

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0048488

Facility Name: Embassy Health Care Center

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: 20-4913784 001

Date of Initial License for Current Owners: 12/16/06

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
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" 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 01/01/07 to 12/31/07 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) _____	(Date) _____
	(Print Name and Title) <u>Bob Kagda</u> <u>Partner</u>	
	(Firm Name & Address) <u>Krupnick, Bokor, Kagda & 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 Health Care Center

0048488 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	2,347		6,326	8,673	8
9	SNF/PED					9
10	ICF	36,172	6,129	390	42,691	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,519	6,129	6,716	51,364	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.29%

D. How many bed-hold days during this year were paid by the Department?

4 (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)

Day Training

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 12/16/06

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/16/06 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 6,326

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/07 Fiscal Year: 12/07

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

Facility Name & ID Number Embassy Health Care Center # 0048488 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	255,039	15,319	7,271	277,629		277,629		277,629		1
2	Food Purchase		261,634		261,634	(22,513)	239,121		239,121		2
3	Housekeeping	163,818	26,085		189,903		189,903	(310)	189,593		3
4	Laundry	103,631	14,804		118,435		118,435		118,435		4
5	Heat and Other Utilities			136,546	136,546		136,546	5,393	141,939		5
6	Maintenance	53,471	16,788	83,524	153,783		153,783	7,632	161,415		6
7	Other (specify):*										7
8	TOTAL General Services	575,959	334,630	227,341	1,137,930	(22,513)	1,115,417	12,715	1,128,132		8
	B. Health Care and Programs										
9	Medical Director			20,450	20,450		20,450		20,450		9
10	Nursing and Medical Records	1,438,518	112,453	557,057	2,108,028		2,108,028	(833)	2,107,195		10
10a	Therapy	46,846	1,027	17,775	65,648		65,648		65,648		10a
11	Activities	293,567	7,720		301,287		301,287		301,287		11
12	Social Services	126,411		8,934	135,345		135,345		135,345		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,905,342	121,200	604,216	2,630,758		2,630,758	(833)	2,629,925		16
	C. General Administration										
17	Administrative	124,558		501,002	625,560		625,560	(501,002)	124,558		17
18	Directors Fees										18
19	Professional Services			61,870	61,870		61,870	4,246	66,116		19
20	Dues, Fees, Subscriptions & Promotions			36,387	36,387		36,387	(10,481)	25,906		20
21	Clerical & General Office Expenses	138,116	28,806	106,905	273,827		273,827	169,445	443,272		21
22	Employee Benefits & Payroll Taxes			428,272	428,272	22,513	450,785		450,785		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,666	3,666		3,666		3,666		24
25	Other Admin. Staff Transportation			9,744	9,744		9,744	(4,550)	5,194		25
26	Insurance-Prop.Liab.Malpractice			159,605	159,605		159,605	3,098	162,703		26
27	Other (specify):* Home ofc emp benefits							50,357	50,357		27
28	TOTAL General Administration	262,674	28,806	1,307,451	1,598,931	22,513	1,621,444	(288,887)	1,332,557		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,743,975	484,636	2,139,008	5,367,619		5,367,619	(277,005)	5,090,614		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 Health Care Center
0048488
COST REPORT RECLASSIFICATIONS
01/01/07
12/31/07

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>22,513</u>
2	FOOD	<u>22,513</u>
33	REAL ESTATE TAX	<u> </u>
19	PROFESSIONAL FEES	<u> </u>

To reclass cost of employee meals from raw food to employee benefits

To reclass cost of appealing real estate taxes

Facility Name & ID Number Embassy Health Care Center

#0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			215,183	215,183	215,183	(67,594)	147,589			30
31	Amortization of Pre-Op. & Org.			6,279	6,279	6,279	(6,279)				31
32	Interest			653,944	653,944	653,944	(187,315)	466,629			32
33	Real Estate Taxes			89,365	89,365	89,365	10,361	99,726			33
34	Rent-Facility & Grounds			17,833	17,833	17,833		17,833			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			982,604	982,604	982,604	(250,827)	731,777			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		346,307	403,707	750,014	750,014		750,014			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops			87	87	87		87			41
42	Provider Participation Fee			93,623	93,623	93,623		93,623			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		346,307	497,417	843,724	843,724		843,724			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,743,975	830,943	3,619,029	7,193,947	7,193,947	(527,832)	6,666,115			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 Health Care Center

0048488

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(78,438)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	3		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	(67,226)	21		18
19	Entertainment	(3,132)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,942)	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	(230,771)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (394,824)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(133,008)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,008)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (527,832)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

Embassy Health Care Center

ID# 0048488

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Veterans Expense	\$ (833)	10	1
2	Bank Charges	(6,999)	21	2
3	Marketing	(7,542)	20	3
4	Travel	(9,744)	25	4
5	Amortization	(6,279)	31	5
6	Other Income	(2,800)	21	6
7	Interest Expense To Related Parties	(122,500)	32	7
8	Interest paid on new mortgage in excess of old			8
9	Mtge	(73,149)	32	9
10	IRS Penalties	(647)	32	10
11	Prior year Legal Bill	(1,181)	19	11
12	Deferred Maintenance	901	6	12
13	Depreciation (round off adj)	2	30	13
14	House Rent			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	(230,771)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(310)	0	0	0	0	0	0	0	0	0	0	(310)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,393	0	0	0	0	0	0	0	0	0	5,393	5
6	Maintenance	901	6,731	0	0	0	0	0	0	0	0	0	7,632	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	591	12,124	0	12,715	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(833)	0	0	0	0	0	0	0	0	0	0	(833)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(833)	0	0	0	0	0	0	0	0	0	0	(833)	16
	C. General Administration													
17	Administrative	0	(501,002)	0	0	0	0	0	0	0	0	0	(501,002)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,181)	5,427	0	0	0	0	0	0	0	0	0	4,246	19
20	Fees, Subscriptions & Promotions	(10,674)	193	0	0	0	0	0	0	0	0	0	(10,481)	20
21	Clerical & General Office Expenses	(91,967)	261,412	0	0	0	0	0	0	0	0	0	169,445	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(9,744)	5,194	0	0	0	0	0	0	0	0	0	(4,550)	25
26	Insurance-Prop.Liab.Malpractice	0	3,098	0	0	0	0	0	0	0	0	0	3,098	26
27	Other (specify):*	0	50,357	0	0	0	0	0	0	0	0	0	50,357	27
28	TOTAL General Administration	(113,566)	(175,321)	0	(288,887)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(113,808)	(163,197)	0	(277,005)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	(78,436)	10,842	0	0	0	0	0	0	0	0	0	(67,594)	30
31	Amortization of Pre-Op. & Org.	(6,279)	0	0	0	0	0	0	0	0	0	0	(6,279)	31
32	Interest	(196,301)	8,986	0	0	0	0	0	0	0	0	0	(187,315)	32
33	Real Estate Taxes	0	10,361	0	0	0	0	0	0	0	0	0	10,361	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL Ownership	(281,016)	30,189	0	(250,827)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(394,824)	(133,008)	0	(527,832)	45								

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
Nachshon Draiman	50%	Peterson Park Health Care	Chicago	Future Associates	Skokie	Mgmt Comp
DR Samuel Lipshitz	28%					
Jack Rajchenbach	22%	Peterson Park Health Care	Chicago			

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

YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Home Office Expense	\$ 501,002	Future Associates		\$	\$ (501,002) 1
2	V	5 Utilities		Future Associates		5,393	5,393 2
3	V	6 Maintenance		Future Associates		6,731	6,731 3
4	V	17 Administrative		Future Associates			
5	V	19 Professional Fees		Future Associates		5,427	5,427 5
6	V	21 Clerical and General		Future Associates		261,412	261,412 6
7	V	27 Employee Benefits		Future Associates		50,357	50,357 7
8	V	25 Auto Expense		Future Associates		5,194	5,194 8
9	V	26 Insurance Expense		Future Associates		3,098	3,098 9
10	V	30 Depreciation		Future Associates		10,842	10,842 10
11	V	32 Interest Expense		Future Associates		8,986	8,986 11
12	V	33 Real Estate Taxes		Future Associates		10,361	10,361 12
13	V	20 License, Dues, Fees		Future Associates		193	193 13
14	Total		\$ 501,002			\$ 367,994	\$ * (133,008) 14

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

Facility Name & ID Number Embassy Health Care Center # 0048488 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Nachshon Draiman	Director	Administrative	0.50		15	25.00		\$	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.

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,106,010	2	\$ 11,905	\$ 501,002	\$ 5,393	1
2	6	Maintenance	Management Fees	1,106,010	2	14,860	501,002	6,731	2
3	17	Administrative	Direct allocation		1	129,000			3
4	19	Professional Fees	Management Fees	1,106,010	2	11,981	501,002	5,427	4
5	21	Clerical and General	Management Fees	1,106,010	2	424,357	320,169	192,226	5
6	27	Employee Benefits	Management Fees	1,106,010	2	98,995	501,002	44,843	6
7	25	Auto Expense	Management Fees	1,106,010	2	11,466	501,002	5,194	7
8	26	Insurance Expense	Management Fees	1,106,010	2	6,840	501,002	3,098	8
9	30	Depreciation	Management Fees	1,106,010	2	23,935	501,002	10,842	9
10	32	Interest Expense	Management Fees	1,106,010	2	19,838	501,002	8,986	10
11	33	Real Estate Taxes	Management Fees	1,106,010	2	22,873	501,002	10,361	11
12	20	License, Dues, Fees	Management Fees	1,106,010	2	425	501,002	193	12
13	21	Clerical and General	Per cent		2	109,960	109,960	69,186	13
14	22	Employee Benefits	Per cent		2	8,766		5,514	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 895,201	\$ 430,129	\$ 367,994	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Brickyard Bank		X	Mortgage	\$45,218.00	12/06	\$ 5,500,000	\$ 5,443,043	12/11	8.7500	\$ 487,660	1								
2	Round off										(5)	2								
3	Frpm Future	X									8,986	3								
4	IRS Penalties										647	4								
5	IDPA										2,308	5								
Working Capital																				
6	Premier Bank		X	Line of Credit		6/11/07	500,000	500,000			24,018	6								
7	IRS		X								12,311	7								
8	Vendors/ Insurance										4,500	8								
9	TOTAL Facility Related				\$45,218.00		\$ 6,000,000	\$ 5,943,043			\$ 540,425	9								
B. Non-Facility Related*																				
10	Embassy Health Care	X									17,500	10								
11	Embassy Building Partnership	X									105,000	11								
12	Less; Related Party int										(195,649)	12								
13	IRS Penalties										(647)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (73,796)	14								
15	TOTALS (line 9+line14)						\$ 6,000,000	\$ 5,943,043			\$ 466,629	15								

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

Facility Name & ID Number Embassy Health Care Center# 0048488 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	61,523	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.)			\$	85,649	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	24,126	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	75,600	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	99,726	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2002	<u>63,352</u>	<u>8</u>	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2006	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
2003	<u>63,005</u>	<u>9</u>																						
2004	<u>66,066</u>	<u>10</u>																						
2005	<u>67,638</u>	<u>11</u>																						
2006	<u>75,288</u>	<u>12</u>																						
<u>Estimate based on 2006 bill adjusted to</u>	<u>75600</u>																							
<u>Allocation from Future</u>	<u>10361</u>																							

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Health Care Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0048488

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 2006 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 2006.

(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>17,925.39</u>	\$ <u>2,307.00</u>
2. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>8,706.55</u>	\$ <u>1,120.00</u>
3. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>8,706.55</u>	\$ <u>1,120.00</u>
4. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>17,948.55</u>	\$ <u>2,310.00</u>
5. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>17,948.50</u>	\$ <u>2,310.00</u>
6. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,891.95</u>	\$ <u>243.00</u>
7. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,891.95</u>	\$ <u>243.00</u>
8. <u>03-17-36-300-010-0000</u>	<u>Facility</u>	\$ <u>75,288.00</u>	\$ <u>75,288.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>150,307.44</u>	\$ <u>84,941.00</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 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Health Care Center

0048488 Report Period Beginning:

01/01/07 Ending:

12/31/07

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>From prior operator</u>	<u>2006</u>	<u>\$ 145,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 145,000	3

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		2006		\$ 2,363,000	\$ 147,234	35	\$ 67,514	\$ (79,720)	\$ 1,008,899	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	55,674		20	2,784	2,784	40,263	9
10	Various			1994	144,492		20	7,224	7,224	97,821	10
11	Various			1995	126,250		20	6,312	6,312	78,694	11
12	Various			1996	94,458		20	4,721	4,721	54,588	12
13	Various			1997	13,974		20	698	698	7,578	13
14	Various			1998	13,694		20	684	684	6,439	14
15	Various			1999	29,626		20	1,480	1,480	12,410	15
16	Various			2000	71,797		20	3,760	3,760	26,069	16
17	Various			2001	4,657		20	213	213	1,353	17
18	Various			2002	1,466		20	73	73	427	18
19	Various			2003	67,271		20	3,362	3,362	14,434	19
20	West wing toilet repairs			01/23/04	855		20	43	43	150	20
21	West wing sewer repairs			01/26/04	532		20	27	27	93	21
22	Voltage regulator tray			02/28/04	1,561		20	78	78	273	22
23	Broken water line			03/13/04	1,700		20	85	85	298	23
24	Clean outside manhole			04/14/04	1,413		20	70	70	247	24
25	Fire alarm service			05/05/04	1,658		20	83	83	290	25
26	A/C replaced roof compressor			05/20/04	3,410		20	171	171	597	26
27	Access control panel			05/21/04	1,205		20	60	60	211	27
28	Tel & comp lines to network			05/21/04	786		20	40	40	138	28
29	Inoized smoke detectors			05/21/04	1,163		20	59	59	204	29
30	Roof work			07/19/04	37,177		20	1,859	1,859	6,506	30
31	Replaced tranformer on rooftop unit			07/19/04	1,082		20	54	54	189	31
32	Ran E.M.T. and cables			08/02/04	846		20	42	42	148	32
33	Compressor			09/29/04	2,900		20	145	145	508	33
34	Repair exit door alarm;rooftop cam			12/01/04	1,287		20	64	64	225	34
35	Heat exchanger			12/01/04	1,658		20	83	83	290	35
36	Heat exchanger			12/01/04	1,732		20	86	86	303	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
37	Service door lock;control panel	01/01/05	\$ 1,835	\$	20	\$ 91	\$ 91	\$ 229	37
38	Install electromagnetic door hldr	01/07/05	1,120		20	56	56	140	38
39	Svce on gate alarm;instl 2 wire	02/03/05	1,047		20	52	52	131	39
40	Heat Exchangers for A C	02/24/05	7,500		20	375	375	938	40
41	Locknetics 101 Plus door	03/09/05	3,461		20	173	173	433	41
42	Install wire push button cafe. door	06/09/05	751		20	38	38	94	42
43	Repalce compressors on A C	07/01/05	1,494		20	75	75	187	43
44	2 compressors	07/25/05	7,291		20	364	364	911	44
45	Fire alarm wiring	07/31/05	968		20	48	48	121	45
46	Sewer line	08/18/05	708		20	36	36	89	46
47	Replace kitchen Exhast fan	09/21/05	608		20	30	30	76	47
48	Tilt mag lock	01/01/06	1,818		20	91	91	136	48
49	Rooftop unit ground wire	01/30/06	2,543		20	127	127	191	49
50	Rooftop unit new solenoid valve	02/27/06	1,287		20	65	65	97	50
51	Video monitoring	03/31/06	1,025		20	51	51	77	51
52	New doors and frames	04/06/06	4,600		20	230	230	345	52
53	Brickface & door canopy	04/21/06	863		20	43	43	65	53
54	Brickface & Gypsum	04/30/06	601		20	30	30	45	54
55	Doorlocks, weatherproofing, magnet locks	04/30/06	7,073		20	353	353	530	55
56	Install to fire alarm sys; trobes & pull stat	07/19/06	2,681		20	134	134	201	56
57	Electric magnet & strike	07/31/06	1,190		20	59	59	89	57
58	Renite zone annunciator & driver	07/31/06	576		20	29	29	43	58
59	Water meter	09/19/06	1,878		20	94	94	141	59
60	Carrir rooftop compressor	11/30/06	2,847		20	143	143	214	60
61	Video monitoring equip	12/21/06	2,000		20	100	100	150	61
62	LIMP from old Embassy	01/01/07		12,484	20		(12,484)		62
63	Replace 28 fire dampers	08/10/07	4,475	42	20	93	51	93	63
64	Roof Repairs	12/30/07	2,682	3	20		(3)		64
65	New York packaged heat/cold rooftop unit	12/08/07	15,850	17	20	66	49	66	65
66	28 fire dampers	12/18/07	4,686	5	20		(5)		66
67	100 gallon hot water heater	02/01/07	4,108	90	20	188	98	188	67
68	Repair TV Antenna	12/05/07	3,000	3	20	1	(2)	1	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,139,890	\$ 159,878		\$ 105,109	\$ (54,769)	\$ 1,365,666	70

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

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,139,890	\$ 159,878		\$ 105,109	\$ (54,769)	\$ 1,365,666	1
2	Allocation From LCF:								2
3	Various	1986	98,449		30	3,282	3,282	69,142	3
4	Various	1987	2,362	75	31.5	75		1,538	4
5	Various	1987	13,550	430	31.5	430		8,710	5
6	Various	1988	761	24	31.5	24		467	6
7	Various	1989	283	9	31.5	9		164	7
8	Various	1993	7,870	202	39	202		2,899	8
9	Various	1994	12,001	308	39	308		4,139	9
10	Various	2001	3,342	86	39	86		556	10
11	Various	2002	819	21	39	21		113	11
12	Various	2003	497	13	39	13		49	12
13	Electrical Repairs	2004	1,723						13
14	Roof repairs	2004	223	48	39	48		184	14
15	Various blower mtrs, control board	2006	252						15
16	Parking lot drainage pump	2006	122						16
17	Catch basin	2006	384						17
18	Remove, replace drywalls, studs	2006	376						18
19	10' water guard, sump pump	2006	295	37	39	37		60	19
20	Carpeting	2007	1,431						20
21	Painting	2007	1,029	44	39	44		44	21
22	Allocation From Future:								22
23	Various	1987	42,701	1,356	31.5	1,378	22	28,769	23
24	Various	1994	12,489	169	Var	169		8,169	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)		\$ 3,340,849	\$ 162,700		\$ 111,235	\$ (51,465)	\$ 1,490,669	34

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

Facility Name & ID Number Embassy Health Care Center # 0048488 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 250,979	\$ 5,065	\$ 26,542	\$ 21,477	10	\$ 147,902	71
72	Current Year Purchases	9,980	53,949	492	(53,457)	10	492	72
73	Fully Depreciated Assets	324,681		1,119	1,119	10	324,681	73
74								74
75	TOTALS	\$ 585,640	\$ 59,014	\$ 28,153	\$ (30,861)		\$ 473,075	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	Allocation From Future			\$ 104,515	\$ 2,957	\$ 2,957		5	\$ 68,409	76
77	Emb Health Care			27,320		5,224	5,224	5	21,760	77
78	Emb Holding				1,356		(1,356)			78
79										79
80	TOTALS			\$ 131,835	\$ 4,313	\$ 8,181	\$ 3,868		\$ 90,169	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)		\$ 4,203,324	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 226,027	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 147,569	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (78,458)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,053,913	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	TOTAL		\$	\$	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.

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)	
TOTAL TRAINED	

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

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

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

	Service	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	\$		\$ 116,098	\$		\$ 116,098	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,895			2,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			233,299			233,299	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				345,461		345,461	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					51,415	846		52,261	13
14	TOTAL			\$		\$ 403,707	\$ 346,307		\$ 750,014	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 Health Care Center

0048488

01/01/07 to

12/31/07

Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1 Med Tube : Ent., & Urol

39-2

2 Equipment Rental

39-2

3 Med Supplies

39-2

846

Total

846

Outside Therapies (Column 5- Other)

1 Other Expense

39-3

25822

2 Lab & XRay

39-3

25593

Total

51415

Facility Name & ID Number Embassy Health Care Center

0048488

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 190,627	\$	1
2	Cash-Patient Deposits	525		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,719,399		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	134,191		6
7	Other Prepaid Expenses	3,647		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Schedule</u>	19,886		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,068,275	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	483,319		13
14	Buildings, at Historical Cost	5,742,115		14
15	Leasehold Improvements, at Historical Cost	542,824		15
16	Equipment, at Historical Cost	276,522		16
17	Accumulated Depreciation (book methods)	(215,183)		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): <u>Mortgage Costs</u>	25,116		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,854,713	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,922,988	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 926,683	\$	26
27	Officer's Accounts Payable	(32,082)		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	73,448		30
31	Accrued Taxes Payable (excluding real estate taxes)	57,843		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,600		32
33	Accrued Interest Payable	166,443		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,767,935	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,750,000		39
40	Mortgage Payable	5,443,043		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,193,043	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,960,978	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (37,990)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,922,988	\$	48

*(See instructions.)

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	(4,268)	
Employee Advances	24,154	
Insurance Escrows		
Repalcement & Repairs Escrows		
Deferred Taxes		
	<u>19,886</u>	<u> </u>

OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Accrued Expenses		
Sale of Assets		
	<u> </u>	<u> </u>

OTHER NON CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
Construction In Progress		
Utility Deposit		
Mortgage Costs - Net		
Exchange		
	<u> </u>	<u> </u>

OTHER NON CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
	<u> </u>	<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Earnings from 12/16/06-12/31/06	(18,918)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (18,918)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(19,072)	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)	\$ (19,072)	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)	\$ (37,990)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Embassy Health Care Center# 0048488Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,739,843	1
2	Discounts and Allowances for all Levels	(556,483)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,183,360	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	663,408	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 663,408	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	259,847	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,060	19
20	Radiology and X-Ray		20
21	Other Medical Services	23,183	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 325,090	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Inc 2800: Day Training 254	3,054	28
28a	Prior Period Adj	(42)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,174,875	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,137,930	31
32	Health Care	2,630,758	32
33	General Administration	1,598,931	33
B. Capital Expense			
34	Ownership	982,604	34
C. Ancillary Expense			
35	Special Cost Centers	750,101	35
36	Provider Participation Fee	93,623	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,193,947	40
41	Income before Income Taxes (line 30 minus line 40)**	(19,072)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (19,072)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Health Care Center

0048488

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	958	1,012	\$ 54,270	\$ 53.63	1
2	Assistant Director of Nursing	1,123	1,152	29,176	25.33	2
3	Registered Nurses	3,176	3,447	81,149	23.54	3
4	Licensed Practical Nurses	25,587	27,271	550,320	20.18	4
5	CNAs & Orderlies	70,506	74,140	723,603	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,649	4,035	46,846	11.61	8
9	Activity Director	3,983	4,304	65,891	15.31	9
10	Activity Assistants	20,713	21,913	227,676	10.39	10
11	Social Service Workers	8,271	8,742	126,411	14.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,565	26,024	255,039	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,999	4,254	53,471	12.57	17
18	Housekeepers	16,885	18,469	163,818	8.87	18
19	Laundry	13,082	13,873	103,631	7.47	19
20	Administrator	1,349	1,497	78,577	52.49	20
21	Assistant Administrator	1,556	1,714	45,981	26.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,313	11,539	138,116	11.97	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,715	223,386	\$ 2,743,975 *	\$ 12.28	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	184	\$ 7,271	1-3	35
36	Medical Director	Monthly	20,450	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,555	10-3	39
40	Physical Therapy Consultant	Monthly	16,545	10a-3	40
41	Occupational Therapy Consultant	11	810	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As required	420	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	177	8,934	12-3	45
46	Other(specify)				46
47	ADON Consultant	216	22,200	10-3	47
48	Nurse Consultant	As required	68,253	10-3	48
49	TOTAL (lines 35 - 48)	588	\$ 147,438		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,998	\$ 196,143	10-3	50
51	Licensed Practical Nurses	10,059	243,772	10-3	51
52	Certified Nurse Assistants/Aides	1,979	24,134	10-3	52
53	TOTAL (lines 50 - 52)	19,036	\$ 464,049		53

Facility Name & ID Number Embassy Health Care Center

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Painting & Decorating	6/04	\$ 3,178		\$ 530	\$ 1,059	\$ 1,059	\$ 530	\$	\$	\$	\$	\$
2	Painting & Decorating	6/05	1,114			186	371	371	186				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,292		\$ 530	\$ 1,245	\$ 1,430	\$ 901	\$ 186	\$	\$	\$	\$

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. No
- (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. \$ 10,018 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Embassy Care Center, 36-3863655-001, 12/16/06
- (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. \$ 22,513 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? Yes
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. \$ No
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.