

		FOR OHF USE					

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**2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)**

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 Facility ID Number:</b> <u>0045153</u></p> <p><b>Facility Name:</b> <u>SYCAMORE HEALTHCARE CENTRE</u></p> <p><b>Address:</b> <u>720 SYCAMORE</u> <u>QUINCY</u> <u>62301</u> Number City Zip Code</p> <p><b>County:</b> <u>ADAMS</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 674-5795</u> Fax # <u>( 847 ) 674-5794</u></p> <p><b>IDPA ID Number:</b> <u>36-4397994</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/18/00</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b> Name: <u>BOB KAGDA</u> Telephone Number: <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>01/01/2005</u> to <u>12/31/2005</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"> <tr> <td rowspan="3" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____</td> </tr> <tr> <td>(Title) <u>MEMBER</u></td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____	(Title) <u>MEMBER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,515	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	74,825	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	7,813	238	4,955	13,006	8
9	SNF/PED					9
10	ICF	30,233	6,762	40	37,035	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,046	7,000	4,995	50,041	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.88%**

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

**E. List all services provided by your facility for non-patients.**  
 (E.g., day care, "meals on wheels", outpatient therapy)

NONE

**F. Does the facility maintain a daily midnight census?** YES

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

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

**I. On what date did you start providing long term care at this location?**  
 Date started 10/18/00

**J. Was the facility purchased or leased after January 1, 1978?**  
 YES  Date 10/18/00 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 4,955

Medicare Intermediary ADMINISTAR FEDERAL

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	204,857	21,509	9,970	236,336		236,336		236,336		1
2	Food Purchase		198,129		198,129		198,129	(1,146)	196,983		2
3	Housekeeping	135,225	19,589		154,814		154,814		154,814		3
4	Laundry	103,143	15,695	215	119,053		119,053	1,087	120,140		4
5	Heat and Other Utilities			134,500	134,500		134,500	223	134,723		5
6	Maintenance	84,010	16,715	41,378	142,103		142,103	1,885	143,988		6
7	Other (specify):*			20,972	20,972		20,972	56	21,028		7
8	<b>TOTAL General Services</b>	527,235	271,637	207,035	1,005,907		1,005,907	2,105	1,008,012		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,469,430	96,642	14,873	1,580,945		1,580,945		1,580,945		10
10a	Therapy	129,259		1,710	130,969		130,969		130,969		10a
11	Activities	72,933	4,153		77,086		77,086		77,086		11
12	Social Services			6,463	6,463		6,463		6,463		12
13	CNA Training										13
14	Program Transportation			265	265		265		265		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,671,622	100,795	35,311	1,807,728		1,807,728		1,807,728		16
	<b>C. General Administration</b>										
17	Administrative	74,167		30,000	104,167		104,167	16,077	120,244		17
18	Directors Fees										18
19	Professional Services			44,337	44,337		44,337	8,721	53,058		19
20	Dues, Fees, Subscriptions & Promotions			42,485	42,485		42,485	(23,466)	19,019		20
21	Clerical & General Office Expenses	53,092	15,321	17,537	85,950		85,950	22,850	108,800		21
22	Employee Benefits & Payroll Taxes			381,924	381,924		381,924		381,924		22
23	Inservice Training & Education			1,117	1,117		1,117	21	1,138		23
24	Travel and Seminar			2,639	2,639		2,639		2,639		24
25	Other Admin. Staff Transportation			7,869	7,869		7,869	428	8,297		25
26	Insurance-Prop.Liab.Malpractice			103,769	103,769		103,769	2,004	105,773		26
27	Other (specify):*			228,833	228,833		228,833	(223,260)	5,573		27
28	<b>TOTAL General Administration</b>	127,259	15,321	860,510	1,003,090		1,003,090	(196,625)	806,465		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,326,116	387,753	1,102,856	3,816,725		3,816,725	(194,520)	3,622,205		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,970
	REPAIRS & MAINTENANCE		0
			0
			9,970
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		215
			0
			215
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		35,250
	ELECTRICITY		59,100
	WATER		27,076
	CABLE TV - LOBBY		13,074
			0
			134,500
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		215
	PAINTING & DECORATING		1,541
	BUILDING REPAIRS		3,649
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		27,185
	ELEVATOR MAINTENANCE & REPAIR		5,805
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,842
	FIRE SERVICE		1,141
			0
			0
			0
			41,378
7	<b>OTHER</b>		
	SCAVENGER		11,972
	SECURITY SERVICE		9,000
			20,972
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		1,081
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,250
	PHARMACY CONSULTANT	XVIII B 39-2	3,292
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	8,250
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			14,873
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		315
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	802
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	593
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			1,710
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	6,463
	SOCIAL WORKER	XVIII B 45-2	0
			0
			6,463
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	265
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	30,000
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,851
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	30,486
		0
		44,337
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	20,416
	EMPLOYEE WANT ADS XIX F	7,189
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,429
	LICENSES & PERMITS XIX F	2,636
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,132
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	150
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,533
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		42,485
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,244
	OUTSIDE CLERICAL SERVICES	3,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,293
	MESSENGER SERVICE	0
		0
		17,537

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	173,468
	UNEMPLOYMENT COMPENSATION XIX D	79,409
	WORKERS COMPENSATION INSURANCE XIX D	51,286
	HOSPITALIZATION INSURANCE XIX D	60,847
	EMPLOYEE BENEFITS - OTHER XIX D	16,914
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		381,924
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,117
		1,117
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	2,639
		0
		0
		2,639
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,869
		7,869
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	103,769
		103,769
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	228,833
		228,833

GRAND TOTAL COLUMN 3 OTHER

1,102,856

SYCAMORE HEALTHCARE CENTRE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2005

TOTAL FOOD PURCHASE	198,129	PATIENT MEALS	150123
LESS SALES TAX	(1,146)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	196,983	TOTAL MEALS/YEAR	150123
TOTAL PATIENT CENSUS	50,041	NET FOOD	196983
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	150123
	-----		
TOTAL PATIENT MEALS	150123	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

#0045153

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			30,958	30,958		30,958	143,744	174,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,057	48,057		48,057	290,844	338,901			32
33	Real Estate Taxes			40,873	40,873		40,873	1,099	41,972			33
34	Rent-Facility & Grounds			477,106	477,106		477,106	(477,106)				34
35	Rent-Equipment & Vehicles			28,357	28,357		28,357	4,012	32,369			35
36	Other (specify):* <b>IME</b>			8,034	8,034		8,034	(8,034)				36
37	<b>TOTAL Ownership</b>			633,385	633,385		633,385	(45,441)	587,944			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,128	334,845	432,973		432,973		432,973			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,238	112,238		112,238		112,238			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		98,128	447,083	545,211		545,211		545,211			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,326,116	485,881	2,183,324	4,995,321		4,995,321	(239,961)	4,755,360			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,996	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,146)	2		13
14	Non-Care Related Interest	(45,521)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,533)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(228,833)	27		24
25	Fund Raising, Advertising and Promotional	(20,416)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,132)	20		28
29	Other-Attach Schedule		3		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (291,732)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	51,771		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 51,771		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (239,961)		37

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

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

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

ID# 0045153

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 3	6 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			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>	3	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE# 0045153

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,087	0	0	0	0	0	0	0	0	1,087	4
5	Heat and Other Utilities	0	0	0	223	0	0	0	0	0	0	0	223	5
6	Maintenance	3	0	1,439	443	0	0	0	0	0	0	0	1,885	6
7	Other (specify):*	0	0	32	24	0	0	0	0	0	0	0	56	7
8	<b>TOTAL General Services</b>	<b>(1,143)</b>	<b>0</b>	<b>2,558</b>	<b>690</b>	<b>0</b>	<b>2,105</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	10,266	5,811	0	0	0	0	0	0	0	0	16,077	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	373	8,311	37	0	0	0	0	0	0	0	8,721	19
20	Fees, Subscriptions & Promotions	(24,231)	0	765	0	0	0	0	0	0	0	0	(23,466)	20
21	Clerical & General Office Expenses	0	5,428	17,244	178	0	0	0	0	0	0	0	22,850	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	21	0	0	0	0	0	0	0	0	21	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	62	366	0	0	0	0	0	0	0	0	428	25
26	Insurance-Prop.Liab.Malpractice	0	154	1,715	135	0	0	0	0	0	0	0	2,004	26
27	Other (specify):*	(228,833)	1,665	3,908	0	0	0	0	0	0	0	0	(223,260)	27
28	<b>TOTAL General Administration</b>	<b>(253,064)</b>	<b>17,948</b>	<b>38,141</b>	<b>350</b>	<b>0</b>	<b>(196,625)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(254,207)</b>	<b>17,948</b>	<b>40,699</b>	<b>1,040</b>	<b>0</b>	<b>(194,520)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE# 0045153

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

## 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	7,996	0	201	707	134,840	0	0	0	0	0	0	143,744	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,521)	0	0	1,172	335,193	0	0	0	0	0	0	290,844	32
33	Real Estate Taxes	0	0	0	1,099	0	0	0	0	0	0	0	1,099	33
34	Rent-Facility & Grounds	0	0	0	0	(477,106)	0	0	0	0	0	0	(477,106)	34
35	Rent-Equipment & Vehicles	0	312	3,543	157	0	0	0	0	0	0	0	4,012	35
36	Other (specify):*	0	0	0	(8,034)	0	0	0	0	0	0	0	(8,034)	36
37	<b>TOTAL Ownership</b>	<b>(37,525)</b>	<b>312</b>	<b>3,744</b>	<b>(4,899)</b>	<b>(7,073)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,441)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(291,732)</b>	<b>18,260</b>	<b>44,443</b>	<b>(3,859)</b>	<b>(7,073)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(239,961)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	75			EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
DANIEL WEISS	25	SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY CORP	LINCOLNWOOD	OFFICE RENT
				QUINCY EXT CARE	LINCOLNWOOD	NSG HOME RENT

**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	17	MANAGEMENT FEE	\$	EMI ENTERPRISES				1
2	V	17	OFFICERS SALARIES			10,266	10,266		2
3	V	19	ACCOUNTING FEES			373	373		3
4	V	21	TOTAL OFFICE			5,428	5,428		4
5	V	25	TRANSPPORTATION			62	62		5
6	V	26	INSURANCE			154	154		6
7	V	27	EMPLOYEE BENEFITS			1,665	1,665		7
8	V	35	AUTO LEASE			312	312		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			18,260	\$ *	18,260	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	21	OUTSIDE CLERICAL	\$ 2,000	EKS MANAGEMENT		\$ (2,000)
16	V						
17	V	4	HOUSEKEEPING SALARIES			1,079	1,079
18	V	4	CLEANING SUPPLIES			8	8
19	V	6	PAINTERS SALARIES			1,439	1,439
20	V	7	SCAVENGER			32	32
21	V	17	C F O SALARY			5,811	5,811
22	V	19	PROFESSIONAL FEES			8,311	8,311
23	V	20	WANT ADS/ BACK GR CKS			765	765
24	V	21	OFFICE EXPENSE			19,244	19,244
25	V	23	SEMINARS			21	21
26	V	25	TRANSPORTATION			366	366
27	V	26	INSURANCE			1,715	1,715
28	V	27	EMPLOYEE BENEFITS			3,908	3,908
29	V	30	DEPRECIATION			201	201
30	V	35	EQUIPMENT RENT			3,543	3,543
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,000			\$ 46,443	\$ * 44,443

\* 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	36 OFFICE RENT	\$ 8,034			\$	\$ (8,034)
16	V						
17	V	5 UTILITIES				223	223
18	V	6 REPAIRS / MAINTENANCE				443	443
19	V	7 ALARM SERVICE				24	24
20	V	19 PROFESSIONAL FEES				37	37
21	V	21 OFFICE EXPENSE				178	178
22	V	26 INSURANCE				135	135
23	V	30 DEPRECIATION				707	707
24	V	32 INTEREST				1,172	1,172
25	V	33 R/E TAX				1,099	1,099
26	V	35 STORAGE FEES				157	157
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		\$ 8,034			\$ 4,175	\$ * (3,859)

\* 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	34 RENT	\$ 477,106	QUINCY EXTENDED CARE LIMITED PARTNERSHIP		\$	(477,106)
16	V	30 DEPRECIATION-SL				134,840	134,840
17	V	32 INTEREST				335,193	335,193
18	V						
19	V						
20	V						
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		\$ 477,106			\$ 470,033	\$ * (7,073)

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

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	MORRIS ESFORMES	MEMBER	ADMINISTRATIVE	75.00	SEE ATTACHED	See Attached		SALARY	\$ 10,266	17-8	1
2	DANIEL WEISS	MEMBER	ADMINISTRATIVE	25.00	SEE ATTACHED	See Attached		MGMT FEE	30,000	17-8	2
3	AVRUM WEINFELD	CFO			SEE ATTACHED	See Attached		SALARY	5,811	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 46,077		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 SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 EMI ENTERPRISES,INC  
 Street Address 6865 N LINCOLN AVE  
 City / State / Zip Code LICOLNWOOD, IL 60712  
 Phone Number ( 847 )674-1946  
 Fax Number ( 847 )674-1962

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	901,761	15	\$ 185,000	\$ 50,041	\$ 10,266	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	50,041	373	2
3	21	TOTAL OFFICE	PATIENT DAYS	901,761	15	97,823	50,041	5,428	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	50,041	62	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	50,041	154	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	50,041	1,665	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	50,041	312	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					\$ 329,044	\$ 264,576	\$ 18,260	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 EKS MANAGEMENT, INC  
 Street Address 6865 N. LINCON  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	\$ 19,441	\$ 19,441	50,041	\$ 1,079	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140	50,041	8		2
3	6	PAINTERS SALARY	PATIENT DAYS	901,761	15	25,925	50,041	1,439		3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573	50,041	32		4
5	17	C F O SALARY	PATIENT DAYS	901,761	15	104,714	50,041	5,811		5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759	50,041	8,311		6
7	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	901,761	15	13,787	50,041	765		7
8	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	50,041	19,244		8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380	50,041	21		9
10	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593	50,041	366		10
11	26	INSURANCE	PATIENT DAYS	901,761	15	30,900	50,041	1,715		11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423	50,041	3,908		12
13	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617	50,041	201		13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	901,761	15	63,848	50,041	3,543		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 836,892	\$ 399,009		\$ 46,443	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 IME REALTY CORP  
 Street Address 6865 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	346,361	15	\$ 9,618	\$ 8,034	\$ 223	1
2	6	REPAIRS / MAINTENANCE	INCOME	346,361	15	19,083	8,034	443	2
3	7	ALARM SERVICE	INCOME	346,361	15	1,056	8,034	24	3
4	19	PROFESSIONAL FEES	INCOME	346,361	15	1,575	8,034	37	4
5	21	OFFICE EXPENSE	INCOME	346,361	15	7,666	8,034	178	5
6	26	INSURANCE	INCOME	346,361	15	5,806	8,034	135	6
7	30	DEPRECIATION (SL)	INCOME	346,361	15	30,446	8,034	707	7
8	32	INTEREST	INCOME	346,361	15	50,514	8,034	1,172	8
9	33	REAL ESTATE TAX	INCOME	346,361	15	47,364	8,034	1,099	9
10	35	STORAGE FEES	INCOME	346,361	15	6,785	8,034	157	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					\$ 179,913	\$	\$ 4,175	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 QUICY EXTENDED CARE LTD. PTSHP  
 Street Address 6865 N LINCOLN  
 City / State / Zip Code LINCOLNWOOD,IL 60712  
 Phone Number ( 847 )674-5795  
 Fax Number ( 847 )674-6794

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	30	DEPRECIATION-SL	DIRECT	1	1	\$ 134,840	\$ 1	\$ 134,840	1
2	32	INTEREST	DIRECT	1	1	335,193	1	335,193	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					\$ 470,033	\$	\$ 470,033	25

Facility Name &amp; ID Number

SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## 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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	RELATED PARTY ALLOC		X	MORTGAGE	\$36,140.00	12/05/01	\$ 5,000,000	\$ 4,689,231	8/18/06	0.0725	\$ 335,193	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST			100,000	REVOLV	PRIME+	2,536	6						
7												7						
8	RELATED PARTY ALLOCATION										1,172	8						
9	TOTAL Facility Related				\$36,140.00		\$ 5,000,000	\$ 4,789,231			\$ 338,901	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	Quincy Care Partnership	X			\$9,003.00	01/01/02	1,157,443	924,220	12/01/16	0.0458	45,521	11						
12												12						
13												13						
14	TOTAL Non-Facility Related				\$9,003.00		\$ 1,157,443	\$ 924,220			\$ 45,521	14						
15	TOTALS (line 9+line14)						\$ 6,157,443	\$ 5,713,451			\$ 384,422	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_

\* 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 2004 report.		\$	<b>34,605</b>	<b>1</b>
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.)		\$	<b>37,739</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,134</b>	<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>37,739</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>40,873</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2000</b>	<b>6,669</b>	<b>8</b>
	<b>2001</b>	<b>33,328</b>	<b>9</b>
	<b>2002</b>	<b>34,270</b>	<b>10</b>
	<b>2003</b>	<b>34,605</b>	<b>11</b>
	<b>2004</b>	<b>37,739</b>	<b>12</b>

<b>FOR OHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SYCAMORE HEALTHCARE CENTRE COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0045153

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>23-4-1476-000-00</u>	<u>NURSING HOME</u>	\$ <u>37,738.70</u>	\$ <u>37,738.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>37,738.70</u>	\$ <u>37,738.70</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES       X       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY	1997		\$ 3,659,759	\$ 93,840	39	\$ 93,840	\$	\$ 832,830	4
5										5
6										6
7	RELATED PARTY			47,170	679		679			7
8										8
<b>Improvement Type**</b>										
9	WALK IN COOLER		2001	18,153	660	27.5	660		2,894	9
10	SMOKE DAMPERS		2002	3,622	132	27.5	132		467	10
11	TILING		2002	8,511	309	27.5	309		1,095	11
12	FURNISHING - CARPETING		2002	10,276	828	5	2,055	1,227	8,220	12
13	FURNISHING - DRAPES		2002	20,425	1,648	5	4,085	2,437	16,340	13
14	FURNISHING - WALLPAPER		2002	6,185	498	5	1,237	739	4,948	14
15	FURNISHING - WINDOW & DOOR TREATMENTS		2003	21,042	2,399	5	4,208	1,809	10,625	15
16	DOORS		2004	4,169	152	27.5	152		234	16
17	WATER HEATER		2004	2,390	87	27.5	87		134	17
18	FIRE ALARM		2004	5,430	197	27.5	197		304	18
19	PARKING LOT		2004	14,398	960	15	960		1,440	19
20	PARKING LOT		2005	14,398	840	15	840		840	20
21	DOWNSPOUTS		2005	2,200	55	15	55		55	21
22	ROOF		2005	87,200	397	27.5	397		397	22
23	FIRE SUPRESSION SYSTEM		2005	3,759	17	27.5	17		17	23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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								69
70	TOTAL (lines 4 thru 69)	\$ 3,929,087	\$ 103,698		\$ 109,910	\$ 6,212	\$ 880,840	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 224,442	\$ 19,356	\$ 22,444	\$ 3,088	10 YRS	\$ 81,664	71
72	Current Year Purchases	10,384	2,077	519	(1,558)	10 YRS	519	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTIES</b>	<b>410,000</b>	<b>41,229</b>	<b>41,229</b>			<b>164,000</b>	74
75	TOTALS	\$ 644,826	\$ 62,662	\$ 64,192	\$ 1,530		\$ 246,183	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		USED VAN	2001	\$ 3,000	\$ 346	\$ 600	\$ 254	5 YRS	\$ 3,000	76
77										77
78										78
79										79
80	TOTALS			\$ 3,000	\$ 346	\$ 600	\$ 254		\$ 3,000	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)	\$ 5,029,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,702	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,996	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,130,023	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

16. Rental Amount for movable equipment: \$ 12,676 Description: SEE SCHEDULE ATTACHED

YES  NO

(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		2003 JEEP GR CHEROKI	\$ 522.00	\$ 6,261	17
18		2004 FORD WAGON	785.00	9,420	18
19					19
20					20
21	TOTAL		\$ #####	\$ 15,681	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 100,014	\$		\$ 100,014	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			31,181			31,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			203,650			203,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				75,934		75,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>supplies, lab</b>	39-8				891	21,303		22,194	13
14	<b>TOTAL</b>			\$		\$ 335,736	\$ 97,237		\$ 432,973	14

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

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 151,776	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000) )	692,427		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,745		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	39,389		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 944,337	\$	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	164,230		15
16	Equipment, at Historical Cost	324,680		16
17	Accumulated Depreciation (book methods)	(290,250)		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>	\$ 198,660	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,142,997	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 152,322	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	78,597		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,230		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,739		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 411,888	\$	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>DUE TO QUINCY EXT CARE PTNR</u>	924,220		43
44	<u>DUE TO MEMBERS</u>	478,189		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,402,409	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,814,297	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (671,300)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,142,997	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(899,402)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(899,402)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>430,502</b>	<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>(202,400)</b>	<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>228,102</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>(671,300)</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,192,526	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,192,526	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,295	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 233,295	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		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>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,425,823	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,005,907	31
32	Health Care	1,807,728	32
33	General Administration	1,003,090	33
	<b>B. Capital Expense</b>		
34	Ownership	633,385	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	432,973	35
36	Provider Participation Fee	112,238	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,995,321	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	430,502	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 430,502	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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 **SYCAMORE HEALTHCARE CENTRE**

# **0045153**

Report Period Beginning: **01/01/2005**

Ending:

**12/31/2005**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,746	1,833	\$ 42,138	\$ 22.99	1
2	Assistant Director of Nursing	2,083	2,232	42,379	18.99	2
3	Registered Nurses	4,828	5,060	91,885	18.16	3
4	Licensed Practical Nurses	36,396	37,965	525,978	13.85	4
5	CNAs & Orderlies	80,938	88,692	720,243	8.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,173	10,794	129,259	11.98	8
9	Activity Director					9
10	Activity Assistants	8,088	8,502	72,933	8.58	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,082	2,195	44,714	20.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,301	21,405	160,143	7.48	15
16	Dishwashers					16
17	Maintenance Workers	5,886	6,453	84,010	13.02	17
18	Housekeepers	17,575	18,569	135,225	7.28	18
19	Laundry	11,431	12,175	103,143	8.47	19
20	Administrator	2,086	2,122	74,167	34.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,920	4,169	53,092	12.73	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	4,533	4,977	46,807	9.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,066	227,143	\$ 2,326,116 *	\$ 10.24	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	monthly fee	\$ 9,970	1-3	35
36	Medical Director	monthly fee	12,000	9-3	36
37	Medical Records Consultant	monthly fee	2,250	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	3,292	10-3	39
40	Physical Therapy Consultant	monthly fee	802	10a-3	40
41	Occupational Therapy Consultant	monthly fee	593	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	monthly fee	6,463	12-3	45
46	Other(specify) <u>psychiatric conslt</u>	monthly fee	8,250	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,620		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	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	
<b>VIOLA HUSKEY</b>	<b>ADMIN</b>		\$ <b>74,167</b>	Workers' Compensation Insurance	\$ <b>51,286</b>	IDPH License Fee	\$ <b>1,990</b>	
	<b>ASST ADMIN</b>		<b>0</b>	Unemployment Compensation Insurance	<b>79,409</b>	Advertising: Employee Recruitment	<b>7,189</b>	
				FICA Taxes	<b>173,468</b>	Health Care Worker Background Check (Indicate # of checks performed _____)	<b>0</b>	
				Employee Health Insurance	<b>60,847</b>	<b>MARKETING/ADV/PROMO</b>	<b>21,548</b>	
				Employee Meals	<b>0</b>	<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>2,683</b>	
				Illinois Municipal Retirement Fund (IMRF)*		<b>LICENSES &amp; PERMITS</b>	<b>646</b>	
				<b>EMPLOYEE BENEFITS - OTHER</b>	<b>16,914</b>	<b>DUES &amp; SUBSCRIPTIONS</b>	<b>8,429</b>	
				<b>EMPLOYEE PHYSICAL EXAMS</b>	<b>0</b>	<b>MGMT CO ALLOCATION</b>	<b>765</b>	
				<b>PENSION/PROFIT SHARING PLANS</b>	<b>0</b>	<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>(2,683)</b>	
				<b>CHICAGO HEAD TAX</b>	<b>0</b>	Less: Public Relations Expense ( _____ )	<b>0</b>	
				<b>INSURANCE - EXECUTIVE LIFE</b>	<b>0</b>	Non-allowable advertising	<b>(20,416)</b>	
				<b>INSURANCE - EXECUTIVE LIFE VI 21</b>	<b>0</b>	Yellow page advertising	<b>(1,132)</b>	
<b>TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</b>			\$ <b>74,167</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>381,924</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <b>19,019</b>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<b>DANIEL WEISS</b>			\$ <b>30,000</b>				Out-of-State Travel	\$ _____
							In-State Travel	<b>2,639</b>
							Seminar Expense	<b>0</b>
							Entertainment Expense ( _____ )	
<b>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</b>			\$ <b>30,000</b>	<b>TOTAL</b>		\$ _____	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	\$ <b>2,639</b>
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$ _____					
<b>SEE SCHEDULE ATTACHED</b>			<b>44,337</b>					
<b>TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</b>			\$ <b>44,337</b>					

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING	2001	\$ 947	3 YRS	\$ 316	\$ 316	\$ 158	\$	\$	\$	\$	\$								
2	PAINT/DECORATING	2002	7,728	3 YRS	1,288	2,576	2,576	1,288												
3	PAINT/DECORATING	2005	1,541	3 YRS				256	514	514	257									
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$ 10,216		\$ 1,604	\$ 2,892	\$ 2,734	\$ 1,544	\$ 514	\$ 514	\$ 257	\$								

Facility Name &amp; ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**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? YES  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$8168
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 153 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES \_\_\_\_\_ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 112,238  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees