			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											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	931		5,181	6,112		6,112	(6,112)				43
44	TOTAL Special Cost Centers	931		68,691	69,622		69,622	(6,112)	63,510			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,149,663	357,256	1,241,267	3,748,186		3,748,186	42,880	3,791,066			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

Sharon Health Care Pines

ID# 0032763

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (80)	21	1
2	Marketing	(5,181)	43	2
3	Penalties	(43)	21	3
4	Patient Clothing	(199)	10	4
5	Additional R&M	14,764	06	5
6	Other Professional Fee - Barton Management	(1,339)	19	6
7	Non Allowable Expense	(931)	43	7
8	PPA-401K Contribution	(2,873)	22	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	0	0		48
49	Total	4,118		49

Sharon Health Care Pines

ID# 0032763

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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 Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(18)											(18)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(545)		888									343	5
6	Maintenance	14,764		1,408									16,172	6
7	Other (specify):*													7
8	TOTAL General Services	14,201		2,296									16,497	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(199)											(199)	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	(199)											(199)	16
	C. General Administration													
17	Administrative				24,011								24,011	17
18	Directors Fees													18
19	Professional Services	(1,339)		(9,993)		985							(10,347)	19
20	Fees, Subscriptions & Promotions	(11,879)		10		248							(11,621)	20
21	Clerical & General Office Expenses	(30,426)											(30,426)	21
22	Employee Benefits & Payroll Taxes	(2,873)											(2,873)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			111									111	26
27	Other (specify):*				1,952								1,952	27
28	TOTAL General Administration	(46,517)		(9,872)	25,963	1,233							(29,193)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,515)		(7,576)	25,963	1,233							(12,895)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sharon Health Care Pines# 0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	32,857				71,407							104,264	30
31	Amortization of Pre-Op. & Org.													31
32	Interest					70,401							70,401	32
33	Real Estate Taxes			2,397		2,158							4,555	33
34	Rent-Facility & Grounds			(7,534)		(109,800)							(117,334)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	32,857		(5,137)		34,166							61,886	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													41
42	Provider Participation Fee													42
43	Other (specify):*	(6,112)											(6,112)	43
44	TOTAL Special Cost Centers	(6,112)											(6,112)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(5,769)		(12,713)	25,963	35,399							42,880	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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		\$			\$	\$	0 1
2	V							0 2
3	V							0 3
4	V							0 4
5	V							0 5
6	V							0 6
7	V							0 7
8	V							0 8
9	V							0 9
10	V							0 10
11	V							0 11
12	V							0 12
13	V							0 13
14	Total		\$ 0			\$ 0	\$ *	0 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	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 888	\$	888	15
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.	100.00%	1,408		1,408	16
17	V	20 DUES, LICENSES, FEES		BARTON MANAGEMENT INC.	100.00%	10		10	17
18	V	26 INSURANCE		BARTON MANAGEMENT INC.	100.00%	111		111	18
19	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.	100.00%	2,397		2,397	19
20	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.	100.00%	6,866		6,866	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V	19 COMPUTER SERVICES	9,993					(9,993)	26
27	V	34 RENT	14,400	BARTON MANAGEMENT INC.	100.00%			(14,400)	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 24,393			\$ 11,680	\$ *	(12,713)	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	17 SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT	100.00%	18,056	\$	18,056	15
16	V	27 PAYROLL TAXES-JS		REDWOOD MANAGEMENT	100.00%	1,483		1,483	16
17	V							0	17
18	V	17 SALARY-S. ARON		REDWOOD MANAGEMENT	100.00%	5,955		5,955	18
19	V	27 PAYROLL TAXES-SA		REDWOOD MANAGEMENT	100.00%	469		469	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V	17 MANAGEMENT FEES		REDWOOD MANAGEMENT	100.00%	0		0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 25,963	\$ *	25,963	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	19 PROFESSIONAL FEES	\$	PEORIA FOREST PARTNERSHIP	100.00%	\$ 985	\$	985	15
16	V	20 DUES, FEES, SUBS.		PEORIA FOREST PARTNERSHIP		248		248	16
17	V	30 DEPRECIATION		PEORIA FOREST PARTNERSHIP		71,407		71,407	17
18	V	32 INTEREST		PEORIA FOREST PARTNERSHIP		70,401		70,401	18
19	V	33 REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		2,158		2,158	19
20	V	34 RENT	109,800	PEORIA FOREST PARTNERSHIP		0		(109,800)	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 109,800			\$ 145,199	\$ *	35,399	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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 0	\$ *	0	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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 0	\$ *	0	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		\$			\$	\$	0	15	
16	V							0	16	
17	V							0	17	
18	V							0	18	
19	V							0	19	
20	V							0	20	
21	V							0	21	
22	V							0	22	
23	V							0	23	
24	V							0	24	
25	V							0	25	
26	V							0	26	
27	V							0	27	
28	V							0	28	
29	V							0	29	
30	V							0	30	
31	V							0	31	
32	V							0	32	
33	V							0	33	
34	V							0	34	
35	V							0	35	
36	V							0	36	
37	V							0	37	
38	V							0	38	
39	Total		\$ 0			\$	\$ 0	\$ *	0	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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 0	\$ *	0	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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 0	\$ *	0	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ANCA OVIEDO	1.000%	BARTON SENIOR RESIDENCES (SLF)	ZION	BARTON MANAGEMENT	NORTHFIELD	BUILDING CO./BOOKEE	1
2	ELISA SHLOFROCK-ZUSMAN	15.747%	CENTRAL PLAZA	CHICAGO	PEORIA FOREST PTNSHP	NORTHFIELD	BUILDING & DIETARY C	2
3	ENID KAPLAN	3.564%	CLAYTON RESIDENTIAL HOME, INC.	CHICAGO	REDWOOD MANAGEMENT			3
4	GARY WEINTRAUB	11.315%	GAF LAKE COOK TERRACE, INC	NORTHBROOK				4
5	JEAN SHLOFROCK	13.370%	RUSH BARTON (SLF)	CHICAGO				5
6	JOEL RUBIN	0.300%	SHARON HEALTH CARE ELMS, INC.	PEORIA				6
7	JOHN SHLOFROCK	19.404%	SHARON HEALTH CARE WILLOWS, INC.	PEORIA				7
8	JUDY S RUBIN TRUST	2.020%	SHARON HEALTH CARE WOODS, INC.	PEORIA				8
9	MARIAN SIMON	1.000%	THORNTON HEIGHTS TERRACE, LTD.	CHICAGO HEIGHTS				9
10	MICHAEL KAPLAN	1.120%						10
11	RICHARD DEAN DUROS DECL. OF TRUST	8.988%						11
12	ROBERT KAPLAN	3.564%						12
13	SALAMON DAYAN	1.220%						13
14	STANTON ARON	17.388%						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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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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	19.40%	See Attached	6.5	13.83%	Alloc. Salary	\$ 18,056	17-7	1
2	Anca Zota-Oviedo	Shareholder	Administrative	1.00%	See Attached	3	6.00%	Alloc. Salary	8,508	17-1	2
3	Rick Duros	Shareholder	Administrative	8.98%	See Attached	5	10.00%	Alloc. Salary	18,766	17-1	3
4	Gary Weintraub	Shareholder	Legal	11.32%	See Attached	4	9.76%	Alloc. Salary	17,255	17-1	4
5	Stan Aron	Shareholder	Administrative	17.89%	See Attached	3.5	6.36%	Alloc. Salary	5,955	17-7	5
6	Elisa Shlofrock-Zusman	Shareholder	Clerical	15.74%	See Attached	5	11.90%				6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 68,540		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

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Facility Name & ID Number Sharon Health Care Pines

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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	5	UTILITIES	AVAILABLE DAYS	555,055	9	\$ 11,639	\$ 42,340	\$ 888	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	555,055	9	18,458	42,340	1,408	2
3	20	DUES, LICENSES, FEES	AVAILABLE DAYS	555,055	9	127	42,340	10	3
4	26	INSURANCE	AVAILABLE DAYS	555,055	9	1,451	42,340	111	4
5	33	REAL ESTATE TAXES	AVAILABLE DAYS	555,055	9	31,421	42,340	2,397	5
6	34	RENT OFFICE SPACE	AVAILABLE DAYS	555,055	9	90,008	42,340	6,866	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS					\$ 153,104	\$ 0	\$ 11,680	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Ending: 12/31/11

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	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED 36	6	100,000	100,000	7	18,056	1
2	27	PAYROLL TAXES-JS	AVG HOURS WORKED 36	6	8,216		7	1,483	2
3									3
4	17	SALARY-S. ARON	AVG HOURS WORKED 39	5	66,360	66,360	4	5,955	4
5	27	PAYROLL TAXES-SA	AVG HOURS WORKED 39	5	5,223		4	469	5
6									6
7									7
8									8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 179,799	\$ 166,360		\$ 25,963	25

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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	\$ 4,965	\$ 116	\$ 985	1
2	20	DUES, FEES, SUBS.	BED SIZE	585	4	1,250	116	248	2
3	30	DEPRECIATION	BED SIZE	585	4	360,112	116	71,407	3
4	32	INTEREST	BED SIZE	585	4	355,040	116	70,401	4
5	33	REAL ESTATE TAX	BED SIZE	585	4	10,881	116	2,158	5
6									6
7									7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS					\$ 732,248	\$ 0	\$ 145,199	25

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Ending: 12/31/11

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Ending: 12/31/11

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					\$			0	1	
2								0	2	
3								0	3	
4								0	4	
5								0	5	
6								0	6	
7								0	7	
8								0	8	
9								0	9	
10								0	10	
11								0	11	
12								0	12	
13								0	13	
14								0	14	
15								0	15	
16								0	16	
17								0	17	
18								0	18	
19								0	19	
20								0	20	
21								0	21	
22								0	22	
23								0	23	
24								0	24	
25	TOTALS				\$	0	\$	0	\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines

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Report Period Beginning:

01/01/11

Ending: 12/31/11

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines

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Report Period Beginning:

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Ending: 12/31/11

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines

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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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Ending: 12/31/11

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

* 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 2010 report.		\$	59,350		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.)		\$	62,969		2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,619		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,167		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.		\$	63,786		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>47,795</u>	<u>8</u>	FOR BHF USE ONLY	
	2007	<u>49,524</u>	<u>9</u>	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	<u>52,876</u>	<u>10</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	<u>57,622</u>	<u>11</u>	15	LESS REFUND FROM LINE 6 \$ 15
	2010	<u>58,414</u>	<u>12</u>	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2011 Accrual - \$58,414 x 1.03 = \$60,167 (Rounded)					
Allocated from Peoria Forest Partnership: \$2,158					
Allocated from Barton Management: \$2,397					

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sharon Health Care Pines COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032763

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>0.00</u>	\$ <u>0.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sharon Health Care Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,272 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 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>126,906</u>	<u>1</u>
2	<u>Allocated from Peoria Forest Partnership</u>			<u>7,131</u>	<u>2</u>
3	TOTALS			\$ 134,037	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	116	1991	1972	\$ 2,204,750	\$ 70,001	31.5	\$ 70,001	\$	\$ 1,449,601
5		2000	1991	46,598	1,406	31.5	1,406		16,171
6									
7									
8									
Improvement Type**									
9	Various		1987	4,748		20			4,263
10	Various		1988	31,896		20			28,565
11	Various		1989	20,183		20			18,503
12	Various		1990	10,549		20			9,891
13	Various		1991	2,580		20	113	113	2,477
14	Various		1992	15,639		20	732	732	14,889
15	Various		1993	3,764		20	188	188	3,425
16	Various		1994	33,543		20	1,677	1,677	28,807
17	Various		1995	11,702		20	585	585	9,652
18	Various		1996	4,012		20	201	201	3,084
19	Various		1997	14,815		20	741	741	10,607
20	Various		1998	27,567		20	1,378	1,378	18,718
21	Various		1999	25,473		20	1,274	1,274	15,765
22	Various		2000	4,404		20	220	220	2,553
23	Various		2001	34,460		20	1,723	1,723	17,784
24	Various		2002	8,876		20	444	444	4,297
25	Various		2003	10,166		20	1,017	1,017	8,681
26	Various		2004	13,297		20	1,330	1,330	10,236
27	Various		2005	49,034		20	4,903	4,903	30,486
28	Various		2006	40,115		20	4,012	4,012	21,922
29	Various		2007	93,696		20	8,953	8,953	38,832
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 and Improvement Costs-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								68
69					45,992	(45,992)		69
70		\$ 2,711,867	\$ 117,399		\$ 100,897	\$ (16,502)	\$ 1,769,206	70

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 Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 2,711,867	\$ 117,399		\$ 100,897	\$ (16,502)	\$ 1,769,206	1
2	Drapes	2008	11,371		20	2,274	2,274	9,097	2
3	Darpes - Freight	2008			20				3
4	A/C Unit-Serve Breakers	2008	7,050		20	588	588	2,252	4
5	Labor-Remodel	2008	2,518		20	252	252	944	5
6	Office-Remodel	2008	5,317		20	532	532	1,994	6
7	Doors	2008	3,499		20	350	350	1,312	7
8	Sliders	2008	3,225		20	323	323	1,209	8
9	Carpet-Dng, Lvg, Fover, Corr	2008	51,998		20	7,428	7,428	27,856	9
10	Install-Sliders	2008	800		20	80	80	293	10
11	Locks	2008	2,329		20	233	233	854	11
12	Doors	2008	1,044		20	104	104	383	12
13	Installation, Vents	2008	7,000		20	700	700	2,508	13
14	Bench Canopy	2008	5,395		20	1,079	1,079	3,777	14
15	Delayed Egree Modif	2008	3,142		20	314	314	1,100	15
16	Ice Machine Work	2008	2,292		20	229	229	802	16
17	Relocate Switches, Pwr	2008	2,636		20	264	264	923	17
18	Replace Front Doors	2008	9,180		20	918	918	3,137	18
19	Doorknobs	2008	2,454		20	245	245	838	19
20	Blinds	2008	559		20	112	112	382	20
21	Posts	2008	769		20	77	77	263	21
22	Alarm System	2008	948		20	95	95	316	22
23	Canopy	2008	1,202		20	120	120	391	23
24	Footings-Picnic Shelter	2008	2,954		20	295	295	960	24
25	New Patio	2008	4,565		20	457	457	1,446	25
26	Crane Lift	2008	570		20	114	114	352	26
27	New Roof-South Side Wing	2008	7,174		20	717	717	2,212	27
28	Downspouts	2008	3,127		20	313	313	964	28
29	Insulation - Roof Deck	2009	6,578		20	658	658	1,973	29
30	Insulation - Roof Deck	2009	13,156		20	1,316	1,316	3,947	30
31	Insulation - Roof Deck	2009	6,584		20	658	658	1,865	31
32	Curtains	2009	2,770		20	277	277	739	32
33	Curtains	2009	2,770		20	277	277	739	33
34	TOTAL (lines 1 thru 33)		\$ 2,886,843	\$ 117,399		\$ 122,295	\$ 4,896	\$ 1,845,033	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 and Improvement Costs-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 12B, Carried Forward		\$ 2,886,843	\$ 117,399		\$ 122,295	\$ 4,896	\$ 1,845,033	1
2	Wallpaper	2009	3,896		20			3,896	2
3	Curtains	2009	2,770		20	277	277	716	3
4	Billiards Room Tables Chairs & Cornices	2009	2,705		20	271	271	676	4
5	Curtains	2009	2,770		20	277	277	693	5
6	Walkway	2009	3,308		20	221	221	551	6
7	Door Plaques	2009	3,000		20	600	600	1,450	7
8	Fire Walls	2009	3,600		20	360	360	840	8
9	Doors	2009	3,308		20	331	331	772	9
10	Ramp System	2009	9,033		20	602	602	1,355	10
11	Water Supply Pipe	2009	3,755		20	376	376	814	11
12	Roof Repair	2009	2,790		20	279	279	581	12
13	Heater	2011	4,822		20	40	40	40	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)		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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 and Improvement Costs-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		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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 (lines 1 thru 33)	\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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 and Improvement Costs-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		\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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 (lines 1 thru 33)	\$ 2,932,600	\$ 117,399		\$ 125,928	\$ 8,529	\$ 1,857,417	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 and Improvement Costs-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 Building Company Information							
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
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17							
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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 and Improvement Costs-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							
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25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$

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 and Improvement Costs-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	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 and Improvement Costs-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							
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26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12H & 12I lines 1 thru 33)	\$	\$		\$	\$	\$

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 Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 199,654	\$	\$ 22,879	\$ 22,879	10	\$ 154,902	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	412,602		924	924	10	412,602	73
74								74
75	TOTALS	\$ 612,256	\$	\$ 23,803	\$ 23,803		\$ 567,504	75

D. Vehicle Costs. (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		1998 CHEV VAN	2001	\$ 2,986	\$	\$	\$	5	\$ 2,986	76
77		2001 DODGE RAM	2004	3,486		214	214	5	3,486	77
78		TRACTOR	2009	2,183		312	312	5	702	78
79										79
80	TOTALS			\$ 8,655	\$	\$ 525	\$ 525		\$ 7,174	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,687,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,399	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,256	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,857	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,432,095	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				287			5
6	Alloc from Barton				6,866			6
7	TOTAL				\$ 7,153			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: \$ 18,089 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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* 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 Pines# 0032763Report Period Beginning: 01/01/11Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(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	\$ 81,416	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	770,163		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,298		6
7	Other Prepaid Expenses	12,436		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	27,894		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 926,207	\$	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	1,135,404		16
17	Accumulated Depreciation (book methods)	(691,988)		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)	\$ 443,416	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,369,623	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,341	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,664		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,597		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,248		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,167		32
33	Accrued Interest Payable	764		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	179,900		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 416,681	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	400,000		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)	\$ 400,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 816,681	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 552,942	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,369,623	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (723,112)	1
2	Restatements (describe):		2
3	401K Contribution	(3,255)	3
4	Rounding	7	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (726,360)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(411,839)	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) Current Year Contribution	1,691,141	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,279,302	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)	\$ 552,942	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sharon Health Care Pines

0032763

Report Period Beginning: 01/01/11

Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,336,267	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,336,267	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	80	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 80	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,336,347	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	986,666	31
32	Health Care	1,555,606	32
33	General Administration	884,669	33
B. Capital Expense			
34	Ownership	251,623	34
C. Ancillary Expense			
35	Special Cost Centers	6,112	35
36	Provider Participation Fee	63,510	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,748,186	40
41	Income before Income Taxes (line 30 minus line 40)**	(411,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (411,839)	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 Pines

0032763

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,902	2,142	\$ 64,926	\$ 30.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,302	21,369	495,717	23.20	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	512,556	56,619	594,060	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,214	5,570	66,339	11.91	10
11	Social Service Workers	11,534	12,756	186,537	14.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,111	14,445	203,731	14.10	15
16	Dishwashers					16
17	Maintenance Workers	5,830	3,099	52,406	16.91	17
18	Housekeepers	16,558	18,526	178,024	9.61	18
19	Laundry	5,789	6,323	67,221	10.63	19
20	Administrator	3,065	3,241	118,278	36.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,544	6,187	93,085	15.05	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	1,920	2,164	28,408	13.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	28	28	931	33.25	33
34	TOTAL (lines 1 - 33)	602,353	152,469	\$ 2,149,663 *	\$ 14.10	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	152	\$ 6,698	01-03	35
36	Medical Director	334	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	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	78	2,857	11-03	44
45	Social Service Consultant	104	4,836	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	258	12,902	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,044	\$ 43,493		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-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	\$ 607		\$ 101	\$	\$	\$	\$	\$	\$	\$	\$											
2	Painting & Decorating	2005	1,072		358	179																		
3	Painting & Decorating	2006	4,454		1,485	1,485	742																	
4	Painting & Decorating	2007	1,723		287	574	574	287																
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 7,856		\$ 2,231	\$ 2,238	\$ 1,316	\$ 287	\$	\$	\$	\$	\$											

SEE ACCOUNTANTS' COMPILATION REPORT

