

Facility Name & ID Number SYCAMORE

0048348 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	409	36	2,853	3,298	8
9	SNF/PED					9
10	ICF	29,890	4,365	319	34,574	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,299	4,401	3,172	37,872	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.61%

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 2,853

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	211,764	19,351	8,210	239,325		239,325		239,325		1
2	Food Purchase		193,666		193,666		193,666	(698)	192,968		2
3	Housekeeping	137,131	26,434		163,565		163,565	3,305	166,870		3
4	Laundry	115,965	16,641	1,350	133,956		133,956		133,956		4
5	Heat and Other Utilities			137,374	137,374		137,374	262	137,636		5
6	Maintenance	78,386	16,872	49,201	144,459		144,459	4,071	148,530		6
7	Other (specify):*			16,676	16,676		16,676	51	16,727		7
8	TOTAL General Services	543,246	272,964	212,811	1,029,021		1,029,021	6,991	1,036,012		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,524,816	76,166	4,301	1,605,283		1,605,283		1,605,283		10
10a	Therapy	29,130		11,507	40,637		40,637		40,637		10a
11	Activities	106,156	6,328		112,484		112,484		112,484		11
12	Social Services	45,588		7,738	53,326		53,326		53,326		12
13	CNA Training										13
14	Program Transportation			136	136		136		136		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,705,690	82,494	41,682	1,829,866		1,829,866		1,829,866		16
	C. General Administration										
17	Administrative	85,001		11,407	96,408		96,408	49,601	146,009		17
18	Directors Fees										18
19	Professional Services			45,153	45,153		45,153	4,282	49,435		19
20	Dues, Fees, Subscriptions & Promotions			32,915	32,915		32,915	(12,584)	20,331		20
21	Clerical & General Office Expenses	79,157	17,693	24,388	121,238		121,238	6,771	128,009		21
22	Employee Benefits & Payroll Taxes			314,997	314,997		314,997		314,997		22
23	Inservice Training & Education							8	8		23
24	Travel and Seminar			1,618	1,618		1,618		1,618		24
25	Other Admin. Staff Transportation			9,670	9,670		9,670	(3,512)	6,158		25
26	Insurance-Prop.Liab.Malpractice			102,641	102,641		102,641	751	103,392		26
27	Other (specify):*			202,907	202,907		202,907	(195,322)	7,585		27
28	TOTAL General Administration	164,158	17,693	745,696	927,547		927,547	(150,005)	777,542		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,413,094	373,151	1,000,189	3,786,434		3,786,434	(143,014)	3,643,420		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	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,210
	REPAIRS & MAINTENANCE	0
		0
		8,210
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,350
		0
		1,350
5	HEAT & OTHER UTILITIES	
	GAS HEAT	26,726
	ELECTRICITY	77,192
	WATER	20,793
	CABLE TV - LOBBY	12,663
		0
		137,374
6	MAINTENANCE	
	GROUNDS MAINTENANCE	810
	PAINTING & DECORATING	2,197
	BUILDING REPAIRS	19,214
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,497
	ELEVATOR MAINTENANCE & REPAIR	8,031
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,336
	FIRE SERVICE	4,116
		0
		0
		0
		0
		49,201
7	OTHER	
	SCAVENGER	16,676
	SECURITY SERVICE	0
		0
		0
		16,676
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	283
	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	1,760
	PHARMACY CONSULTANT XVIII B 39-2	2,258
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		4,301
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	548
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	9,051
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,867
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	41
		11,507
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	7,738
	SOCIAL WORKER XVIII B 45-2	0
		0
		7,738
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	136
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	11,407
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,144
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	23,009
		0
		45,153
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,483
	EMPLOYEE WANT ADS XIX F	3,054
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	13,273
	LICENSES & PERMITS XIX F	2,006
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	318
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,206
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	75
	PATIENT BACKGROUND CHECKS XIX F	0
		32,915
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,356
	EQUIPMENT REPAIR & MAINTENANCE	250
	OUTSIDE CLERICAL SERVICES	6,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,782
	MESSENGER SERVICE	0
		0
		24,388

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	181,949
	UNEMPLOYMENT COMPENSATION XIX D	17,670
	WORKERS COMPENSATION INSURANC XIX D	48,840
	HOSPITALIZATION INSURANCE XIX D	50,091
	EMPLOYEE BENEFITS - OTHER XIX D	16,447
	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
		314,997
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,618
	TRAVEL XIX G	0
		1,618
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,670
		9,670
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	102,641
		102,641
27	OTHER	
	BAD DEBTS VI 24	202,907
		202,907

GRAND TOTAL COLUMN 3 OTHER

1,000,189

**SYCAMORE
SCHEDULES
12/31/2009**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	193,666
LESS SALES TAX	<u>(698)</u>
NET FOOD	192,968

TOTAL PATIENT CENSUS	37,872
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	113,616

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	113,616
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	113,616

NET FOOD	192,968
DIVIDE TOTAL MEALS/YEAR	<u>113,616</u>

COST PER MEAL	1.70
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number SYCAMORE

#0048348

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,798	15,798	15,798	(10,868)	4,930				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,425	9,425	9,425	(14,456)	(5,031)				32
33	Real Estate Taxes			41,371	41,371	41,371	1,027	42,398				33
34	Rent-Facility & Grounds			532,100	532,100	532,100		532,100				34
35	Rent-Equipment & Vehicles			43,113	43,113	43,113	608	43,721				35
36	Other (specify):* IME			8,034	8,034	8,034	(6,533)	1,501				36
37	TOTAL Ownership			649,841	649,841	649,841	(30,222)	619,619				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,707	404,756	487,463	487,463		487,463				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	TOTAL Special Cost Centers		82,707	516,994	599,701	599,701		599,701				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,413,094	455,858	2,167,024	5,035,976	5,035,976	(173,236)	4,862,740				45

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

Facility Name & ID Number **SYCAMORE**

0048348

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,725)	30		9
10	Interest and Other Investment Income	(15,779)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(698)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(6,706)	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	(202,907)	27		24
25	Fund Raising, Advertising and Promotional	(7,483)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(318)	20		28
29	Other-Attach Schedule	(9,948)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (255,564)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	82,328		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 82,328		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (173,236)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

SYCAMORE

ID# 0048348

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARIES	(5,968)	21	2
3	MARKETING TRANSPORATION	(3,980)	25	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	Total		(9,948)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE# 0048348

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(698)	0	0	0	0	0	0	0	0	0	0	(698)	2
3	Housekeeping	0	0	0	3,305	0	0	0	0	0	0	0	3,305	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	262	0	0	0	0	0	0	262	5
6	Maintenance	0	0	1,702	1,160	1,209	0	0	0	0	0	0	4,071	6
7	Other (specify):*	0	0	0	38	13	0	0	0	0	0	0	51	7
8	TOTAL General Services	(698)	0	1,702	4,503	1,484	0	0	0	0	0	0	6,991	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	59,665	(15,204)	5,140	0	0	0	0	0	0	0	49,601	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	49	306	3,888	39	0	0	0	0	0	0	4,282	19
20	Fees, Subscriptions & Promotions	(14,507)	0	0	1,903	20	0	0	0	0	0	0	(12,584)	20
21	Clerical & General Office Expenses	(5,968)	0	4,217	8,516	6	0	0	0	0	0	0	6,771	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	8	0	0	0	0	0	0	0	8	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,980)	0	146	322	0	0	0	0	0	0	0	(3,512)	25
26	Insurance-Prop.Liab.Malpractice	0	0	553	128	70	0	0	0	0	0	0	751	26
27	Other (specify):*	(202,907)	0	4,812	2,773	0	0	0	0	0	0	0	(195,322)	27
28	TOTAL General Administration	(227,362)	59,714	(5,170)	22,678	135	0	0	0	0	0	0	(150,005)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(228,060)	59,714	(3,468)	27,181	1,619	0	0	0	0	0	0	(143,014)	29

STATE OF ILLINOIS

Facility Name & ID Number SYCAMORE# 0048348

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(11,725)	0	34	78	745	0	0	0	0	0	0	(10,868)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,779)	0	0	0	1,323	0	0	0	0	0	0	(14,456)	32
33	Real Estate Taxes	0	0	0	0	1,027	0	0	0	0	0	0	1,027	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	280	0	328	0	0	0	0	0	0	608	35
36	Other (specify):*	0	0	0	1,501	(8,034)	0	0	0	0	0	0	(6,533)	36
37	TOTAL Ownership	(27,504)	0	314	1,579	(4,611)	0	0	0	0	0	0	(30,222)	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(255,564)	59,714	(3,154)	28,760	(2,992)	0	0	0	0	0	0	(173,236)	45

Facility Name & ID Number SYCAMORE

0048348

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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
PHILIP ESFORMES	36.75	LIST ATTACHED		6865 Financial Inc	LINCOLNWOOD	MGMT
DANIEL WEISS	24.5			EMI ENTERPRISES	LINCOLNWOOD	MGMT
AVRUM WEINFELD	2			EKS MGMT	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	36.75			IME REALTY	LINCOLNWOOD	HOME OFFICE

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	MANAGEMENT FEE	\$ 11,407	6865 FINANCIAL, INC		\$	(11,407)	1
2	V								2
3	V	17	EMI ENTERPRISES			27,835		27,835	3
4	V	17	PHILIP ESFORMES INC			32,896		32,896	4
5	V	17	DANIEL WEISS			2,109		2,109	5
6	V	17	AVRUM WEINFELD			8,232		8,232	6
7	V	19	ACCOUNTING FEES			49		49	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 11,407			\$ 71,121	\$ *	59,714	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	17 MANAGEMENT FEE	\$ 27,835	EMI ENTERPRISES INC		\$ 1,702	\$ (27,835)
16	V	6 DRIVER SALARIES				8,719	1,702
17	V	17 OFFICER SALARY				3,912	8,719
18	V	17 REGIONAL DIRECTOR				306	3,912
19	V	19 ACCOUNTING FEE				4,217	306
20	V	21 OFFICE				146	4,217
21	V	25 TRANSPORTATION				553	146
22	V	26 INSURANCE				4,812	553
23	V	27 EMPLOYEE BENEFITS				34	4,812
24	V	30 DEPRECIATION S/L				280	34
25	V	35 AUTO LEASE					280
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		\$ 27,835			\$ 24,681	\$ * (3,154)

* 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	\$ 6,000	EKS MANAGEMENT		\$		(6,000)	15
16	V	3 HOUSEKEEPING SALARIES				3,305		3,305	16
17	V	6 PAINTERS SALARIES				1,160		1,160	17
18	V	7 SCAVENGER				38		38	18
19	V	17 CFO - SALARY A. WEINFELD				5,140		5,140	19
20	V	19 PROFESSIONAL FEES				3,888		3,888	20
21	V	20 WANT ADS / BACKGR CKS				1,903		1,903	21
22	V	21 OFFICE				14,516		14,516	22
23	V	23 SEMINARS				8		8	23
24	V	25 TRANSPORTAION				322		322	24
25	V	26 INSURANCE				128		128	25
26	V	27 EMPLOYEE BENEFITS				2,773		2,773	26
27	V	30 DEPRECIATION S/L				78		78	27
28	V	36 EQUIPMENT RENT				1,501		1,501	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 6,000			\$ 34,760	\$ *	28,760	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 8,034	IME REALTY		\$	\$ (8,034)
16	V	5 UTILITIES				262	262
17	V	6 PAINTERS FEES				528	528
18	V	6 REPAIRS / MAINT				681	681
19	V	7 ALARM SERVICE				13	13
20	V	19 ACCOUNTING FEES				39	39
21	V	21 OFFICE EXPENSE				6	6
22	V	26 INSURANCE				70	70
23	V	30 DEPRECIATION S/L				745	745
24	V	32 INTEREST				1,323	1,323
25	V	33 R/E TAX				1,027	1,027
26	V	35 STORAGE FEES				328	328
27	V	20 LICENSES & PERMITS				20	20
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			\$ 5,042	\$ * (2,992)

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

Facility Name & ID Number SYCAMORE # 0048348 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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		ADIMINSTRATIV	36.75				COMP EMI	\$ 8,719	17-7	1
2								ADM CONS		19-3	2
3	PHILIP ESFORMES		ADMINISTRATIV	36.75				COMP 6865	32,896	17-7	3
4											4
5	DANIEL WEISS		ADMINISTRATIV	24.50				COMP 6865	2,109	17-7	5
6					SEE						6
7	AVRUM WEINFELD		ADMINISTRATIV	2.00	ATTACHED			COMP 6865	8,232	17-7	7
8					SCHEDULE			COMP EKS	5,140	17-7	8
9	FLORA WEISS		CLERICAL					COMP EKS	748	21-7	9
10											10
11											11
12											12
13								TOTAL	\$ 57,844		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

0048348

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 6865 FINANCIAL INC
 Street Address 6865 N. LINCOLN AVE.
 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	17	EMI ENTERPRISES	PATIENT DAYS	538,796	10	\$ 396,000	\$ 37,872	\$ 27,835	1	
2	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	10	468,000	468,000	37,872	32,896	2
3	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	30,000	37,872	2,109	3
4	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	117,111	37,872	8,232	4
5	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700	37,872	49		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					\$ 1,011,811	\$ 615,111	\$ 71,121		25

Facility Name & ID Number SYCAMORE

0048348

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	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	6	DRIVER SALARIES	PATIENT DAYS	847,051	14	\$ 38,060	\$ 37,872	\$ 1,702	1
2	17	OFFICER SALARY	PATIENT DAYS	847,051	14	195,000	37,872	8,719	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	37,872	3,912	3
4	19	ACCOUNTING FEE	PATIENT DAYS	847,051	14	6,850	37,872	306	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	37,872	4,217	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	37,872	146	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	37,872	553	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	37,872	4,812	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765	37,872	34	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	37,872	280	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					\$ 552,018	\$ 378,811	\$ 24,681	25

Facility Name & ID Number SYCAMORE

0048348 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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. 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	3	HOUSEKEEPING SALARIES	PATIENT CENSUS	847,051	14	\$ 73,923	\$ 73,923	37,872	\$ 3,305	1
2	6	PAINTERS SALARIES	PATIENT CENSUS	847,051	14	25,953	25,953	37,872	1,160	2
3	7	SCAVENGER	PATIENT CENSUS	847,051	14	842		37,872	38	3
4	17	CFO - SALARY	PATIENT CENSUS	847,051	14	114,971	114,971	37,872	5,140	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	847,051	14	86,967	74,170	37,872	3,888	5
6	20	WANT ADS / BACKGR CKS	PATIENT CENSUS	847,051	14	42,556		37,872	1,903	6
7	21	OFFICE	PATIENT CENSUS	847,051	14	324,660	246,961	37,872	14,516	7
8	23	SEMINARS	PATIENT CENSUS	847,051	14	190		37,872	8	8
9	25	TRANSPORTAION	PATIENT CENSUS	847,051	14	7,194		37,872	322	9
10	26	INSURANCE	PATIENT CENSUS	847,051	14	2,872		37,872	128	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	847,051	14	62,031		37,872	2,773	11
12	30	DEPRECIATION S/L	PATIENT CENSUS	847,051	14	1,757		37,872	78	12
13	36	EQUIPMENT RENT	PATIENT CENSUS	847,051	14	33,562		37,872	1,501	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					\$ 777,478	\$ 535,978		\$ 34,760	25

Facility Name & ID Number SYCAMORE

0048348

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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
 Street Address 6865 N. LINCOLN AVE.
 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	RENTAL INCOME	14	\$ 6,106	\$	8,034	\$ 262	1
2	6	PAINTERS FEES	RENTAL INCOME	14	12,303		8,034	528	2
3	6	REPAIRS / MAINT	RENTAL INCOME	14	15,863		8,034	681	3
4	7	ALARM SERVICE	RENTAL INCOME	14	301		8,034	13	4
5	19	ACCOUNTING FEES	RENTAL INCOME	14	897		8,034	39	5
6	21	OFFICE EXPENSE	RENTAL INCOME	14	136		8,034	6	6
7	26	INSURANCE	RENTAL INCOME	14	1,627		8,034	70	7
8	30	DEPRECIATION S/L	RENTAL INCOME	14	17,336		8,034	745	8
9	32	INTEREST	RENTAL INCOME	14	30,806		8,034	1,323	9
10	33	R/E TAX	RENTAL INCOME	14	23,914		8,034	1,027	10
11	35	STORAGE FEES	RENTAL INCOME	14	7,635		8,034	328	11
12	20	LICENSES & PERMITS	RENTAL INCOME	14	468		8,034	20	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				\$ 117,392	\$		\$ 5,042	25

Facility Name & ID Number

SYCAMORE

0048348

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4	RELATED PARTY - IME										1,323					
5																
	Working Capital															
6	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLD	PRIME +	9,425					
7																
8																
9	TOTAL Facility Related						\$	\$			\$	10,748				
	B. Non-Facility Related*															
10	IRS, IDR, ETC		X	LATE FEES												
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$	10,748				

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.)

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>39,697.12</u>	\$ <u>39,697.12</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number SYCAMORE

0048348 Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number SYCAMORE

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				\$	\$		\$	\$	4
5									5
6									6
7	RELATED PARTY			47,170	715	39	715		7
8	HOME OFFICE								8
	Improvement Type**								
9	SIDEWALK	2008		6,865	458	15	458		687
10	BATHROOM TILE AND PLUMBING	2009		16,720	380	27.5	380		380
11	HVAC SYSTEMS	2009		6,500	148	27.5	148		148
12	STAINLESS STEEL DUCTING	2009		2,750	62	27.5	62		62
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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number SYCAMORE

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)		\$ 80,005	\$ 1,763		\$ 1,763	\$	\$ 1,277	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	\$ 21,240	\$ 3,942	\$ 2,124	\$ (1,818)	10 YRS	\$ 4,307	71
72	Current Year Purchases	18,013	10,808	901	(9,907)	10 YRS	901	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		142	142				74
75	TOTALS	\$ 39,253	\$ 14,892	\$ 3,167	\$ (11,725)		\$ 5,208	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 119,258	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,930	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,725)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,485	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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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>
--	---	--

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	97,967	\$		\$	97,967	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				16,670				16,670	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				289,145				289,145	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 prescrpts					73,877			73,877	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>supplies,lab,radiology</u>	39-8					974	8,830			9,804	13
14	TOTAL			\$		\$	404,756	\$	82,707	\$	487,463	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

0048348

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 68,135	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (135,000))	469,760		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,610		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E. & ins. Escrow</u>	50,616		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 663,121	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	32,835		15
16	Equipment, at Historical Cost	39,253		16
17	Accumulated Depreciation (book methods)	(27,411)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	173,427		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 218,104	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 881,225	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 502,032	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,881		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,087		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,697		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 656,697	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 656,697	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 224,528	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 881,225	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):	501,238	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 501,238	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(105,608)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(171,102)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (276,710)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 224,528	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,552,473	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,552,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	362,116	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 362,116	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,779	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,779	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,930,368	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,029,021	31
32	Health Care	1,829,866	32
33	General Administration	927,547	33
B. Capital Expense			
34	Ownership	649,841	34
C. Ancillary Expense			
35	Special Cost Centers	487,463	35
36	Provider Participation Fee	112,238	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,035,976	40
41	Income before Income Taxes (line 30 minus line 40)**	(105,608)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (105,608)	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**

0048348

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	2,016	2,144	\$ 56,690	\$ 26.44	1
2	Assistant Director of Nursing	1,992	2,080	43,682	21.00	2
3	Registered Nurses	5,947	6,184	120,814	19.54	3
4	Licensed Practical Nurses	32,225	33,805	523,815	15.50	4
5	CNAs & Orderlies	78,730	81,706	738,060	9.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,932	2,100	29,130	13.87	8
9	Activity Director					9
10	Activity Assistants	11,676	12,381	106,156	8.57	10
11	Social Service Workers	4,780	4,975	45,588	9.16	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,176	46,133	21.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,116	19,621	165,631	8.44	15
16	Dishwashers					16
17	Maintenance Workers	8,411	5,679	78,386	13.80	17
18	Housekeepers	16,044	16,995	137,131	8.07	18
19	Laundry	13,164	14,135	115,965	8.20	19
20	Administrator	1,968	2,080	85,001	40.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,353	5,819	79,157	13.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,852	2,044	16,969	8.30	31
32	Other Health Care <u>ward clerk</u>	2,559	2,658	24,786	9.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,805	216,582	\$ 2,413,094 *	\$ 11.14	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	\$ 8,210	1-3	35
36	Medical Director	O	18,000	9-3	36
37	Medical Records Consultant	N	1,760	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,258	10-3	39
40	Physical Therapy Consultant	L	9,051	10a-3	40
41	Occupational Therapy Consultant	Y	1,867	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	41	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	7,738	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,925		49

C. CONTRACT NURSES

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

XIX-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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number SYCAMORE

0048348

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 \$9292
- (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? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
SYCAMORE HEALTHCARE, LLC 0045153 11/01/06
- (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? 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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.