FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048348

Facility Name: SYCAMORE OPERATOR, LLC

Address: 720 SYCAMORE (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	734	578	2,942	4,254	8
9	SNF/PED					9
10	ICF	28,546	4,199	22	32,767	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,280	4,777	2,964	37,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.48%

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 [X]

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

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 [X] Date 11/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 94 and days of care provided 2,761

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	223,417	27,106	8,767	259,290		259,290		259,290			1
2	Food Purchase		218,339		218,339		218,339	(1,017)	217,322			2
3	Housekeeping	161,358	28,293		189,651		189,651		189,651			3
4	Laundry	112,351	19,768	115	132,234		132,234		132,234			4
5	Heat and Other Utilities			151,945	151,945		151,945	227	152,172			5
6	Maintenance	72,197	16,781	51,766	140,744		140,744	4,048	144,792			6
7	Other (specify):*			18,478	18,478		18,478	42	18,520			7
8	**TOTAL General Services**	569,323	310,287	231,071	1,110,681		1,110,681	3,300	1,113,981			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,753,074	132,914	10,402	1,896,390		1,896,390		1,896,390			10
10a	Therapy	31,215			31,215		31,215		31,215			10a
11	Activities	117,442	6,122		123,564		123,564		123,564			11
12	Social Services	57,159		6,945	64,104		64,104		64,104			12
13	CNA Training											13
14	Program Transportation			761	761		761		761			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,958,890	139,036	36,108	2,134,034		2,134,034		2,134,034			16
	C. General Administration											
17	Administrative	87,075		11,400	98,475		98,475	60,053	158,528			17
18	Directors Fees											18
19	Professional Services			62,238	62,238		62,238	4,223	66,461			19
20	Dues, Fees, Subscriptions & Promotions			36,251	36,251		36,251	(12,205)	24,046			20
21	Clerical & General Office Expenses	60,531	27,931	29,350	117,812		117,812	13,292	131,104			21
22	Employee Benefits & Payroll Taxes			340,653	340,653		340,653		340,653			22
23	Inservice Training & Education			2,511	2,511		2,511	5	2,516			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,822	9,822		9,822	685	10,507			25
26	Insurance-Prop.Liab.Malpractice			103,512	103,512		103,512	725	104,237			26
27	Other (specify):*			132,041	132,041		132,041	(125,298)	6,743			27
28	**TOTAL General Administration**	147,606	27,931	727,778	903,315		903,315	(58,520)	844,795			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,675,819	477,254	994,957	4,148,030		4,148,030	(55,220)	4,092,810			29

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

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

Facility Name & ID#: SYCAMORE OPERATOR, LLC **#0048348** **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,767	
	REPAIRS & MAINTENANCE		0	
			0	8,767
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		115	
			0	115
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,444	
	ELECTRICITY		90,108	
	WATER		27,358	
	CABLE TV - LOBBY		15,035	
			0	151,945
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,375	
	PAINTING & DECORATING		1,506	
	BUILDING REPAIRS		11,330	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		23,961	
	ELEVATOR MAINTENANCE & REPAIR		6,500	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,401	
	FIRE SERVICE		1,693	
			0	
			0	
			0	
			0	51,766
7	**OTHER**			
	SCAVENGER		18,478	
	SECURITY SERVICE		0	
			0	
			0	18,478
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		1,932	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,760	
	PHARMACY CONSULTANT	XVIII B 39-2	6,710	
	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	10,402
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,945	
				6,945
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SYCAMORE OPERATOR, LLC **#0048348** **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		761	761
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	11,400	11,400
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,360	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	48,878	
			0	62,238
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,267	
	EMPLOYEE WANT ADS	XIX F	4,482	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	16,577	
	LICENSES & PERMITS	XIX F	1,135	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	256	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,234	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	300	
				36,251
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,005	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		6,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,345	
	MESSENGER SERVICE			
			0	29,350

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	202,505	
	UNEMPLOYMENT COMPENSATION	XIX D	28,196	
	WORKERS COMPENSATION INSURANC	XIX D	45,261	
	HOSPITALIZATION INSURANCE	XIX D	40,292	
	EMPLOYEE BENEFITS - OTHER	XIX D	24,399	
	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	340,653
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,511	
				2,511
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,822	
				9,822
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		103,512	
				103,512
27	**OTHER**			
	BAD DEBTS	VI 24	132,041	
				132,041

GRAND TOTAL COLUMN 3 OTHER **994,957**

SYCAMORE OPERATOR, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	218,339
LESS SALES TAX	(1,017)
NET FOOD	217,322
TOTAL PATIENT CENSUS	37,021
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	111,063
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	111,063
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	111,063
NET FOOD	217,322
DIVIDE TOTAL MEALS/YEAR	111,063
COST PER MEAL	1.96
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number SYCAMORE OPERATOR, LLC #0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			10,786	10,786		10,786	(1,458)	9,328			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,060	4,060		4,060	(2,951)	1,109			32
33	Real Estate Taxes			43,834	43,834		43,834	1,223	45,057			33
34	Rent-Facility & Grounds			481,350	481,350		481,350		481,350			34
35	Rent-Equipment & Vehicles			44,167	44,167		44,167	2,219	46,386			35
36	Other (specify):* IME			8,634	8,634		8,634	(8,634)				36
37	**TOTAL Ownership**			592,831	592,831		592,831	(9,601)	583,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,729	380,085	443,814		443,814		443,814			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**		63,729	492,323	556,052		556,052		556,052			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,675,819	540,983	2,080,111	5,296,913		5,296,913	(64,821)	5,232,092			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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(2,273)	30		9
10	Interest and Other Investment Income	(4,217)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,017)	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	(5,234)	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	(132,041)	27		24
25	Fund Raising, Advertising and Promotional	(8,267)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(256)	20		28
29	Other-Attach Schedule	(1,005)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,310)		$	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 Amount	2 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)	89,489		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 89,489		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,821)		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 Yes	2 No	3 Amount	4 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

SYCAMORE OPERATOR, LLC

ID# 0048348

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	BANK CHARGES	(1,005)	21	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	**Total**	(1,005)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,017)	0	0	0	0	0	0	0	0	0	0	(1,017)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	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	227	0	0	0	0	0	0	227	5
6	Maintenance	0	0	1,700	1,767	581	0	0	0	0	0	0	4,048	6
7	Other (specify):*	0	0	42	0	0	0	0	0	0	0	0	42	7
8	**TOTAL General Services**	(1,017)	0	1,742	1,767	808	0	0	0	0	0	0	3,300	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	53,393	5,021	1,639	0	0	0	0	0	0	0	60,053	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	54	3,843	283	43	0	0	0	0	0	0	4,223	19
20	Fees, Subscriptions & Promotions	(13,757)	0	1,529	0	23	0	0	0	0	0	0	(12,205)	20
21	Clerical & General Office Expenses	(1,005)	0	10,491	3,806	0	0	0	0	0	0	0	13,292	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	5	0	0	0	0	0	0	0	0	5	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	582	103	0	0	0	0	0	0	0	685	25
26	Insurance-Prop.Liab.Malpractice	0	0	109	561	55	0	0	0	0	0	0	725	26
27	Other (specify):*	(132,041)	0	2,628	4,115	0	0	0	0	0	0	0	(125,298)	27
28	**TOTAL General Administration**	(146,803)	53,447	24,208	10,507	121	0	0	0	0	0	0	(58,520)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(147,820)	53,447	25,950	12,274	929	0	0	0	0	0	0	(55,220)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(2,273)	0	67	0	748	0	0	0	0	0	0	(1,458)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,217)	0	0	0	1,266	0	0	0	0	0	0	(2,951)	32
33	Real Estate Taxes	0	0	0	0	1,223	0	0	0	0	0	0	1,223	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,609	237	373	0	0	0	0	0	0	2,219	35
36	Other (specify):*	0	0	0	0	(8,634)	0	0	0	0	0	0	(8,634)	36
37	**TOTAL Ownership**	(6,490)	0	1,676	237	(5,024)	0	0	0	0	0	0	(9,601)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,310)	53,447	27,626	12,511	(4,095)	0	0	0	0	0	0	(64,821)	45

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				6865 FINANCIAL	LINCOLNWOOD	MGMT
				EMI ENTERPRISES	LINCOLNWOOD	MGMT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 11,400	6865 FINANCIAL, INC		$	$ (11,400)	1
2	V	17	EMI ENTERPRISES				15,655	15,655	2
3	V	17	PHILIP ESFORMES INC				31,309	31,309	3
4	V	17	M. ROSEN				15,655	15,655	4
5	V	17	D. WEISS				2,174	2,174	5
6	V	19	ACCOUNTING FEES				54	54	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 11,400			$ 64,847	$ * 53,447	14

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 6,000	EKS MANAGEMENT		$	$ (6,000)	15
16	V	6	PAINTERS SALARY		EKS MANAGEMENT		1,700	1,700	16
17	V	7	SCAVENGER		EKS MANAGEMENT		42	42	17
18	V	17	CFO - SALARY		EKS MANAGEMENT		5,021	5,021	18
19	V	19	PROFESSIONAL FEES		EKS MANAGEMENT		3,843	3,843	19
20	V	20	WANT ADS/ BACK GRD CKS		EKS MANAGEMENT		1,529	1,529	20
21	V	21	OFFICE / CLERICAL		EKS MANAGEMENT		16,491	16,491	21
22	V	23	SEMINARS		EKS MANAGEMENT		5	5	22
23	V	25	TRANSPORTATION		EKS MANAGEMENT		582	582	23
24	V	26	INSURANCE		EKS MANAGEMENT		109	109	24
25	V	27	EMPLOYEE BENEFITS		EKS MANAGEMENT		2,628	2,628	25
26	V	30	SL DEPRECIATION		EKS MANAGEMENT		67	67	26
27	V	35	EQUIPMENT RENTAL		EKS MANAGEMENT		1,609	1,609	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,000			$ 33,626	$ * 27,626	39

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEE	$ 15,655	EMI MANAGEMENT		$	$ (15,655)	15
16	V	6	DRIVERS SALARY		EMI MANAGEMENT		1,767	1,767	16
17	V	17	OFFICER SALARY		EMI MANAGEMENT		8,516	8,516	17
18	V	17	REGIONAL DIRECTOR		EMI MANAGEMENT		262	262	18
19	V	17	MGT CONSULTANT		EMI MANAGEMENT		8,516	8,516	19
20	V	19	ACCOUNTING FEES		EMI MANAGEMENT		283	283	20
21	V	21	OFFICE		EMI MANAGEMENT		3,806	3,806	21
22	V	25	TRANSPORTATION		EMI MANAGEMENT		103	103	22
23	V	26	INSURANCE		EMI MANAGEMENT		561	561	23
24	V	27	EMPLOYEE BENEFITS		EMI MANAGEMENT		4,115	4,115	24
25	V	35	AUTO LEASE		EMI MANAGEMENT		237	237	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,655			$ 28,166	$ * 12,511	39

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 8,634	IME REALTY		$	$ (8,634)	15
16	V	5	UTILITIES		IME REALTY		227	227	16
17	V	6	REPAIRS / MAINTENCE		IME REALTY		581	581	17
18	V	19	ACCOUNTING FEES		IME REALTY		43	43	18
19	V	20	LICENSE & PERMITS		IME REALTY		23	23	19
20	V	26	INSURANCE		IME REALTY		55	55	20
21	V	30	SL DEPRECIATION		IME REALTY		748	748	21
22	V	32	INTEREST		IME REALTY		1,266	1,266	22
23	V	33	REAL ESTATE TAX		IME REALTY		1,223	1,223	23
24	V	35	STORAGE FEES		IME REALTY		373	373	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,634			$ 4,539	$ * (4,095)	39

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alloc from Emi Entertprises:								$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	36.75		3	3.75	Salary	8,516	17-7	2
3	PHILIP ESFORMES	Admin Consultant	Administrative	36.75	SEE	0		Consult Fee	8,516	17-7	3
4											4
5	Alloc from Eks Management:										5
6	AVRUM WEINFELD	CFO	CFO	2.00	ATTACHED	3	4.62	Salary	5,021	17-7	6
7	FLORA WEISS	o/s consulting	Bookkeeping	0.00		0.5	0.89	Consult Fee	756	21-7	7
8											8
9	Alloc from 6865 Management										9
10	PHILIP ESFORMES	Admin Consultant	Admin Consult		SCHEDULE	0		Consult Fee	31,309	17-7	10
11	DANIEL WEISS	Admin Consultant	Admin Consult	24.50		0		Consult Fee	2,174	17-7	11
12											12
13								TOTAL	$ 56,292		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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

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

	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	17	EMI ENTERPRISES	PATIENT DAYS	510,807	10	$ 216,000	$	37,021	$ 15,655	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000		37,021	31,309	2
3	17	M. ROSEN	PATIENT DAYS	510,807	10	216,000		37,021	15,655	3
4	17	D. WEISS	PATIENT DAYS	510,807	10	30,000		37,021	2,174	4
5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750		37,021	54	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					$ 894,750	$		$ 64,847	25

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

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

	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	PAINTERS SALARY	PATIENT DAYS	847,662	14	$ 38,929	$ 38,929	37,021	$ 1,700	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		37,021	42	2
3	17	CFO - SALARY	PATIENT DAYS	847,662	14	114,971	114,971	37,021	5,021	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	37,021	3,843	4
5	20	WANT ADS/ BACK GRD CKS	PATIENT DAYS	847,662	14	35,000		37,021	1,529	5
6	21	OFFICE / CLERICAL	PATIENT DAYS	847,662	14	377,586	282,348	37,021	16,491	6
7	23	SEMINARS	PATIENT DAYS	847,662	14	115		37,021	5	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		37,021	582	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		37,021	109	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		37,021	2,628	10
11	30	SL DEPRECIATION	PATIENT DAYS	847,662	14	1,536		37,021	67	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	847,662	14	36,848		37,021	1,609	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					$ 769,917	$ 512,782		$ 33,626	25

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: EMI MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	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	DRIVERS SALARY	PATIENT DAYS	847,662	14	$ 40,460	$ 40,460	37,021	$ 1,767	1
2	17	OFFICER SALARY	PATIENT DAYS	847,662	14	195,000	195,000	37,021	8,516	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,662	14	6,000	6,000	37,021	262	3
4	17	MGT CONSULTANT	PATIENT DAYS	847,662	14	195,000		37,021	8,516	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		37,021	283	5
6	21	OFFICE	PATIENT DAYS	847,662	14	87,144	58,016	37,021	3,806	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		37,021	103	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		37,021	561	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		37,021	4,115	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,453		37,021	237	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					$ 644,941	$ 299,476		$ 28,166	25

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

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

	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	5	UTILITIES	RENTAL INCOME	195,459	14	$ 5,131	$	8,634	$ 227	1
2	6	REPAIRS / MAINTENCE	RENTAL INCOME	195,459	14	13,157		8,634	581	2
3	19	ACCOUNTING FEES	RENTAL INCOME	195,459	14	973		8,634	43	3
4	20	LICENSE & PERMITS	RENTAL INCOME	195,459	14	526		8,634	23	4
5	26	INSURANCE	RENTAL INCOME	195,459	14	1,254		8,634	55	5
6	30	SL DEPRECIATION	RENTAL INCOME	195,459	14	16,930		8,634	748	6
7	32	INTEREST	RENTAL INCOME	195,459	14	28,650		8,634	1,266	7
8	33	REAL ESTATE TAX	RENTAL INCOME	195,459	14	27,693		8,634	1,223	8
9	35	STORAGE FEES	RENTAL INCOME	195,459	14	8,451		8,634	373	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					$ 102,765	$		$ 4,539	25

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	THE PRIVATE BANK		X	WORKING CAPITAL	INTEREST	REVOLV		674,000		PRIME +	4,060	7
8	RELATED PARTY ALLOC										1,266	8
9	TOTAL Facility Related						$	$ 674,000			$ 5,326	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 674,000			$ 5,326	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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.)**

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,212	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.)		$ 42,523	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,311	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,523	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 43,834	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	6,648	8
	2007	38,023	9
	2008	39,697	10
	2009	41,212	11
	2010	42,523	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYCAMORE OPERATOR, LLC COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0048348

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-4-1476-000-00	NURSING HOME	$ 42,522.96	$ 42,522.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,522.96	$ 42,522.96

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] (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. [X] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7	RELATED PARTY				47,170	719	39	719			7
8	HOME OFFICE										8
	Improvement Type**										
9	SIDEWALK			2008	6,865	458	15	458		1,603	9
10	BATHROOM TILE AND PLUMBING			2009	16,720	608	27.5	608		1,596	10
11	HVAC SYSTEMS			2009	6,500	236	27.5	236		620	11
12	STAINLESS STEEL DUCTING			2009	2,750	100	27.5	100		262	12
13	FIRE ALARM SYSTEM			2010	38,512	1,400	27.5	1,400		2,158	13
14	ELEVATOR REHAB			2011	6,633	191	27.5	191		191	14
15	WATER HEATER			2011	5,551	160	27.5	160		160	15
16											16
17											17
18											18
19											19
20											20
21											21
22	WINDOWS- LANDLORD			2009	50,538						22
23	WINDOWS- LANDLORD			2010	43,242						23
24	PARKING LOT- LANDLORD			2010	32,000						24
25	NURSES CALL STATION- LANDLORD			2010	35,984						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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 292,465	$ 3,872		$ 3,872	$	$ 6,590	70

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 52,310	$ 5,045	$ 5,231	$ 186	10 YRS	$ 15,017	71
72	Current Year Purchases	2,588	2,588	129	(2,459)	10 YRS	129	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		98	98				74
75	TOTALS	$ 54,898	$ 7,731	$ 5,458	$ (2,273)		$ 15,146	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	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)	$ 347,363	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,603	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,330	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,273)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 21,736	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.

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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:		205	11/01/06	$ 481,350	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		205		$ 481,350 **			7

10. Effective dates of current rental agreement:
    Beginning 11/01/96
    Ending 4/30/12

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 27,727 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	FACILITY	2009 FORD WAGON	$ 775.00	$ 9,300	17
18	ADMINISTRATOR	2009 TOYOTA HIGHLANDER	594.98	7,140	18
19					19
20					20
21	TOTAL		$ #######	$ 16,440	21

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

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number SYCAMORE OPERATOR, LLC

STATE OF ILLINOIS
0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	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	$		$ 151,465	$		$ 151,465	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,430			13,430	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			191,603			191,603	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				60,686		60,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): med.sup. Radiology					23,587	3,043		26,630	13
14	TOTAL			$		$ 380,085	$ 63,729		$ 443,814	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.

STATE OF ILLINOIS

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 12,955	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,000))	1,158,454		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,288		6
7	Other Prepaid Expenses	950		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): real estate & ins. Escrow	58,210		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,312,857	$	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	83,531		15
16	Equipment, at Historical Cost	54,898		16
17	Accumulated Depreciation (book methods)	(54,939)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	296,427		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 379,917	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,692,774	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 882,800	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	674,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,832		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,504		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,523		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)**	$ 1,742,659	$	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)**	$ 1,742,659	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (49,885)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,692,774	$	48

***(See instructions.)**

Facility Name & ID Number SYCAMORE OPERATOR, LLC **#** 0048348 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 235,521	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 235,525	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(285,410)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (285,410)	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)**	$ (49,885)	24 *

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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,732,088	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,732,088	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	270,984	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 270,984	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***	4,217	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,217	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)**	$ 5,007,289	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,110,681	31
32	Health Care	2,134,034	32
33	General Administration	903,315	33
	B. Capital Expense		
34	Ownership	592,831	34
	C. Ancillary Expense		
35	Special Cost Centers	443,814	35
36	Provider Participation Fee	112,238	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(4,214)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,292,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	(285,410)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (285,410)	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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,104	2,195	$ 65,475	$ 29.83	1
2	Assistant Director of Nursing	1,920	2,136	52,949	24.79	2
3	Registered Nurses	13,256	13,681	283,497	20.72	3
4	Licensed Practical Nurses	31,145	33,148	549,413	16.57	4
5	CNAs & Orderlies	74,559	78,087	764,806	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,959	2,127	31,215	14.68	8
9	Activity Director					9
10	Activity Assistants	12,217	13,100	117,442	8.97	10
11	Social Service Workers	5,899	6,136	57,159	9.32	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	45,139	21.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,729	20,223	178,278	8.82	15
16	Dishwashers					16
17	Maintenance Workers	4,437	4,882	72,197	14.79	17
18	Housekeepers	18,346	19,338	161,358	8.34	18
19	Laundry	12,194	13,012	112,351	8.63	19
20	Administrator	2,032	2,080	87,075	41.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,115	4,445	60,531	13.62	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	1,857	2,050	18,446	9.00	31
32	Other Health C: Ward Clerks	2,025	2,151	18,488	8.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,762	220,871	$ 2,675,819 *	$ 12.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,767	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	6,710	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	6,945	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,182		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HUSKEY,VIOLA	ADMINISTRATOR		$ 87,075
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,075

B. Administrative - Other

Description	Amount
6865 FINANCIAL INC.-ANAGEMENT FEE	$ 11,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 11,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		62,238
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 62,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,261
Unemployment Compensation Insurance	28,196
FICA Taxes	202,505
Employee Health Insurance	40,292
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	24,399
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,653

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,482
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 6	300
TRUST/FRANCHISE/CONTRIB/ETC	5,234
MARKETING/ADV/PROMO	8,523
LICENSES/DUES/SUBSCRIPTIONS	17,712
MGMT CO ALLOC	1,552
TRUST/FRANCHISE/CONTRIB/ETC	(5,234)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,267)
Yellow page advertising	(256)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,046

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYCAMORE OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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 OPERATOR, LLC # 0048348 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $14,454**

(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.