

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0038711

**Facility Name:** Embassy Care Center, Inc

**Address:** 555 West Kahler Road Wilmington 60481  
 Number City Zip Code

**County:** Will

**Telephone Number:** (815) 476-7931 **Fax #** (815) 476-7939

**HFS ID Number:** 36-3863655-001

**Date of Initial License for Current Owners:** \_\_\_\_\_

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Bob Kagda</u> <u>Partner</u>	
	(Firm Name & Address) <u>Krupnick, Bokor, Kagda &amp; Brooks, Ltd.</u> <u>3750 W. Devon Ave. Lincolnwood, IL 60712-1124</u>	
	(Telephone) <u>(847)-675-3585</u> Fax # <u>(847) 675-5777</u>	

**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 Embassy Care Center, Inc

# 0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	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	10		4,075	4,085	8
9	SNF/PED					9
10	ICF	31,514	7,653	398	39,565	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,524	7,653	4,473	43,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.94%

D. How many bed-hold days during this year were paid by the Department? 12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/1/93 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 16 and days of care provided 4,075

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/06 Fiscal Year: 12/06

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

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	224,942	10,567	5,391	240,900		240,900		240,900			1
2	Food Purchase		176,127		176,127	(17,535)	158,592	(306)	158,286			2
3	Housekeeping	145,747	26,314		172,061		172,061		172,061			3
4	Laundry	70,779	16,701		87,480		87,480		87,480			4
5	Heat and Other Utilities			159,954	159,954		159,954	4,499	164,453			5
6	Maintenance	42,861	12,014	45,146	100,021		100,021	6,449	106,470			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>484,329</b>	<b>241,723</b>	<b>210,491</b>	<b>936,543</b>	<b>(17,535)</b>	<b>919,008</b>	<b>10,642</b>	<b>929,650</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,650	7,650		7,650		7,650			9
10	Nursing and Medical Records	1,265,580	67,963	217,704	1,551,247		1,551,247	(157)	1,551,090			10
10a	Therapy	51,043	116	18,312	69,471		69,471		69,471			10a
11	Activities	169,425	2,501		171,926		171,926		171,926			11
12	Social Services	79,073		4,620	83,693		83,693		83,693			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,565,121</b>	<b>70,580</b>	<b>248,286</b>	<b>1,883,987</b>		<b>1,883,987</b>	<b>(157)</b>	<b>1,883,830</b>			16
	<b>C. General Administration</b>											
17	Administrative	95,903		393,330	489,233		489,233	(376,730)	112,503			17
18	Directors Fees											18
19	Professional Services			99,770	99,770		99,770	5,270	105,040			19
20	Dues, Fees, Subscriptions & Promotions			21,229	21,229		21,229	(3,020)	18,209			20
21	Clerical & General Office Expenses	138,753	20,961	34,254	193,968		193,968	208,865	402,833			21
22	Employee Benefits & Payroll Taxes			368,464	368,464	17,535	385,999	40,871	426,870			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,405	1,405		1,405		1,405			24
25	Other Admin. Staff Transportation			13,359	13,359		13,359	(7,037)	6,322			25
26	Insurance-Prop.Liab.Malpractice			186,808	186,808		186,808	2,956	189,764			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>234,656</b>	<b>20,961</b>	<b>1,118,619</b>	<b>1,374,236</b>	<b>17,535</b>	<b>1,391,771</b>	<b>(128,825)</b>	<b>1,262,946</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,284,106</b>	<b>333,264</b>	<b>1,577,396</b>	<b>4,194,766</b>		<b>4,194,766</b>	<b>(118,340)</b>	<b>4,076,426</b>			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.

Embassy Care Center, Inc  
0038711  
COST REPORT RECLASSIFICATIONS  
01/01/06  
12/31/06

SCHEDULE V LINE #
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22	EMPLOYEE BENEFITS	17,535	
2	FOOD		17,535
	<u>To reclass cost of employee meals from raw food to employee benefits</u>		
33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		
	<u>To reclass cost of appealing real estate taxes</u>		

Facility Name & ID Number Embassy Care Center, Inc #0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			35,917	35,917		35,917	109,091	145,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,238	130,238		130,238	358,061	488,299			32
33	Real Estate Taxes			68,638	68,638		68,638	8,422	77,060			33
34	Rent-Facility & Grounds			560,158	560,158		560,158	(560,158)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			794,951	794,951		794,951	(84,584)	710,367			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,594	205,815	382,409		382,409		382,409			39
40	Barber and Beauty Shops			458	458		458		458			40
41	Coffee and Gift Shops			242	242		242		242			41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		176,594	300,138	476,732		476,732		476,732			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,284,106	509,858	2,672,485	5,466,449		5,466,449	(202,924)	5,263,525			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 Embassy Care Center, Inc

# 0038711

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,191	30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(306)	2		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				18
19	Entertainment	(1,592)	20		19
20	Contributions	(350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,835)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(926)	21		24
25	Fund Raising, Advertising and Promotional				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	(188,548)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (130,413)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(72,511)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (72,511)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (202,924)</b>		<b>37</b>

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Embassy Care Center, Inc

ID# 0038711

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Veterans Expense	\$ (157)	10	1
2	Bank Charges	(13,112)	21	2
3	Marketing	(628)	20	3
4	Travel	(12,825)	25	4
5	Depr round off adj	(1)	30	5
6	Deferred Maintenance	1,545	6	6
7				7
8	From Embassy Building Partnership:			8
9	Trust Fees	(1,041)	20	9
10	Bank Charges	(476)	21	10
11	Non Patient Care - Interest Exp	(9,386)	32	11
12	R E Taxes	(4,122)	33	12
13	Depreciation House	(4,046)	30	13
14	Mtge Costs	(68)	32	14
15	Mtge Costs	(116,626)	32	15
16	Depreciation - Section 754	(4,639)	30	16
17	Legal	(22,966)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(188,548)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(306)	0	0	0	0	0	0	0	0	0	0	(306)	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	4,499	0	0	0	0	0	0	0	0	4,499	5
6	Maintenance	1,545	0	4,904	0	0	0	0	0	0	0	0	6,449	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,239</b>	<b>0</b>	<b>9,403</b>	<b>0</b>	<b>10,642</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(157)	0	0	0	0	0	0	0	0	0	0	(157)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(157)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(157)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(376,730)	0	0	0	0	0	0	0	0	(376,730)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,801)	22,966	8,105	0	0	0	0	0	0	0	0	5,270	19
20	Fees, Subscriptions & Promotions	(3,611)	0	591	0	0	0	0	0	0	0	0	(3,020)	20
21	Clerical & General Office Expenses	(14,514)	1,517	221,862	0	0	0	0	0	0	0	0	208,865	21
22	Employee Benefits & Payroll Taxes	0	0	40,871	0	0	0	0	0	0	0	0	40,871	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(12,825)	0	5,788	0	0	0	0	0	0	0	0	(7,037)	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,956	0	0	0	0	0	0	0	0	2,956	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(56,751)</b>	<b>24,483</b>	<b>(96,557)</b>	<b>0</b>	<b>(128,825)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(55,669)</b>	<b>24,483</b>	<b>(87,154)</b>	<b>0</b>	<b>(118,340)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	55,505	45,993	7,593	0	0	0	0	0	0	0	0	109,091	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(126,127)	475,604	8,584	0	0	0	0	0	0	0	0	358,061	32
33	Real Estate Taxes	(4,122)	4,122	8,422	0	0	0	0	0	0	0	0	8,422	33
34	Rent-Facility & Grounds	0	(560,158)	0	0	0	0	0	0	0	0	0	(560,158)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(74,744)</b>	<b>(34,439)</b>	<b>24,599</b>	<b>0</b>	<b>(84,584)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(130,413)</b>	<b>(9,956)</b>	<b>(62,555)</b>	<b>0</b>	<b>(202,924)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See schedule		See Schedule		See Schedule		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 560,158	Embassy Care LLC		\$	\$ (560,158)	1
2	V	20 Licenses & Fees		Embassy Care LLC				2
3	V	21 Bank Charges		Embassy Care LLC		476	476	3
4	V	21 Trust Fees		Embassy Care LLC		1,041	1,041	4
5	V	32 Interest Expense		Embassy Care LLC		358,918	358,918	5
6	V	33 RE Tax		Embassy Care LLC		4,122	4,122	6
7	V	30 Depreciation		Embassy Care LLC		45,993	45,993	7
8	V	32 Amort Mtge Costs		Embassy Care LLC		116,694	116,694	8
9	V	19 Legal Fees		Embassy Care LLC		22,966	22,966	9
10	V	32 Interest Income		Embassy Care LLC		(8)	(8)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 560,158			\$ 550,202	\$ * (9,956)	14

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

Facility Name & ID Number Embassy Care Center, Inc# 0038711Report Period Beginning: 01/01/06Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 393,330	Future Associates		\$	(393,330)	15
16	V	5 Utilities		Future Associates		4,499	4,499	16
17	V	6 Maintenance		Future Associates		4,904	4,904	17
18	V	17 Administrative		Future Associates		16,600	16,600	18
19	V	19 Professional Fees		Future Associates		8,105	8,105	19
20	V	21 Clerical and General		Future Associates		221,862	221,862	20
21	V	22 Employee Benefits		Future Associates		40,871	40,871	21
22	V	25 Auto Expense		Future Associates		5,788	5,788	22
23	V	26 Insurance Expense		Future Associates		2,956	2,956	23
24	V	30 Depreciation		Future Associates		7,593	7,593	24
25	V	32 Interest Expense		Future Associates		8,584	8,584	25
26	V	33 Real Estate Taxes		Future Associates		8,422	8,422	26
27	V	20 License, Dues, Fees		Future Associates		591	591	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		\$ 393,330			\$ 330,775	\$ * (62,555)	39

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

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Haim Perlstein	Director	Administrative	22.96	None	10	20.00	Admin	\$ 16,600	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40	None	15	25.00	Finance			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,600		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 Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

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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 Future Associates  
 Street Address 7514 N. Skokie Blvd  
 City / State / Zip Code Skokie, IL  
 Phone Number ( 847)982-1195  
 Fax Number ( 847)982-0992

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Management Fees	958,016	2	\$ 10,959	\$ 393,330	\$ 4,499	1	
2	6	Maintenance	Management Fees	958,016	2	11,944	393,330	4,904	2	
3	17	Administrative	Direct allocation		2	232,600		16,600	3	
4	19	Professional Fees	Management Fees	958,016		19,742	393,330	8,105	4	
5	21	Clerical and General	Management Fees	958,016		387,143	327,750	158,948	5	
6	22	Employee Benefits	Management Fees	958,016		87,284	393,330	35,836	6	
7	25	Auto Expense	Management Fees	958,016		14,097	393,330	5,788	7	
8	26	Insurance Expense	Management Fees	958,016		7,200	393,330	2,956	8	
9	30	Depreciation	Management Fees	958,016		18,494	393,330	7,593	9	
10	32	Interest Expense	Management Fees	958,016		20,907	393,330	8,584	10	
11	33	Real Estate Taxes	Management Fees	958,016		20,513	393,330	8,422	11	
12	20	License, Dues, Fees	Management Fees	958,016		1,440	393,330	591	12	
13	21	Clerical and General	Per cent		3	100,692	100,692	Var	62,914	13
14	22	Employee Benefits	Per cent		3	8,057		Var	5,035	14
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 941,072	\$ 428,442	\$ 330,775	25	

Facility Name &amp; ID Number

Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

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12/31/06

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	CIB Bank		X	Mtge	\$43,220.44	12/30/99	\$ 4,510,000	\$			\$ 314,664	1
2	RE Taxes		X								41,114	2
3	Payroll Taxes		X								2,552	3
4	IDPA		X								9,363	4
5	Allocation from Future	X									8,584	5
	<b>Working Capital</b>											
6	State Financial		X	Working Capital							34,868	6
7	CIB Bank		X	Working Capital							68,746	7
8	Insurance		X								7,758	8
9	<b>TOTAL Facility Related</b>				\$43,220.44		\$ 4,510,000	\$			\$ 487,649	9
	<b>B. Non-Facility Related*</b>											
10	House		X								9,386	10
11	Adjust out House Int		X								(9,386)	11
12	Interest Income		X								(55)	12
13	American Express										705	13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 650	14
15	<b>TOTALS (line 9+line14)</b>						\$ 4,510,000	\$			\$ 488,299	15

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Embassy Care Center, Inc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

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

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

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>16,751.44</u>	\$ <u>1,954.00</u>
2. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>8,136.37</u>	\$ <u>949.00</u>
3. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>8,136.37</u>	\$ <u>949.00</u>
4. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>16,773.08</u>	\$ <u>1,956.00</u>
5. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>16,773.08</u>	\$ <u>1,956.00</u>
6. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,768.02</u>	\$ <u>206.00</u>
7. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,768.02</u>	\$ <u>206.00</u>
8. <u>03-17-36-300-010-0000</u>	<u>Facility</u>	\$ <u>67,637.86</u>	\$ <u>67,637.86</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>137,744.24</u>	\$ <u>75,813.86</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Embassy Care Center, Inc

# 0038711 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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	<u>Facility</u>		<u>1993</u>	<u>\$ 145,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 145,000</b>	<b>3</b>

Facility Name &amp; ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	171		1993		\$ 2,363,000	\$ 37,508	35	\$ 67,514	\$ 30,006	\$ 940,585	4
5	From EMB										5
6	Holding										6
7	Alloc LCF		1986		89,232		19	2,975	2,975	59,736	7
8	Alloc LCF		1987		2,141	68	31.5	68		1,326	8
	Improvement Type**										
9	Various		1993		55,674	1,096	20	2,782	1,686	37,479	9
10	Various		1994		144,492	2,934	20	7,221	4,287	90,597	10
11	Various		1995		126,250	3,223	20	6,310	3,087	72,382	11
12	Various		1996		94,458	2,420	20	4,725	2,305	49,867	12
13	Various		1997		13,974	358	20	699	341	6,880	13
14	Various		1998		13,694	220	20	684	464	5,755	14
15	Various		1999		29,626	759	20	1,481	722	10,930	15
16	Various		2000		68,597	606	20	3,597	2,991	21,909	16
17	Various		2001		4,657	119	20	214	95	1,140	17
18	Alarm system		2/27/02		1,466	37	20	73	36	354	18
19	Exterior sewer connection		1/24/03		8,498	218	20	425	207	1,487	19
20	Rooftop Htg. Unit Module		2/24/03		768	19	20	38	19	134	20
21	Rooftop compressor unit		5/17/03		1,250	32	20	63	31	219	21
22	Hood suppression system		6/6/03		1,489	38	20	75	37	261	22
23	CCTV monitoring system		6/23/03		1,409	36	20	71	35	247	23
24	New roof		7/29/03		25,000	641	20	1,250	609	4,375	24
25	Smoke detectors, door holders		11/28/03		805	21	20	40	19	141	25
26	West wing toilet repairs		1/23/04		855	22	20	43	21	107	26
27	West wing sewer reairs		1/26/04		532	13	20	26	13	66	27
28	Heat Exchanger		3/20/00		3,200	82	20	160	78	400	28
29	New roof		10/31/03		20,000	512	20	1,000	488	3,000	29
30	Voltage regulator tray		2/28/04		1,561	40	20	78	38	195	30
31	Plastering & Painting		11/12/03		8,052	206	20	403	197	1,208	31
32	Broken water line		3/13/04		1,700	44	20	85	41	213	32
33	Clean outside manhole		4/14/04		1,413	36	20	71	35	177	33
34	Fire alarm service		5/5/04		1,658	43	20	83	40	207	34
35	Access control panel		5/21/04		1,205	31	20	61	30	151	35
36	Tel & comp lines to network		5/21/04		786	20	20	39		98	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 &amp; ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Inoized smoke detectors	5/21/04	\$ 1,163	\$ 30	20	\$ 58	\$ 28	\$ 145	37
38	Roof work	7/19/04	37,177	953	20	1,859	906	4,647	38
39	A/C replaced roof compressor	5/20/04	3,410	88	20	170	82	426	39
40	Replaced tranformer on rooftop unit	7/19/04	1,082	28	20	54	26	135	40
41	Ran E.M.T. and cables	8/2/04	846	22	20	43	21	106	41
42	Repair exit door alarm;rooftop cam	12/1/04	1,287	33	20	64	31	161	42
43	Heat exchanger	12/1/04	1,658	43	20	83	40	207	43
44	Heat exchanger	12/1/04	1,732	45	20	87	42	217	44
45	Compressor	9/29/04	2,900	74	20	145	71	363	45
46	Heat Exchangers for A C	2/24/05	7,500	193	20	375	182	563	46
47	Locknetics 101 Plus door	3/9/05	3,461	89	20	173	84	260	47
48	Service door lock;control panel	1/1/05	1,835	47	20	92	45	138	48
49	Install electromagnetic door hldr	1/7/05	1,120	28	20	56	28	84	49
50	Svce on gate alarm;instl 2 wire	2/3/05	1,047	27	20	53	26	79	50
51	Install wire push button cafe. door	6/9/05	751	20	20	37	17	56	51
52	2 compressors	7/25/05	7,291	187	20	365	178	547	52
53	Fire alarm wiring	7/31/05	968	25	20	49	24	73	53
54	Sewer line	8/18/05	708	18	20	35	17	53	54
55	Replace kitchen Exhast fan	9/21/05	608	15	20	31	16	46	55
56	Repalce compressors on A C	7/1/05	1,494	38	20	75	37	112	56
57	Rooftop unit ground wire	1/30/06	2,543	62	20	64	2	64	57
58	Rooftop unit new solenoid valve	2/27/06	1,287	29	20	32	3	32	58
59	Video monitoring	3/31/06	1,025	21	20	26	5	26	59
60	Tilt mag lock	1/1/06	1,818	45	20	45		45	60
61	New doors and frames	4/6/06	4,600	84	20	115	31	115	61
62	Brickface & Gypsum	4/30/06	601	11	20	15	4	15	62
63	Brickface & door canopy	4/21/06	863	16	20	22	6	22	63
64	Doorlocks, weatherproofing, magnet locks	4/30/06	7,073	128	20	177	49	177	64
65	Install to fire alarm svcs; trobes & pull stat	7/19/06	2,681	32	20	67	35	67	65
66	Electric magnet & strike	7/31/06	1,190	14	20	30	16	30	66
67	Renite zone annunciator & driver	7/31/06	576	7	20	14	7	14	67
68	Carrir rooftop compressor	11/30/06	2,847	9	20	71	62	71	68
69	Video monitoring equip	12/21/06	2,000	2	20	50	48	50	69
70	TOTAL (lines 4 thru 69)		\$ 3,194,584	\$ 53,865		\$ 106,986	\$ 53,102	\$ 1,320,772	70

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

Facility Name & ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 3,194,584	\$ 53,865		\$ 106,986	\$ 53,121	\$ 1,320,772	1	
2	Water meter	9/19/2006	1,878	14	20	47	33	47	2	
3									3	
4	Allocation from LCF	1987	12,281	390	31.5	390		7,504	4	
5	Allocation from LCF	1988	690	22	31.5	22		402	5	
6	Allocation from LCF	1989	257	8	31.5	8		141	6	
7	Allocation from LCF	1993	7,133	183	39	183		2,445	7	
8	Allocation from LCF	1994	10,877	279	39	279		3,473	8	
9	Allocation from LCF	2001	3,029	78	39	78		426	9	
10	Allocation from LCF-5 Ton Trane A/C	2002	742	19	39	19		83	10	
11	Allocation from LCF-Office Remodeling	2003	451	11	39	11		34	11	
12	Allocation from LCF-Electrical	2004	1,561	44	39	44		123	12	
13	Allocation from LCF-Roof repairs	2004	202	Columns 5 to 9 included on line 12						13
14	Alloc from LCF 2006:								14	
15	Various blower mtrs, control board	2006	228	22	39	22		22	15	
16	Parking lot drainage pump	2006	111						16	
17	Catch basin	2006	348						17	
18	Remove, replace drywalls, studs	2006	340						18	
19	10' water guard, sump pump	2006	268	Columns 5 to 9 included on line 15						19
20	Allocation From Future	1987	38,703	1,228	31.5	1,248	20	24,827	20	
21	Allocation From Future	1994	11,320	153	Var	153		10,409	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	TOTAL (lines 1 thru 33)		\$ 3,285,003	\$ 56,316		\$ 109,490	\$ 53,174	\$ 1,370,708	34	

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

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 217,542	\$ 7,460	\$ 21,951	\$ 14,491	10-20	\$ 142,574	71
72	Current Year Purchases	57,355	11,470	3,847	(7,623)	10	3,847	72
73	Fully Depreciated Assets	677,278		3,443	3,443	5-10	677,278	73
74								74
75	TOTALS	\$ 952,175	\$ 18,930	\$ 29,241	\$ 10,311		\$ 823,699	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	6/16/1998	\$ 1,200	\$	\$	\$	5	\$ 1,200	76
77		Dodge 2000 Caravan	4/7/2003	18,750	2,160	3,750	1,590	5	13,125	77
78		2001 Toyota Corolla	4/15/2005	7,370	2,358	1,474	(884)	5	2,211	78
79		Allocation from Future	Var	94,730	1,053	1,053		5	59,325	79
80	TOTALS			\$ 122,050	\$ 5,571	\$ 6,277	\$ 706		\$ 75,861	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)	\$ 4,504,228	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,817	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,008	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,191	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,270,268	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	House	\$ 150,000	\$ 3,846	\$ 41,184	86
87	Furniture 2006	1,000	200	200	87
88					88
89					89
90					90
91	TOTALS	\$ 151,000	\$ 4,046	\$ 41,384	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: 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	<b>TOTAL</b>				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 42,433	\$		\$ 42,433	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			402			402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			115,145			115,145	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				171,095		171,095	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					47,835	5,499		53,334	13
14	TOTAL			\$		\$ 205,815	\$ 176,594		\$ 382,409	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.

Embassy Care Center, Inc

0038711

01/01/06 to

12/31/06

Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1 Med Tube : Ent., & Urol

39-2

3694

2 Equipment Rental

39-2

1805

Total

5499

Outside Therapies (Column 5- Other)

1 Other Expense

39-3

32163

2 Lab & XRay

39-3

15672

Total

47835

Facility Name &amp; ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 32,998	\$ 33,466	1
2	Cash-Patient Deposits	60,272	60,272	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 110,000 )	1,490,774	1,490,774	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,494	117,494	6
7	Other Prepaid Expenses	3,547	12,303	7
8	Accounts Receivable (owners or related parties)	3,602,796	6,828,567	8
9	Other(specify):	37,601	37,601	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,345,482	\$ 8,580,477	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		4,058	13
14	Buildings, at Historical Cost		150,000	14
15	Leasehold Improvements, at Historical Cost	648,830	648,830	15
16	Equipment, at Historical Cost	463,802	463,802	16
17	Accumulated Depreciation (book methods)	(555,266)	(596,450)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(10,482)	(4,967)	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 546,884	\$ 665,273	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,892,366	\$ 9,245,750	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,636,443	\$ 1,658,532	26
27	Officer's Accounts Payable	2,183,530	2,469,768	27
28	Accounts Payable-Patient Deposits	54,488	54,488	28
29	Short-Term Notes Payable	293,268	293,268	29
30	Accrued Salaries Payable	232,516	232,516	30
31	Accrued Taxes Payable (excluding real estate taxes)	288,254	288,254	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,477	10,476	32
33	Accrued Interest Payable	139,496	139,496	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule	569,346	569,346	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,403,818	\$ 5,716,144	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		105,975	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 105,975	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,403,818	\$ 5,822,119	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 488,548	\$ 3,423,631	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,892,366	\$ 9,245,750	48

\*(See instructions.)

## STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name &amp; ID Numb Embassy Care Center, Inc

# 0038711

Report Period Beginning: 01/01/06

Ending: 12/31/06

## SUPPLEMENTAL SCHEDULE OF OTHER ASSETS &amp; LIABILITIES

As of 12/31/06

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow	22,073	22,073	Accrued Expenses		
Employee Advances	3,010	3,010	Sale of Assets	569,346	569,346
Insurance Escrows					
Repalcement & Repairs Escrows					
Deferred Taxes	12,518	12,518			
	<u>37,601</u>	<u>37,601</u>		<u>569,346</u>	<u>569,346</u>
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Utility Deposit	3,478	3,478			
Mortgage Costs - Net		515			
Exchange	(13,960)	(8,960)			
	<u>(10,482)</u>	<u>(4,967)</u>			

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 418,079	1
2	Restatements (describe):		2
3	Adjustment to Prior year's Interest Expense	(24,892)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 393,187	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	95,361	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)	\$ 95,361	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 488,548	24 *

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

Facility Name &amp; ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,402,250	1
2	Discounts and Allowances for all Levels	(295,063)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,107,187	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	319,313	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 319,313	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4	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	145,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,022	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,085	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 193,228	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	47	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 47	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Prior Year Adjustments</b>	(57,965)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (57,965)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,561,810	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	936,543	31
32	Health Care	1,883,987	32
33	General Administration	1,374,236	33
<b>B. Capital Expense</b>			
34	Ownership	794,951	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	383,109	35
36	Provider Participation Fee	93,623	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,466,449	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	95,361	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 95,361	43

\* 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.

Facility Name & ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,162	2,275	\$ 59,310	\$ 26.07	1
2	Assistant Director of Nursing	1,255	1,255	30,128	24.01	2
3	Registered Nurses	5,384	5,701	125,202	21.96	3
4	Licensed Practical Nurses	17,363	18,623	367,236	19.72	4
5	CNAs & Orderlies	65,234	69,131	683,704	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,133	3,526	43,648	12.38	9
10	Activity Assistants	13,194	13,822	125,777	9.10	10
11	Social Service Workers	4,469	5,261	79,073	15.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,337	23,930	224,942	9.40	15
16	Dishwashers					16
17	Maintenance Workers	3,978	4,190	42,861	10.23	17
18	Housekeepers	15,456	16,928	145,747	8.61	18
19	Laundry	9,430	10,011	70,779	7.07	19
20	Administrator	1,917	2,183	65,072	29.81	20
21	Assistant Administrator	1,194	1,221	30,831	25.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,894	11,769	138,753	11.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,827	4,297	51,043	11.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,227	194,123	\$ 2,284,106 *	\$ 11.77	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 5,391	1-3	35
36	Medical Director	Monthly	7,650	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,950	10-3	39
40	Physical Therapy Consultant	Monthly	15,949	10a-3	40
41	Occupational Therapy Consultant	30	2,290	10a-3	41
42	Respiratory Therapy Consultant	7	73	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	77	4,620	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	210	\$ 37,923		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,709	\$ 46,662	10-3	50
51	Licensed Practical Nurses	6,471	150,792	10-3	51
52	Certified Nurse Assistants/Aides	1,408	18,300	10-3	52
53	TOTAL (lines 50 - 52)	9,588	\$ 215,754		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
--	---	---	------------------------------------

\$

\$

<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#####</u>
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Facility Name & ID Number Embassy Care Center, Inc

# 0038711

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Pearl Boulnois	Admin		\$ 2,308	Workers' Compensation Insurance	\$ 120,560	IDPH License Fee	\$ 6,089	
Suzanne Glenn	Admin		62,321	Unemployment Compensation Insurance	46,947	Advertising: Employee Recruitment		
Paula Deddo	Asst Admin		27,636	FICA Taxes	171,783	Health Care Worker Background Check		
Year end Accrual Adjustment			3,638	Employee Health Insurance	20,053	(Indicate # of checks performed 448 )	7,168	
				Employee Meals	17,535	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Donations	350	
				Employee Life Ins	573	Due & Subscriptions	2,538	
				Holiday Exp	8,548	Licenses & Fees	2,864	
				Allocation from Future Associates	40,871	Entertainment	1,592	
						Schedule attached	(2,392)	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 95,903</b>			<b>TOTAL (agree to Sch. V,</b>	<b>\$ 18,209</b>	
<b>(List each licensed administrator separately.)</b>					<b>\$ 426,870</b>	<b>line 20, col. 8)</b>		
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Future Associates			\$ 393,330				Out-of-State Travel	\$
							In-State Travel	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 393,330</b>				Seminar Expense	1,405
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>				<b>TOTAL</b>			<b>Entertainment Expense</b>	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Security Service	Security		\$ 26,360				line 24, col. 8)	\$ 1,405
Krupnick,Bokor, Kagda, & Brooks	Acctg		4,250					
L J Cohn	Acctg		22,610					
R Peelo	Med Acctg		4,200					
M Schultz	Legal (adj out)		45					
Metro Process Server	Legal (adj out)		145					
Michael Margolies	Legal (adj out)		2,645					
Personnel Planners	UC Cons		1,655					
Insurance Cons	Ins		5,000					
Haim Perlstein	Admin		5,000					
Classen White	Alta survey		850					
Various	Data Processing		27,010					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 99,770</b>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Embassy Care Center, Inc  
01/01/06 to 12/31/06

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Page 21- **F. Dues, Fees, Subscriptions and Promotions**

<b>Allocation From Future</b>	591
Marketing	628
Adjustments:	
Donations	(350)
Entertainment	(1,592)
Trust Fee	(1,041)
Marketing	(628)

(2,392)

Facility Name & ID Number Embassy Care Center, Inc

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting & Decorating	6/03	\$ 690	3	\$	\$	\$ 230	\$ 115	\$	\$	\$	\$	\$
2	Painting & Decorating	6/04	3,178	3			1,059	1,059	530				
3	Painting & Decorating	6/05	1,114	3			186	371	371	186			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,982		\$	\$	\$ 1,475	\$ 1,545	\$ 901	\$ 186	\$	\$	\$

Facility Name &amp; ID Number Embassy Care Center, Inc

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,250 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. No
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES No 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 93,623  
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. \$ 17,535 Has any meal income been offset against related costs? No 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? None  
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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Less than 5000  
Attach invoices and a summary of services for all architect and appraisal fees.