



Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>111</u>	Intermediate (ICF)	<u>111</u>	<u>40,515</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>205</u>	TOTALS	<u>205</u>	<u>74,825</u>	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	<u>8,526</u>	<u>931</u>	<u>3,300</u>	<u>12,757</u>	8
9	SNF/PED					9
10	ICF	<u>27,855</u>	<u>5,292</u>	<u>55</u>	<u>33,202</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,381</u>	<u>6,223</u>	<u>3,355</u>	<u>45,959</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.42%

D. How many bed-hold days during this year were paid by the Department? 0 (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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 94 and days of care provided 3,300

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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	204,731	16,035	9,110	229,876		229,876	0	229,876		1
2	Food Purchase		199,878		199,878	(2,610)	197,268	(714)	196,554		2
3	Housekeeping	134,456	22,364	0	156,820		156,820	0	156,820		3
4	Laundry	94,310	14,702	3,012	112,024	0	112,024	1,037	113,061		4
5	Heat and Other Utilities			137,402	137,402		137,402	243	137,645		5
6	Maintenance	77,143	11,579	34,481	123,203		123,203	3,785	126,988		6
7	Other (specify):*			22,982	22,982		22,982	69	23,051		7
8	<b>TOTAL General Services</b>	<b>510,640</b>	<b>264,558</b>	<b>206,987</b>	<b>982,185</b>	<b>(2,610)</b>	<b>979,575</b>	<b>4,420</b>	<b>983,995</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		14,500	14,500		14,500	0	14,500		9
10	Nursing and Medical Records	1,472,706	81,326	6,424	1,560,456		1,560,456	0	1,560,456		10
10a	Therapy	110,809		2,643	113,452		113,452	0	113,452		10a
11	Activities	91,934	5,264	1,000	98,198		98,198	0	98,198		11
12	Social Services	0		7,728	7,728		7,728	0	7,728		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			8,045	8,045		8,045	0	8,045		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,675,449</b>	<b>86,590</b>	<b>40,340</b>	<b>1,802,379</b>	<b>0</b>	<b>1,802,379</b>	<b>0</b>	<b>1,802,379</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	85,000		50,905	135,905		135,905	13,824	149,729		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			58,471	58,471		58,471	7,746	66,217		19
20	Dues, Fees, Subscriptions & Promotions			21,767	21,767		21,767	(3,609)	18,158		20
21	Clerical & General Office Expenses	53,314	22,249	21,958	97,521		97,521	18,199	115,720		21
22	Employee Benefits & Payroll Taxes			379,091	379,091	2,610	381,701	0	381,701		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			8,940	8,940		8,940	6	8,946		24
25	Other Admin. Staff Transportation			10,896	10,896		10,896	568	11,464		25
26	Insurance-Prop.Liab.Malpractice			106,761	106,761		106,761	445	107,206		26
27	Other (specify):*			77,010	77,010		77,010	(68,059)	8,951		27
28	<b>TOTAL General Administration</b>	<b>138,314</b>	<b>22,249</b>	<b>735,799</b>	<b>896,362</b>	<b>2,610</b>	<b>898,972</b>	<b>(30,880)</b>	<b>868,092</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,324,403</b>	<b>373,397</b>	<b>983,126</b>	<b>3,680,926</b>	<b>0</b>	<b>3,680,926</b>	<b>(26,460)</b>	<b>3,654,466</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,110
	REPAIRS & MAINTENANCE	0
		0
		9,110
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	3,012
		0
		3,012
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	30,298
	ELECTRICITY	71,415
	WATER	22,511
	CABLE TV - LOBBY	13,178
		0
		137,402
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	210
	PAINTING & DECORATING	63
	BUILDING REPAIRS	1,868
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	20,404
	ELEVATOR MAINTENANCE & REPAIR	7,598
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,750
	FIRE SERVICE	1,588
		0
		0
		0
		0
		34,481
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	14,482
	SECURITY SERVICE	8,500
		0
		0
		22,982
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,500
		14,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	678
	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	2,430
	PHARMACY CONSULTANT XVIII B 39-2	3,268
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	48
		0
		6,424
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	617
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	2,026
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,643
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,000
		0
		1,000
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	7,728
	SOCIAL WORKER XVIII B 45-2	0
		0
		7,728
<b>13</b>	<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	8,045
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	50,905
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	21,122
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	37,349
		0
		58,471
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,754
	EMPLOYEE WANT ADS XIX F	2,368
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,806
	LICENSES & PERMITS XIX F	846
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	963
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,000
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	30
	PATIENT BACKGROUND CHECKS XIX F	0
		21,767
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,057
	EQUIPMENT REPAIR & MAINTENANCE	642
	OUTSIDE CLERICAL SERVICES	7,500
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,759
	MESSENGER SERVICE	0
		0
		21,958

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	174,370
	UNEMPLOYMENT COMPENSATION XIX D	81,371
	WORKERS COMPENSATION INSURANC XIX D	53,082
	HOSPITALIZATION INSURANCE XIX D	56,482
	EMPLOYEE BENEFITS - OTHER XIX D	13,786
	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
		0
		379,091
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	6,126
	TRAVEL XIX G	2,814
		8,940
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	10,896
		10,896
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	106,761
		106,761
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	77,010
		77,010

GRAND TOTAL COLUMN 3 OTHER

983,126

SYCAMORE HEALTHCARE CENTRE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	199,878	PATIENT MEALS	137877
LESS SALES TAX	(714)	ADD EMPLOYEE MEALS	1825
	-----		-----
NET FOOD	199,164	TOTAL MEALS/YEAR	139702
TOTAL PATIENT CENSUS	45,959	NET FOOD	199164
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	139702
	-----		
TOTAL PATIENT MEALS	137877	COST PER MEAL	1.43
		TIME EMPLOYEE MEALS	1825
ADD # EMPLOYEE MEALS/DAY	5		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	2610
	-----		=====
TOTAL EMPLOYEE MEALS	1825		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			206,585	206,585		206,585	(28,533)	178,052		30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0		31
32	Interest			15,476	15,476		15,476	303,603	319,079		32
33	Real Estate Taxes			39,040	39,040		39,040	1,024	40,064		33
34	Rent-Facility & Grounds			112,373	112,373		112,373	0	112,373		34
35	Rent-Equipment & Vehicles			37,605	37,605		37,605	3,006	40,611		35
36	Other (specify):* <b>IME</b>			8,034	8,034		8,034	(8,034)	0		36
37	<b>TOTAL Ownership</b>			419,113	419,113	0	419,113	271,066	690,179		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		62,078	258,755	320,833		320,833	0	320,833		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			112,238	112,238		112,238	0	112,238		42
43	Other (specify):*				0		0	0	0		43
44	<b>TOTAL Special Cost Centers</b>	0	62,078	370,993	433,071	0	433,071	0	433,071		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,324,403	435,475	1,773,232	4,533,110	0	4,533,110	244,606	4,777,716		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	(164,461)	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	(714)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,010)	27		24
25	Fund Raising, Advertising and Promotional	(4,754)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(963)	20		28
29	Other-Attach Schedule	(1,391)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (250,293)		\$ 0	30

BHF 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)	494,899		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 494,899		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 244,606		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 514	6	1
2	MANAGEMENT FEE - 6865 FINANCIAL INC	(1,905)	17	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>	(1,391)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE# 0045153

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(714)	0	0	0	0	0	0	0	0	0	0	(714)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,037	0	0	0	0	0	0	0	0	1,037	4
5	Heat and Other Utilities	0	0	0	243	0	0	0	0	0	0	0	243	5
6	Maintenance	514	1,448	1,381	442	0	0	0	0	0	0	0	3,785	6
7	Other (specify):*	0	0	44	25	0	0	0	0	0	0	0	69	7
8	<b>TOTAL General Services</b>	<b>(200)</b>	<b>1,448</b>	<b>2,462</b>	<b>710</b>	<b>0</b>	<b>4,420</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	(1,905)	9,246	6,483	0	0	0	0	0	0	0	0	13,824	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	827	6,882	37	0	0	0	0	0	0	0	7,746	19
20	Fees, Subscriptions & Promotions	(6,717)	0	3,108	0	0	0	0	0	0	0	0	(3,609)	20
21	Clerical & General Office Expenses	0	8,387	9,767	45	0	0	0	0	0	0	0	18,199	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	228	340	0	0	0	0	0	0	0	0	568	25
26	Insurance-Prop.Liab.Malpractice	0	132	211	102	0	0	0	0	0	0	0	445	26
27	Other (specify):*	(77,010)	4,032	4,919	0	0	0	0	0	0	0	0	(68,059)	27
28	<b>TOTAL General Administration</b>	<b>(85,632)</b>	<b>22,852</b>	<b>31,716</b>	<b>184</b>	<b>0</b>	<b>(30,880)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(85,832)</b>	<b>24,300</b>	<b>34,178</b>	<b>894</b>	<b>0</b>	<b>(26,460)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE# 0045153

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

## 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	(164,461)	172	206	710	134,840	0	0	0	0	0	0	(28,533)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	1,428	302,175	0	0	0	0	0	0	303,603	32
33	Real Estate Taxes	0	0	0	1,024	0	0	0	0	0	0	0	1,024	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	327	2,444	235	0	0	0	0	0	0	0	3,006	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>(164,461)</b>	<b>499</b>	<b>2,650</b>	<b>(4,637)</b>	<b>437,015</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>271,066</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>(250,293)</b>	<b>24,799</b>	<b>36,828</b>	<b>(3,743)</b>	<b>437,015</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>244,606</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
<u>LIST ATTACHED</u>		<u>LIST ATTACHED</u>		<u>EKS MGMT.</u>	<u>LINCOLNWOOD</u>	<u>BOOKKEEPING</u>
				<u>EMI ENTERPRISES</u>	<u>LINCOLNWOOD</u>	<u>MGMT CONSULT</u>
				<u>IME REALTY</u>	<u>LINCOLNWOOD</u>	<u>HOME OFFICE</u>
				<u>QUINCY EXTEND.</u>	<u>LINCOLNWOOD</u>	<u>LANDLORD</u>
				<u>CARE</u>		

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)	
1	V	17						
			\$	<u>EMI</u>		\$		1
2	V	6				1,448	1,448	2
3	V	17				9,246	9,246	3
4	V	19				827	827	4
5	V	21				8,387	8,387	5
6	V	25				228	228	6
7	V	26				132	132	7
8	V	27				4,032	4,032	8
9	V	30				172	172	9
10	V	35				327	327	10
11	V							11
12	V							12
13	V							13
14	Total		\$			24,799	\$ *	24,799 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	\$ 7,500	EKS MANAGEMENT		\$	(7,500)
16	V	4 HOUSEKEEPING SALARIES				1,037	1,037
17	V	6 PAINTERS' SALARIES				1,381	1,381
18	V	7 SCAVENGER				44	44
19	V	17 CFO SALARY - A. WEINFELD				6,483	6,483
20	V	19 PROFESSIONAL FEES				6,882	6,882
21	V	20 WANT ADS / BACKGR CKS				3,108	3,108
22	V	21 OFFICE EXPENSE				17,267	17,267
23	V	24 IN- STATE TRAVEL				6	6
24	V	25 TRANSPORTATION				340	340
25	V	26 INSURANCE				211	211
26	V	27 EMPLOYEE BENEFITS				4,919	4,919
27	V	30 DEPRECIATION S.L				206	206
28	V	35 EQUIPMENT RENT				2,444	2,444
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,500			\$ 44,328	\$ * 36,828

\* 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	IME REALTY		\$	\$ (8,034)
16	V	5 UTILITIES				243	243
17	V	6 REPAIRS / MAINT				442	442
18	V	7 ALARM SERVICE				25	25
19	V	19 PROFESSIONAL FEES				37	37
20	V	21 OFFICE EXPENSE				45	45
21	V	26 INSURANCE				102	102
22	V	30 DEPRECIATION				710	710
23	V	32 INTEREST				1,428	1,428
24	V	33 R/E TAX				1,024	1,024
25	V	35 STORAGE FEES				235	235
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		\$ 8,034			\$ 4,291	\$ * (3,743)

\* 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	\$	QUINCY EXTENDED CARE		\$		15
16	V	30 DEPRECIATION				134,840	134,840	16
17	V	32 INTEREST				302,175	302,175	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>		\$			\$ 437,015	\$ * 437,015	39

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

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	ADMIN.	75.00	See Attached	See Attached		SALARY	\$ 9,246	17-7	1
2											2
3	DANIEL WEIS	MEMBER	ADMIN.	25.00	See Attached	See Attached		MGMT FEE	49,000	17-8	3
4											4
5	AVRUM WEINFELD	CFO			See Attached	See Attached		SALARY	6,483	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,729		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:

01/01/2006

Ending: 2/31/2006

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  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	6	DRIVER'S SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 28,965	38,887	\$ 1,448	1
2	17	OFFICER'S SALARY	PATIENT DAYS	778,042	14	185,000	185,000	38,887	9,246	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537		38,887	827	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	132,028	38,887	8,387	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565		38,887	228	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648		38,887	132	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669		38,887	4,032	7
8	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451		38,887	172	8
9	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544		38,887	327	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					\$ 496,190	\$ 345,993		\$ 24,799	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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  
 Street Address 6865 N LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, 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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 45,959	\$ 1,037	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	863,827	14	25,953	45,959	1,381	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	45,959	44	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	863,827	14	121,844	45,959	6,483	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	45,959	6,882	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423	45,959	3,108	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	45,959	17,267	7
8	24	IN- STATE TRAVEL	PATIENT DAYS	863,827	14	112	45,959	6	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	45,959	340	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	45,959	211	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	45,959	4,919	11
12	30	DEPRECIATION S.L	PATIENT DAYS	863,827	14	3,880	45,959	206	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	45,959	2,444	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					\$ 833,178	\$ 496,665	\$ 44,328	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 AVE.  
 City / State / Zip Code LINCOLNWOOD, 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	5	UTILITIES	INCOME	344,402	16	\$ 10,404	\$ 8,034	\$ 243	1
2	6	REPAIRS / MAINT	INCOME	344,402	16	18,957	8,034	442	2
3	7	ALARM SERVICE	INCOME	344,402	16	1,056	8,034	25	3
4	19	PROFESSIONAL FEES	INCOME	344,402	16	1,575	8,034	37	4
5	21	OFFICE EXPENSE	INCOME	344,402	16	1,942	8,034	45	5
6	26	INSURANCE	INCOME	344,402	16	4,387	8,034	102	6
7	30	DEPRECIATION	INCOME	344,402	16	30,446	8,034	710	7
8	32	INTEREST	INCOME	344,402	16	61,229	8,034	1,428	8
9	33	R/E TAX	INCOME	344,402	16	43,904	8,034	1,024	9
10	35	STORAGE FEES	INCOME	344,402	16	10,073	8,034	235	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					\$ 183,973	\$	\$ 4,291	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 QUINCY EXTENDED CARE LTD.PTCHP  
 Street Address 6865 N LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674-5795  
 Fax Number ( 847 ) 674-5794

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	302,175	1	302,175	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					\$ 437,015	\$	\$ 437,015	25

**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	Related Party-QUINCY						\$		\$			\$	1	
2	LASALLE		X	MORTGAGE	\$36,140.00	12/05/01		5,000,000		0		0.0725	302,175	2
3	Related Party- IME			HOME OFFICE									1,428	3
4														4
5														5
	<b>Working Capital</b>													
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV				122,000	REVOLV	PRIME +	15,476	6
7														7
8														8
9	<b>TOTAL Facility Related</b>				\$36,140.00		\$	5,000,000	\$	122,000		\$	319,079	9
	<b>B. Non-Facility Related*</b>													
10	IRS, IDR, ETC		X	LATE FEES										10
11														11
12														12
13														13
14	<b>TOTAL Non-Facility Related</b>						\$	0	\$	0		\$	0	14
15	<b>TOTALS (line 9+line14)</b>						\$	5,000,000	\$	122,000		\$	319,079	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 2005 report.		\$	<b>37,739</b>	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.)		\$	<b>70,371</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>32,632</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>6,408</b>	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>		\$		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.		\$	<b>39,040</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>33,328</b>	8
	2002	<b>34,270</b>	9
	2003	<b>34,605</b>	10
	2004	<b>37,739</b>	11
	2005	<b>38,451</b>	12

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**2/12 OF 2005 BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 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 2005 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 2005.

(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>38,450.56</u>	\$ <u>38,450.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>38,450.56</u>	\$ <u>38,450.56</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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.



XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY	1997		\$ 3,659,759	\$ 93,840	39	\$ 93,840	\$	\$ 926,670	4
5										5
6										6
7	RELATED PARTY			47,170	682	39	682			7
8	OFFICE									8
Improvement Type**										
9	WALK IN COOLER		2001	18,153	15,259	27.5	660	(14,599)	3,554	9
10	SMOKE DAMPERS		2002	3,622	3,156	27.5	132	(3,024)	599	10
11	TILING		2002	8,511	7,415	27.5	309	(7,106)	1,404	11
12	FURNISHING - CARPETING		2002	10,276	1,243	5	2,056	813	10,276	12
13	FURNISHING - DRAPES		2002	20,425	2,471	5	4,085	1,614	20,425	13
14	FURNISHING - WALLPAPER		2002	6,185	749	5	1,237	488	6,185	14
15	FURNISHING - WINDOW & DOOR TREATMENTS		2003	21,042	3,598	5	4,208	610	14,833	15
16	DOORS		2004	4,169	3,935	27.5	152	(3,783)	386	16
17	WATER HEATER		2004	2,390	2,256	27.5	87	(2,169)	221	17
18	FIRE ALARM		2004	5,430	5,126	27.5	197	(4,929)	501	18
19	PARKING LOT		2004	14,398	13,318	15	960	(12,358)	2,400	19
20	PARKING LOT		2005	14,398	13,558	15	960	(12,598)	1,800	20
21	DOWNSPOUTS		2005	2,200	2,145	15	147	(1,998)	202	21
22	ROOF		2005	87,200	86,803	27.5	3,171	(83,632)	3,568	22
23	FIRE SUPRESSION SYSTEM		2005	3,759	3,742	27.5	137	(3,605)	154	23
24	3 TON A/C SYTEM		2006	3,642	3,642	27.5	66	(3,576)	66	24
25	100 GALLON WATER HEATER		2006	4,283	4,283	27.5	78	(4,205)	78	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)	\$	\$ 3,937,012		\$ 113,164	\$ (154,057)	\$ 993,322	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	\$ 234,826	\$ 33,714	\$ 23,482	\$ (10,232)	10 YRS	\$ 105,665	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74		410,000	41,406	41,406	0		205,000	74
75	TOTALS	\$ 644,826	\$ 75,120	\$ 64,888	\$ (10,232)		\$ 310,665	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	\$ 172	\$ 0	\$ (172)	5 YRS	\$ 3,000	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 3,000	\$ 172	\$ 0	\$ (172)		\$ 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)	\$ 5,037,033	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 342,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,052	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (164,461)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,306,987	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: GRANITE SYCAMORE,LLC

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:				\$ 112,373	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 112,373			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 21,248 Description: SEE SCHEDULE ATTACHED

(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	\$ 1,043	17
18		2006 JEEP GR CHEROKEE	521.00	5,874	18
19		2004 FORD WAGON	785.00	9,440	19
20					20
21	TOTAL		\$ #####	\$ 16,357	21

10. Effective dates of current rental agreement:

Beginning 11/01/06

Ending 4/30/12

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 674,236

13. /2008 \$ 679,855

14. /2009 \$ 707,948

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<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	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	39-3	hrs	\$		\$ 91,181	\$		\$ 91,181	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,076			5,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			151,519			151,519	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				55,963		55,963	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,radiology</b>	39-8				10,979	6,115		17,094	13
14	<b>TOTAL</b>			\$		\$ 258,755	\$ 62,078		\$ 320,833	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 SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 58,039	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 15,000 )	460,458		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,348		6
7	Other Prepaid Expenses	9,335		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 593,180	\$ 0	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	180,517		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>ADVANCED RENT</b>	6,290		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 186,807	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 779,987	\$ 0	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 159,658	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	122,000		29
30	Accrued Salaries Payable	77,515		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,783		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,408		32
33	Accrued Interest Payable	277		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</b> (sum of lines 26 thru 37)	\$ 403,641	\$ 0	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				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 403,641	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 376,346	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 779,987	\$ 0	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>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>0</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(3,654)</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>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>CAPITAL CONTRIBUTED</b>	<b>380,000</b>	<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>376,346</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>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>376,346</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	\$ 4,602,492	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,602,492	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,777	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 178,777	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>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	19	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PRIOR YEAR INCOME</b>	5,340	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,340	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,786,628	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	982,185	31
32	Health Care	1,802,379	32
33	General Administration	896,362	33
	<b>B. Capital Expense</b>		
34	Ownership	419,113	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	320,833	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>	\$ 4,533,110	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	253,518	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 253,518	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: **01/01/2006**

Ending:

**12/31/2006**

**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	2,082	2,142	\$ 53,562	\$ 25.01	1
2	Assistant Director of Nursing	2,084	2,135	41,622	19.50	2
3	Registered Nurses	6,179	6,523	124,360	19.06	3
4	Licensed Practical Nurses	35,707	37,688	525,593	13.95	4
5	CNAs & Orderlies	78,356	85,411	684,338	8.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,225	8,737	110,809	12.68	8
9	Activity Director					9
10	Activity Assistants	10,356	10,843	91,934	8.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,082	2,176	44,776	20.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,170	21,047	159,955	7.60	15
16	Dishwashers					16
17	Maintenance Workers	4,987	5,607	77,143	13.76	17
18	Housekeepers	17,641	18,849	134,456	7.13	18
19	Laundry	10,591	11,175	94,310	8.44	19
20	Administrator	2,090	2,287	85,000	37.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,822	4,128	53,314	12.92	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	3,865	4,215	42,401	10.06	31
32	Other Health Care <u>nursing admin</u>	79	79	830	10.51	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,316	223,042	\$ 2,324,403 *	\$ 10.42	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	M	\$ 9,110	1-3	35
36	Medical Director	O	14,500	9-3	36
37	Medical Records Consultant	N	2,430	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,268	10-3	39
40	Physical Therapy Consultant	L	617	10a-3	40
41	Occupational Therapy Consultant	Y	2,026	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,000	11-3	44
45	Social Service Consultant	E	7,728	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,679		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			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>ADMINISTRATOR</b>	<b>0.00%</b>	\$ <b>85,000</b>	Workers' Compensation Insurance	\$ <b>53,082</b>	IDPH License Fee	\$	
	<b>ASST ADMIN</b>		<b>0</b>	Unemployment Compensation Insurance	<b>81,371</b>	Advertising: Employee Recruitment	<b>2,368</b>	
				FICA Taxes	<b>174,370</b>	Health Care Worker Background Check	<b>30</b>	
				Employee Health Insurance	<b>56,482</b>	(Indicate # of checks performed _____)		
				Employee Meals	<b>2,610</b>	<b>Patient Background Checks</b>	<b>0</b>	
				Illinois Municipal Retirement Fund (IMRF)*		<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>1,000</b>	
				<b>EMPLOYEE BENEFITS - OTHER</b>	<b>13,786</b>	<b>MARKETING/ADV/PROMO</b>	<b>5,717</b>	
				<b>EMPLOYEE PHYSICAL EXAMS</b>	<b>0</b>	<b>LICENSES/DUES/SUBSCRIPTIONS</b>	<b>12,652</b>	
				<b>PENSION/PROFIT SHARING PLANS</b>	<b>0</b>	<b>MGMT CO ALLOC</b>	<b>3,108</b>	
				<b>CHICAGO HEAD TAX</b>	<b>0</b>	<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>(1,000)</b>	
				<b>INSURANCE - EXECUTIVE LIFE</b>	<b>0</b>	Less: Public Relations Expense (	<b>0</b> )	
				<b>INSURANCE - EXECUTIVE LIFE VI 21</b>	<b>0</b>	Non-allowable advertising	<b>(4,754)</b>	
						Yellow page advertising	<b>(963)</b>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <b>85,000</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>381,701</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <b>18,158</b>	
<b>(List each licensed administrator separately.)</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 - MANAGEMENT FEE</b>			\$ <b>49,000</b>			\$	Out-of-State Travel	\$
<b>6865 FINANCIAL INC - MANAGEMENT FEE</b>			<b>1,905</b>					
							In-State Travel	<b>2,814</b>
							<b>MGMT CO ALLOC</b>	<b>6</b>
							Seminar Expense	<b>6,126</b>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <b>50,905</b>	<b>TOTAL</b>		\$	<b>Entertainment Expense</b> (	
<b>(Attach a copy of any management service agreement)</b>							(agree to Sch. V, line 24, col. 8)	
							<b>TOTAL</b>	\$ <b>8,946</b>
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
<b>SEE SCHEDULE ATTACHED</b>			<b>58,471</b>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <b>58,471</b>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	205	\$ 1,541	3 YRS	\$	\$	\$ 256	\$ 514	\$ 514	\$ 257	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,541		\$	\$	\$ 256	\$ 514	\$ 514	\$ 257	\$	\$	\$

Facility Name &amp; ID Number SYCAMORE HEALTHCARE CENTRE

# 0045153

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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?  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$11,726
- (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. \$ 0 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? YES  
If YES, give effective date of lease. 11/01/06
- (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. \$ 2,610 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. \$ \_\_\_\_\_  
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