

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0051649

Facility Name: Sycamore Healthcare Center

Address: 720 Sycamore Street Quincy 62301
Number City Zip Code

County: Adams

Telephone Number: (217) 222-1480 Fax # (217) 222-0962

HFS ID Number:

Date of Initial License for Current Owners: 41087

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
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 1/1/16 to 12/31/16 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) _____
(Title) _____

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sycamore Healthcare Center

0051649 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,404</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>111</u>	Intermediate (ICF)	<u>111</u>	<u>40,626</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	75,030	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,597</u>	<u>153</u>	<u>1,166</u>	<u>2,916</u>	8
9	SNF/PED					9
10	ICF	<u>18,680</u>	<u>1,593</u>		<u>20,273</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,277	1,746	1,166	23,189	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 30.91%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
None (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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 06/27/2012

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/27/2012 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 1,166

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sycamore Healthcare Center # 0051649 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	195,464	37,564	6,458	239,486		239,486		239,486			1
2	Food Purchase		144,138		144,138		144,138	(2,924)	141,214			2
3	Housekeeping	108,356	18,971		127,327		127,327		127,327			3
4	Laundry	82,394	17,492		99,886		99,886		99,886			4
5	Heat and Other Utilities			108,254	108,254		108,254		108,254			5
6	Maintenance	42,216	4,801	53,461	100,478		100,478	2,480	102,958			6
7	Other (specify):* Waste Removal			26,883	26,883		26,883		26,883			7
8	TOTAL General Services	428,430	222,966	195,056	846,452		846,452	(444)	846,008			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,523,926	91,519	56,318	1,671,763		1,671,763		1,671,763			10
10a	Therapy	12,920		750	13,670		13,670		13,670			10a
11	Activities	89,264		9,886	99,150		99,150		99,150			11
12	Social Services	120,897		2,967	123,864		123,864		123,864			12
13	CNA Training											13
14	Program Transportation			5,331	5,331		5,331		5,331			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,747,007	91,519	93,252	1,931,778		1,931,778		1,931,778			16
	C. General Administration											
17	Administrative	110,620		157,486	268,106		268,106		268,106			17
18	Directors Fees											18
19	Professional Services			102,816	102,816		102,816	(12,040)	90,776			19
20	Dues, Fees, Subscriptions & Promotions			38,286	38,286		38,286	(7,086)	31,200			20
21	Clerical & General Office Expenses	62,921	15,932	63,458	142,311		142,311		142,311			21
22	Employee Benefits & Payroll Taxes			458,974	458,974		458,974		458,974			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,018	1,018		1,018		1,018			24
25	Other Admin. Staff Transportation			(908)	(908)		(908)		(908)			25
26	Insurance-Prop.Liab.Malpractice			50,168	50,168		50,168	13,117	63,285			26
27	Other (specify):*											27
28	TOTAL General Administration	173,541	15,932	871,298	1,060,771		1,060,771	(6,009)	1,054,762			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,348,978	330,417	1,159,606	3,839,001		3,839,001	(6,453)	3,832,548			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							164,673	164,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			126,438	126,438		126,438	83,114	209,552			32
33	Real Estate Taxes							23,129	23,129			33
34	Rent-Facility & Grounds			386,063	386,063		386,063	(386,063)				34
35	Rent-Equipment & Vehicles			10,463	10,463		10,463		10,463			35
36	Other (specify):*											36
37	TOTAL Ownership			522,964	522,964		522,964	(115,147)	407,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,848	155,210	213,058		213,058		213,058			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,149	246,149		246,149		246,149			42
43	Other (specify):* See Att Sch 4A			80,229	80,229		80,229	(77,094)	3,135			43
44	TOTAL Special Cost Centers		57,848	481,588	539,436		539,436	(77,094)	462,342			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,348,978	388,265	2,164,158	4,901,401		4,901,401	(198,694)	4,702,707			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Period Beginning 1/1/16
Period End 12/31/16

Schedule 4A

V. Cost Center Expenses

		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	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			2,866	2,866		2,866		2,866			
	Radiology Expenses			269	269		269		269			
	Non-Allowable Expenses			77,094	77,094		77,094	(77,094)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	0	0	80,229	80,229	0	80,229	(77,094)	3,135			

SEE ACCOUNTANTS' COMPILATION REPORT

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	(18,769)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	164,673	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,227)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,040)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,990)	43		24
25	Fund Raising, Advertising and Promotional	(4,000)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(15,767)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 60,711		\$	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)	(259,405)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (259,405)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (198,694)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Vending Income	\$ (2,924)	2	1
2	Resident Needs/Charity	(900)	43	2
3	Theft and Damage Loss	(39)	43	3
4	PAC Dues	(7,086)	20	4
5	Building Co. - Admin Expenses	(250)	21	5
6	Building Co. - Other Financing Costs	(6,429)	36	6
7	Building Co. - Licenses & Fees	(619)	20	7
8	Additional Repairs & Maintenance	2,480	6	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	(15,767)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	20	Licenses & Fees	\$	SH Quincy LLC	100.00%	\$ 619	\$ 619	1
2	V	21	Bank Charges		SH Quincy LLC	100.00%	250	250	2
3	V	26	Property Insurance		SH Quincy LLC	100.00%	13,117	13,117	3
4	V	32	Interest		SH Quincy LLC	100.00%	83,114	83,114	4
5	V	33	Real Estate Taxes		SH Quincy LLC	100.00%	23,129	23,129	5
6	V	34	Rent	386,063	SH Quincy LLC	100.00%		(386,063)	6
7	V	36	Finance Costs		SH Quincy LLC	100.00%	6,429	6,429	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 386,063			\$ 126,658	\$ * (259,405)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Jimmy Nassour	50	Bourbonnais Terrace NH	Bourbonnais	SH Quincy LLC	Quincy	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Crestwood Terrace Nursing Ctr	Crestwood				3
4			Frankfort Terrace Nursing Center	Frankfort				4
5			Joliet Terrace Nursing Center	Joliet				5
6			Kankakee Terrace Nursing Center	Bourbonnais				6
7			Southview Manor Nursing Center	Chicago				7
8			Terrace Nursing Home, The	Waukegan				8
9			West Chicago Terrace NH	West Chicago				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

SEE ACCOUNTANTS' PREPARATION REPORT

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sycamore Healthcare Center # 0051649 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Mortgage		X	Mortgage Payable			\$	2,853,325			\$	82,461	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap		X	Line of Credit				4,204,384				104,258	6
7													7
8													8
9	TOTAL Facility Related						\$	7,057,709			\$	186,719	9
	B. Non-Facility Related*												
10								Amortization Expense				22,833	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	22,833	14
15	TOTALS (line 9+line14)						\$	7,057,709			\$	209,552	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	58,927	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.)		2015	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	(58,927)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	82,056	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.			\$		6
TOTAL REFUND \$ <u> </u> For <u> </u> 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.			\$	23,129	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	<u> </u>	39,830	8	
	2012	<u> </u>	39,943	9	
	2013	<u> </u>	57,210	10	
	2014	<u> </u>	56,247	11	
	2015	<u> </u>	23,129	12	
Accrual based on prior year tax bill.					

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.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Sycamore Healthcare Center COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0051649

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

TELEPHONE (630) 501-0996 FAX #: (630) 501-0987

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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.

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).

None

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	Facility		2012	\$ 100,000	1
2					2
3	TOTALS			\$ 100,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	205		2012	1973	\$ 2,620,279	\$	35	\$ 74,865	\$ 74,865	\$ 374,325	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System		2012		249,900		20	12,495	12,495	56,228	9
10	Fire Alarm Systems		2012		6,037		20	302	302	1,233	10
11	Installed Hvac In South Office		2014		5,207		20	260	260	560	11
12	Heater Repair		2014		3,973		20	199	199	1,258	12
13	Replace Obsolete Transfer Switch		2014		3,360		20	168	168	896	13
14	Flooring Repair And Re-Tile		2015		4,426		20	221	221	627	14
15	Replace Door		2016		2,786		20	139	139	139	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sycamore Healthcare Center

0051649

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Leasehold Improvements (Real Estate Entity:						\$	\$	37
38 Condenser Replacement	2013	4,314		20	216	216	864	38
39 Elevator Repair - Shunt trip disconnect	2014	10,700		20	535	535	1,605	39
40 Elevator Repair - Installed 3 door operators	2014	48,467		20	2,423	2,423	7,269	40
41 20 PTAC Units	2014	27,763		20	1,388	1,388	4,164	41
42 Electric Work	2015	3,500		20	175	175	350	42
43 Electric Work	2015	3,700		20	185	185	370	43
44 Elevator Repair	2015	23,467		20	1,173	1,173	2,346	44
45 Strip Floor to Remove All Wax from Floor	2015	3,600		20	180	180	360	45
46 Install VCT Tile & Cove Base on Floor	2015	14,441		20	722	722	1,444	46
47 Scrub/Seal/Wax, Applied 4 Coats	2015	4,600		20	230	230	460	47
48 Modify Generator & Emergency & Critical Loads	2016	9,100		20	455	455	455	48
49 Install Fire Alarm Panel	2016	10,680		20	534	534	534	49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,060,300	\$		\$ 96,865	\$ 96,865	\$ 455,487	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 653,557	\$	\$ 65,356	\$ 65,356	10	\$ 321,558	71
72	Current Year Purchases	6,959		696	696	10	696	72
73	Fully Depreciated Assets	3,337					3,337	73
74								74
75	TOTALS	\$ 663,853	\$	\$ 66,052	\$ 66,052		\$ 325,591	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		2009 FORD E350 WAGON	2014	\$ 8,779	\$	\$ 1,756	\$ 1,756	5	\$ 4,376	76
77										77
78										78
79										79
80	TOTALS			\$ 8,779	\$	\$ 1,756	\$ 1,756		\$ 4,376	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,832,932	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,673	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 164,673	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 785,454	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 10,463 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17				\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Sycamore Healthcare Center
IDPH License ID Number: 0051649
Fiscal Year End: 12/31/16

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Ice Machine	2,100
Copier	5,041
Postage Machine	340
Computer Equip	380
Dishwasher	2,602
Total - Line 16	10,463

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

☒ NO

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$		\$	52,416	\$		\$	52,416	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs				13,853				13,853	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39(3)	hrs				88,941				88,941	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					44,719			44,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Attached Schedule 16A							13,129			13,129	13
14	TOTAL			\$		\$	155,210	\$	57,848	\$	213,058	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Urological Supplies	39(2)	hrs	\$		\$		\$	1	
2	Oxygen Rental/Cost	39(2)	hrs			9,547		9,547	2	
3	Respiratory Rental/Cost	39(2)	hrs			3,582		3,582	3	
4			hrs						4	
5			visits						5	
6			visits						6	
7			hrs						7	
8			hrs						8	
9			# of prescrpts						9	
10			hrs						10	
11			hrs						11	
12									12	
13									13	
14	TOTAL			\$		\$	13,129	\$	13,129	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 126,518	\$ 121,602	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 192,514)	583,849	583,849	3
4	Supply Inventory (priced at Cost)	4,650	4,650	4
5	Short-Term Investments			5
6	Prepaid Insurance	49,443	54,035	6
7	Other Prepaid Expenses	12,562	12,562	7
8	Accounts Receivable (owners or related parties)	79,365	69,462	8
9	Other(specify): See Attached Schedule 17A	1,782	142,968	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 858,169	\$ 989,128	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,800	100,000	13
14	Buildings, at Historical Cost		2,669,753	14
15	Leasehold Improvements, at Historical Cost	30,207	390,547	15
16	Equipment, at Historical Cost	77,227	672,632	16
17	Accumulated Depreciation (book methods)	(9,555)	(785,454)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Goodwill)	731,841	731,841	22
23	Other(specify): Loan Costs		17,786	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 837,520	\$ 3,797,105	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,695,689	\$ 4,786,233	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,130,211	\$ 1,151,595	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,204,384	4,204,384	29
30	Accrued Salaries Payable	230,722	230,722	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,769	7,769	31
32	Accrued Real Estate Taxes(Sch.IX-B)		82,056	32
33	Accrued Interest Payable		103,258	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	89,460	89,460	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,662,546	\$ 5,869,244	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,853,325	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	638,071	32,519	43
44	Mortgage Premium		67,635	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 638,071	\$ 2,953,479	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,300,617	\$ 8,822,723	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,604,928)	\$ (4,036,490)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,695,689	\$ 4,786,233	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Sycamore Healthcare Center
IDPH License ID Number: 0051649
Fiscal Year End: 12/31/16

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
IMPOUND RESERVE	1,782	1,782
MORTGAGE ESCROWS		141,186
Total - Line 9	1,782	142,968

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED EXPENSES	41,360	41,360
ALLIED ACCRUAL	48,452	48,452
PAYROLL WITHHOLDINGS	1,928	1,928
DUE TO/FROM PRIOR PERIOD	(1,184)	(1,184)
DUE TO/FROM ALIEN RECIPIEN	(1,096)	(1,096)
Total - Line 36	89,460	89,460

XV. Balance Sheet

Line 43 Long-Term Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED RENT	211,367	-
DUE TO/FROM FACILITIES	32,519	32,519
DUE TO/FROM PROPERTY	394,185	-
Total - Line 43	638,071	32,519

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,043,124)	1
2	Restatements (describe):		2
3	Rounding	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,043,119)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,694,219)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	132,410	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)	\$ (1,561,809)	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)	\$ (4,604,928)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sycamore Healthcare Center

0051649

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,093,626	1
2	Discounts and Allowances for all Levels	(1,932)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,091,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,354	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 102,354	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	(35)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (35)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a	Vend Inc (2,924), Adj Prior AP-Lab/X-Ray (10,245)	13,169	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,169	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,207,182	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	846,452	31
32	Health Care	1,931,778	32
33	General Administration	1,060,771	33
	B. Capital Expense		
34	Ownership	522,964	34
	C. Ancillary Expense		
35	Special Cost Centers	293,287	35
36	Provider Participation Fee	246,149	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,901,401	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,694,219)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,694,219)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,294,666	44
45	Private Pay - Net Inpatient Revenue	295,150	45
46	Medicare - Net Inpatient Revenue	453,336	46
47	Other-(specify) <u>Hospice</u>	48,542	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,091,694	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,080	\$ 96,227	\$ 46.26	1
2	Assistant Director of Nursing	1,510	1,551	55,570	35.83	2
3	Registered Nurses	8,662	8,935	242,962	27.19	3
4	Licensed Practical Nurses	15,590	16,515	323,221	19.57	4
5	CNAs & Orderlies	52,929	55,835	727,441	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	558	742	12,920	17.41	8
9	Activity Director					9
10	Activity Assistants	7,461	8,197	89,264	10.89	10
11	Social Service Workers	6,915	7,596	120,897	15.92	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,080	31,241	15.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,926	18,558	164,223	8.85	15
16	Dishwashers					16
17	Maintenance Workers	2,629	2,965	42,216	14.24	17
18	Housekeepers	8,969	9,199	108,356	11.78	18
19	Laundry	8,420	9,206	82,394	8.95	19
20	Administrator	1,768	2,080	110,620	53.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,816	4,168	62,921	15.10	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	1,419	1,419	17,311	12.20	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	1,681	1,721	61,194	35.56	33
34	TOTAL (lines 1 - 33)	144,021	152,847	\$ 2,348,978 *	\$ 15.37	34

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	144	\$ 6,458	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	24	2,417	L10, C3	37
38	Nurse Consultant	146	7,218	L10, C3	38
39	Pharmacist Consultant	Monthly	3,775	L10, C3	39
40	Physical Therapy Consultant	8	750		40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	1,083	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) Psychosocial	38	2,818	L12, C3	46
47	Psychiatric Medical Director	Monthly	6,000	L9,C3	47
48					48
49	TOTAL (lines 35 - 48)	371	\$ 42,519		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

AIX. SUPPORT SCHEDULES									
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Jonni Bullington	Administrator	0.00%	\$ 110,620	Workers' Compensation Insurance		\$ 91,308	IDPH License Fee		\$ 1,990
				Unemployment Compensation Insurance		39,703	Advertising: Employee Recruitment		10,669
				FICA Taxes		173,543	Health Care Worker Background Check		
				Employee Health Insurance		149,601	(Indicate # of checks performed 19)		640
				Employee Meals			Patient Background Checks	54	1,045
				Illinois Municipal Retirement Fund (IMRF)*			IL Council on LTC		21,279
				Other Employee Benefits		4,004	Dues & Subscriptions		1,125
				Employee Drug Screening		815	Licenses & Fees		1,538
							Less PAC Dues		(7,086)
							Less: Public Relations Expense	(	
							Non-allowable advertising	(	
							Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$	31,200
				TOTAL (agree to Schedule V, line 22, col.8)					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		Amount
TM Healthcare Management - Management Fees			\$ 157,486	N/A			Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel		

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number <u>Sycamore Healthcare Center</u>	STATE OF ILLINOIS # <u>0051649</u>	Report Period Beginning: <u>1/1/16</u>	Ending: <u>12/31/16</u>
--	--	---	--------------------------------

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. 21,279 IL Council on LTC

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,257 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 246,149
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? 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: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT