

		FOR BHF USE					

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**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0032763</u></p> <p><b>Facility Name:</b> <u>Sharon Health Care Pines</u></p> <p><b>Address:</b> <u>3614 N. Rochelle</u> <u>Peoria</u> <u>61604</u>  Number City Zip Code</p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> <u>(309) 685-8800</u> <b>Fax #</b> <u>(309) 686-8609</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>8/15/1987</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 282-6300</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ * Subject to the attached Accountants' Consulting Report (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name &amp; Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE  ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ * Subject to the attached Accountants' Consulting Report (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ * Subject to the attached Accountants' Consulting Report (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u> (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>							

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	116	Intermediate (ICF)	116	42,340	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	33,415	466	139	34,020	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,415	466	139	34,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.35%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 8/15/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/15/1987 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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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
	<b>A. General Services</b>										
1	Dietary	236,730	29,652	6,276	272,658		272,658		272,658		1
2	Food Purchase		219,113		219,113		219,113	(30)	219,083		2
3	Housekeeping	288,907	29,774		318,681		318,681		318,681		3
4	Laundry		22,018		22,018		22,018		22,018		4
5	Heat and Other Utilities			110,912	110,912		110,912	(1,271)	109,641		5
6	Maintenance	44,987		67,682	112,669		112,669	(2,967)	109,702		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	570,624	300,557	184,870	1,056,051		1,056,051	(4,268)	1,051,783		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,347,823	76,138	27,939	1,451,900		1,451,900	(11,686)	1,440,214		10
10a	Therapy		11,749		11,749		11,749		11,749		10a
11	Activities	64,174	11,110	1,597	76,881		76,881		76,881		11
12	Social Services	275,539		1,585	277,124		277,124		277,124		12
13	CNA Training										13
14	Program Transportation			23,165	23,165		23,165		23,165		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,687,536	98,997	72,286	1,858,819		1,858,819	(11,686)	1,847,133		16
	<b>C. General Administration</b>										
17	Administrative	114,878			114,878		114,878	65,454	180,332		17
18	Directors Fees										18
19	Professional Services			40,458	40,458	(744)	39,714	603	40,317		19
20	Dues, Fees, Subscriptions & Promotions			9,071	9,071		9,071	(1,991)	7,080		20
21	Clerical & General Office Expenses	141,102	1,864	70,570	213,536		213,536	(36,368)	177,168		21
22	Employee Benefits & Payroll Taxes			387,164	387,164		387,164		387,164		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,300	4,300		4,300		4,300		24
25	Other Admin. Staff Transportation			2,751	2,751		2,751		2,751		25
26	Insurance-Prop.Liab.Malpractice			82,659	82,659		82,659	129	82,788		26
27	Other (specify):*							2,049	2,049		27
28	<b>TOTAL General Administration</b>	255,980	1,864	596,973	854,817	(744)	854,073	29,876	883,949		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,514,140	401,418	854,129	3,769,687	(744)	3,768,943	13,922	3,782,865		29

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

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

Facility Name &amp; ID Number

Sharon Health Care Pines

#0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			24,373	24,373		24,373	95,004	119,377			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							41,385	41,385			32
33	Real Estate Taxes			64,800	64,800	744	65,544	5,968	71,512			33
34	Rent-Facility & Grounds			124,455	124,455		124,455	(116,888)	7,567			34
35	Rent-Equipment & Vehicles			3,884	3,884		3,884		3,884			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			217,512	217,512	744	218,256	25,469	243,725			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			267,797	267,797		267,797		267,797			42
43	Other (specify):*	6,241		1,129	7,370		7,370	(7,370)				43
44	<b>TOTAL Special Cost Centers</b>	6,241		268,926	275,167		275,167	(7,370)	267,797			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,520,381	401,418	1,340,567	4,262,366		4,262,366	32,021	4,294,387			45

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



Sharon Health Care Pines

ID# 0032763

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous Income	\$ (308)	21	1
2	Veterans - Pharmacy	(10,833)	10	2
3	Patient Clothing	(853)	10	3
4	Marketing	(1,129)	43	4
5	Meals	(3,653)	21	5
6	Additional R&M	4,322	06	6
7	Non Allowable Compensation	(6,241)	43	7
8	Capitalized R&M	(8,855)	06	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(27,550)		49

Sharon Health Care Pines

Report Period Beginning: ID# 0032763  
 Ending: 01/01/18  
 12/31/18

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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sharon Health Care Pines# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(30)											(30)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,995)		694	30								(1,271)	5
6	Maintenance	(4,533)		1,566									(2,967)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(6,558)</b>		<b>2,260</b>	<b>30</b>								<b>(4,268)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(11,686)											(11,686)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(11,686)</b>											<b>(11,686)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative					65,454							65,454	17
18	Directors Fees													18
19	Professional Services			109	494								603	19
20	Fees, Subscriptions & Promotions	(2,024)		33									(1,991)	20
21	Clerical & General Office Expenses	(36,441)		73									(36,368)	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			129									129	26
27	Other (specify):*					2,049							2,049	27
28	<b>TOTAL General Administration</b>	<b>(38,465)</b>		<b>344</b>	<b>494</b>	<b>67,503</b>							<b>29,876</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(56,709)</b>		<b>2,604</b>	<b>524</b>	<b>67,503</b>							<b>13,922</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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	32,016			62,988								95,004	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,774)			56,159								41,385	32
33	Real Estate Taxes			3,601	2,367								5,968	33
34	Rent-Facility & Grounds			(7,088)	(109,800)								(116,888)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	17,242		(3,487)	11,714								25,469	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(7,370)											(7,370)	43
44	<b>TOTAL Special Cost Centers</b>	(7,370)											(7,370)	44
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	(46,837)		(883)	12,238	67,503							32,021	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 Page 6 Supplemental		See Page 6 Supplemental		See Page 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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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.		\$ 694	\$ 694
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,566	1,566
17	V	19 PROFESSIONAL FEES		BARTON MANAGEMENT INC.		109	109
18	V	20 DUES, LICENSES, FEES		BARTON MANAGEMENT INC.		33	33
19	V	21 CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		73	73
20	V	26 INSURANCE		BARTON MANAGEMENT INC.		129	129
21	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.		3,601	3,601
22	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.		7,312	7,312
23	V						
24	V						
25	V						
26	V						
27	V	34 RENT	14,400	BARTON MANAGEMENT INC.			(14,400)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 14,400			\$ 13,517	\$ * (883)

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	\$	PEORIA FOREST PARTNERSHIP		\$ 30	\$ 30
16	V	19 PROFESSIONAL FEES		PEORIA FOREST PARTNERSHIP		494	494
17	V	30 DEPRECIATION		PEORIA FOREST PARTNERSHIP		62,988	62,988
18	V	32 INTEREST		PEORIA FOREST PARTNERSHIP		56,159	56,159
19	V	33 REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		2,367	2,367
20	V	34 RENT	109,800	PEORIA FOREST PARTNERSHIP			(109,800)
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		\$ 109,800			\$ 122,038	\$ * 12,238

\* 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 MANAGEMENT FEES		REDWOOD MANAGEMENT				17
18	V							18
19	V	17 SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT		26,210	26,210	19
20	V	27 PAYROLL TAXES-JS		REDWOOD MANAGEMENT		2,049	2,049	20
21	V							21
22	V	17 MGMT. FEE - S. ARON		REDWOOD MANAGEMENT		39,244	39,244	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		\$			\$ 67,503	\$ * 67,503	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name &amp; ID Number

Sharon Health Care Pines

#

0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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	27.04%	See Attached	6.50	15.48%	Alloc Salary	\$ 26,210	17-7	1	
2	Anca Zota-Oviedo	Shareholder	Administrative	1.03%	See Attached	3.00	5.45%	Salary	15,487	17-1	2	
3	Gary Weintraub	Shareholder	Legal	11.73%	See Attached	4.00	10.81%	Salary	16,643	17-1	3	
4	Stan Aron	Shareholder	Administrative	18.02%	See Attached	4.00	10.81%	Alloc Salary	39,244	17-7	4	
5	Rick Duros	Relative	Administrative	0	See Attached	5.00	11.24%				5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 97,584		13	

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	500,035	8	\$ 8,194	\$ 42,340	\$ 694	1
2	6	REPAIRS AND MAINT.	AVAILABLE DAYS	500,035	8	18,494	42,340	1,566	2
3	19	PROFESSIONAL FEES	AVAILABLE DAYS	500,035	8	1,285	42,340	109	3
4	20	DUES, LICENSES, FEES	AVAILABLE DAYS	500,035	8	395	42,340	33	4
5	21	CLERICAL AND GENERAL	AVAILABLE DAYS	500,035	8	856	42,340	73	5
6	26	INSURANCE	AVAILABLE DAYS	500,035	8	1,519	42,340	129	6
7	33	REAL ESTATE TAXES	AVAILABLE DAYS	500,035	8	42,531	42,340	3,601	7
8	34	RENT OFFICE SPACE	AVAILABLE DAYS	500,035	8	86,350	42,340	7,312	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					\$ 159,624	\$	\$ 13,517	25

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	5	UTILITIES	BED SIZE	584	4	\$ 149	\$ 116	\$ 30	1
2	19	PROFESSIONAL FEES	BED SIZE	584	4	2,486	116	494	2
3	30	DEPRECIATION	BED SIZE	584	4	317,113	116	62,988	3
4	32	INTEREST	BED SIZE	584	4	282,730	116	56,159	4
5	33	REAL ESTATE TAX	BED SIZE	584	4	11,918	116	2,367	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					\$ 614,396	\$	\$ 122,038	25

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

REDWOOD MANAGEMENT

Street Address

465 CENTRAL AVE., SUITE 100

City / State / Zip Code

NORTHFIELD, IL. 60093

Phone Number

( 847) 441-8200

Fax Number

( 847) 441-0800

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

1	2	3	4	5	6	7	8	9			
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6			
1					\$	\$		\$	1		
2									2		
3									3		
4									4		
5	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	31	5	125,000	125,000	6.50	26,210	5	
6	27	PAYROLL TAXES-JS	AVG HOURS WORKED	31	5	9,773		6.50	2,049	6	
7										7	
8	17	MGMT. FEE - S. ARON	AVG HOURS WORKED	16	4	156,976		4.00	39,244	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				\$	291,749	\$	125,000	\$	67,503	25

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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

Facility Name & ID Number Sharon Health Care Pines

# 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number

Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Allocated from Peoria Forest	X								56,159										
7																				
8																				
9	<b>TOTAL Facility Related</b>									56,159										
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(14,774)										
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>									(14,774)										
15	<b>TOTALS (line 9+line14)</b>									41,385										

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.	\$	<u>2,526</u>	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.)	\$	<u>6,442</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>3,916</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>66,853</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<u>744</u>	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>71,513</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>58,405</u>	8			
	2014	<u>59,110</u>	9			
	2015	<u>61,858</u>	10	13	FROM R. E. TAX STATEMENT FOR 2017	\$
	2016	<u>63,157</u>	11	14	PLUS APPEAL COST FROM LINE 5	\$
	2017	<u>63,631</u>	12	15	LESS REFUND FROM LINE 6	\$
<u>2018 Accrual = \$63,631 x 1.05 = \$66,853</u>				16	AMOUNT TO USE FOR RATE CALCULATION	\$
<u>Allocated from Barton Management = \$3,601</u>						
<u>Allocated from Peoria Forest = \$2,367</u>						
<u>RE taxes on Line 2 are reduced by the prepayment of the 2017 taxes in 2017. Only \$473 of the 2017 tax bill was paid in 2018.</u>						

**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.**

# 2017 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 (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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>13-25-427-014</u>	<u>Long Term Care Property</u>	\$ <u>63,631.20</u>	\$ <u>63,631.20</u>
2.	<u>05-19-112-017-0000</u>	<u>Allocated from Barton Management</u>	\$ <u>85,062.21</u>	\$ <u>3,601.28</u>
3.	<u>See Attached</u>	<u>Allocated from Peoria Forest</u>	\$ <u>11,573.26</u>	\$ <u>2,299.00</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u><u>160,266.67</u></u>	\$ <u><u>69,531.48</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 and 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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.**

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2017 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2017 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 (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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.	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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 and 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Pines

# 0032763

Report Period Beginning:

01/01/18 Ending:

12/31/18

**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 Health Care Willows - Facility 218 Beds
- Sharon Health Care Elms- Facility 98 Beds
- Sharon Health Care Woods - Facility 152 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1991</u>	<u>\$ 127,123</u>	<u>1</u>
2	<u>Allocated from Peoria Forest Partnership</u>		<u>1999</u>	<u>7,143</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 134,266</b>	<b>3</b>

Facility Name &amp; ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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	\$ 2,208,525	\$ 61,562	35	\$ 70,121	\$ 8,558	\$ 1,942,928	4
5		2000	1991	46,678	1,426	31.5	1,408	(18)	26,056	5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1987	4,748		20			4,263	9
10	Various		1988	31,896		20			28,565	10
11	Various		1989	20,183		20			18,503	11
12	Various		1990	10,549		20			9,891	12
13	Various		1991	2,580		20			2,477	13
14	Various		1992	15,639		20			15,195	14
15	Various		1993	3,764		20			3,735	15
16	Various		1994	33,543		20			33,538	16
17	Various		1995	11,702		20			11,695	17
18	Various		1996	4,012		20			4,012	18
19	Various		1997	14,815		20			14,811	19
20	Various		1998	27,567		20	575	575	27,562	20
21	Various		1999	25,473		20	1,273	1,273	24,680	21
22	Various		2000	4,404		20	220	220	4,094	22
23	Various		2001	34,460		20	1,723	1,723	29,845	23
24	Various		2002	8,876		20	444	444	7,403	24
25	Various		2003	10,166		20			10,166	25
26	Various		2004	13,297		20			13,297	26
27	Various		2005	49,034		20			49,034	27
28	Various		2006	40,115		20			40,115	28
29	Various		2007	93,696		20	1,814	1,814	86,940	29
30	Various		2008	130,151		20	3,614	3,614	129,466	30
31	Various		2009	70,088		20	5,908	5,908	63,835	31
32	Various		2011	4,822		20	482	482	3,415	32
33	Various		2012	51,914		20	3,952	3,952	25,901	33
34	Various		2014	51,483		20	2,574	2,574	10,737	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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					24,373		(24,373)	69
70		\$ 3,024,180	\$ 87,361		\$ 94,108	\$ 6,747	\$ 2,642,158	70

\*\*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 12A, Carried Forward		\$ 3,024,180	\$ 87,361		\$ 94,108	\$ 6,747	\$ 2,642,158	1
2	Guter Replacement	2015	3,330		20	167	167	666	2
3	Water Heater	2015	3,809		20	190	190	746	3
4	Generator	2015	3,605		20	180	180	661	4
5	Rooring & Shingling On West Side Of C-Wing	2015	9,692		20	485	485	1,535	5
6	New Generators - Laser Portion	2015	34,008		20	1,700	1,700	6,377	6
7	New Generators	2015	45,065		20	2,253	2,253	8,450	7
8	5-Ton Rooftop Heat/Cool Unit	2017	9,600		20	480	480	640	8
9	Foundation Repair / Waterproofing	2017	7,661		20	383	383	479	9
10	100 Gallon Water Heater	2018	4,539		20	19	19	19	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)		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	34

\*\*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		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	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
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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)		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	34

\*\*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 12C, Carried Forward		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	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
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16									16
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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)		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	34

\*\*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	4	5	6	7	8	9	
		Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
		Constructed		Depreciation	in Years	Depreciation		Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	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)		\$ 3,145,490	\$ 87,361		\$ 99,966	\$ 12,604	\$ 2,661,730	34

\*\*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:

01/01/18

Ending:

12/31/18

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	Building Company		\$	\$		\$	\$	\$	1
2									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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

\*\*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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

\*\*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:

01/01/18

Ending:

12/31/18

**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	4	Cost	5	Current Book	6	Life	7	Straight Line	8	Adjustments	9	Accumulated	
			Constructed				Depreciation		in Years		Depreciation				Depreciation	
1	Related Party			\$		\$				\$		\$		\$		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	TOTAL (lines 1 thru 33)			\$		\$				\$		\$		\$		34

\*\*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 12H, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

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

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	\$ 157,426	\$	\$ 19,081	\$ 19,081	10	\$ 130,626	71
72	Current Year Purchases	9,075		331	331	10	331	72
73	Fully Depreciated Assets	561,311				10	561,311	73
74								74
75	TOTALS	\$ 727,813	\$	\$ 19,412	\$ 19,412		\$ 692,269	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				5	3,486	77
78		TRACTOR	2009	2,183				5	2,183	78
79										79
80	TOTALS			\$ 8,655	\$	\$	\$		\$ 8,655	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)	\$ 4,016,223	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,378	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,016	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,362,654	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				255			5
6	Allocated from Barton Management				7,312			6
7	TOTAL				\$ 7,567			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021                      \$ \_\_\_\_\_

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: \$ 3,884 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

\* 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.

Facility Name & ID Number Sharon Health Care Pines # 0032763 Report Period Beginning: 01/01/18 Ending: 12/31/18  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

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

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

Facility Name &amp; ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning: 01/01/18

Ending:

12/31/18

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 621,802	\$	1
2	Cash-Patient Deposits	4,195		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	842,397		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,027		6
7	Other Prepaid Expenses	15,030		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	28,760		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,551,211	\$	10
	<b>B. Long-Term Assets</b>			
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	757,167		15
16	Equipment, at Historical Cost	596,614		16
17	Accumulated Depreciation (book methods)	(1,149,454)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 204,327	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,755,538	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 25,723	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,174		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,519		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,410		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,853		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	175,157		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 536,836	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	500,000		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 500,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,036,836	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 718,702	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,755,538	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>646,180</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>401K Contribution</b>	(7,116)	<b>3</b>
<b>4</b>	<b>State Replacement Tax</b>	(219)	<b>4</b>
<b>5</b>	<b>Rounding</b>	(2)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>638,843</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	79,859	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>79,859</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>718,702</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning: 01/01/18

Ending: 12/31/18

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,305,714	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,305,714	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	21,429	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 21,429	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,774	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,774	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	308	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 308	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,342,225	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,056,051	31
32	Health Care	1,858,819	32
33	General Administration	854,817	33
<b>B. Capital Expense</b>			
34	Ownership	217,512	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,370	35
36	Provider Participation Fee	267,797	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,262,366	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	79,859	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 79,859	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,195,138	44
45	Private Pay - Net Inpatient Revenue	87,900	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans</u>	22,676	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,305,714	49

\* 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.

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

Facility Name & ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 79,936	\$ 38.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,000	9,738	292,840	30.07	3
4	Licensed Practical Nurses	9,842	11,002	287,594	26.14	4
5	CNAs & Orderlies	52,499	54,526	650,476	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,486	5,438	64,174	11.80	10
11	Social Service Workers	15,738	17,415	275,539	15.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,543	18,002	236,730	13.15	15
16	Dishwashers					16
17	Maintenance Workers	1,836	2,046	44,987	21.99	17
18	Housekeepers	22,904	25,123	288,907	11.50	18
19	Laundry					19
20	Administrator	2,080	2,080	82,748	39.78	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	32,130	30.89	22
23	Office Manager					23
24	Clerical	5,374	5,642	141,102	25.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,054	2,290	36,977	16.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	202	202	6,241	30.89	33
34	TOTAL (lines 1 - 33)	145,678	156,624	\$ 2,520,381 *	\$ 16.09	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	142	\$ 6,276	01-03	35
36	Medical Director	207	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	124	13,889	10-03	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	52	1,597	11-03	44
45	Social Service Consultant	22	1,585	12-03	45
46	Other(specify)				46
47	Bio-Feedback Consultant	96	4,750	10-03	47
48	Psychiatric Director	145	7,500	10-03	48
49	TOTAL (lines 35 - 48)	884	\$ 55,397		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Randal Bauer	Administrator	0	\$ 82,748	Workers' Compensation Insurance	\$ 43,431	IDPH License Fee	\$	
Gary Weintraub	Administrative	11.73	16,643	Unemployment Compensation Insurance	13,123	Advertising: Employee Recruitment	595	
Anca Zota-Oviedo	Administrative	1.03	15,487	FICA Taxes	186,784	Health Care Worker Background Check		
				Employee Health Insurance	129,609	(Indicate # of checks performed 144 )	1,443	
				Employee Meals		Patient Background Checks	37 370	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	637	
				Christmas Expense	2,707	Licenses & Fees	4,002	
				Employee Benefit	4,383	Allocated from Barton Management	33	
				401K Contribution	7,127			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	( )	
			\$ 114,878			Non-allowable advertising	( )	
B. Administrative - Other						Yellow page advertising	( )	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$			\$ 7,080		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 387,164		
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
Marcum LLP	Accounting		\$ 8,730			\$	Out-of-State Travel	\$
HK Payroll Services	Accounting		1,950					
Sharon Healthcare Complex	Accounting		422					
Personnel Planners	Unemployment Consultant		720				In-State Travel	
See Attached	Legal Fees		943					
Paychex	Payroll Processing		5,372					
Point Click Care Technologies	Data Processing		12,911					
Galaxy Hosted Software	Data Processing		3,527				Seminar Expense	4,300
Information Controls	Data Processing		945					
PTC Select	Data Processing		195					
Tiger Connect	Data Processing		976					
See Supplemental Schedule			3,767				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 40,458	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							\$ 4,300	

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Sharon Health Care Pines

# 0032763

Report Period Beginning:

01/01/18

Ending: 12/31/18

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (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. \$ 6,239 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. \$ 267,797  
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? 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% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees