

Facility Name & ID Number Embassy Holdings LLC

0038711 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	355		4,731	5,086	8
9	SNF/PED					9
10	ICF	43,028	4,622	449	48,099	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,383	4,622	5,180	53,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.21%

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

55 (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)

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 4,731

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/09 Fiscal Year: 12/09

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

Facility Name & ID Number Embassy Holdings LLC # 0038711 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	288,079	15,975	8,192	312,246		312,246		312,246		1
2	Food Purchase		330,339		330,339	(30,797)	299,542	(287)	299,255		2
3	Housekeeping	223,106	39,598		262,704		262,704		262,704		3
4	Laundry	52,522	9,044		61,566		61,566		61,566		4
5	Heat and Other Utilities			166,011	166,011		166,011	8,252	174,263		5
6	Maintenance	50,501	24,485	78,089	153,075		153,075	5,539	158,614		6
7	Other (specify):*										7
8	TOTAL General Services	614,208	419,441	252,292	1,285,941	(30,797)	1,255,144	13,504	1,268,648		8
	B. Health Care and Programs										
9	Medical Director			17,950	17,950		17,950		17,950		9
10	Nursing and Medical Records	1,924,033	129,938	231,187	2,285,158		2,285,158	29	2,285,187		10
10a	Therapy	106,477		30,066	136,543		136,543		136,543		10a
11	Activities	268,305	4,468		272,773		272,773		272,773		11
12	Social Services	174,285		6,940	181,225		181,225		181,225		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,473,100	134,406	286,143	2,893,649		2,893,649	29	2,893,678		16
	C. General Administration										
17	Administrative	78,520		484,740	563,260		563,260	(471,740)	91,520		17
18	Directors Fees										18
19	Professional Services			195,532	195,532		195,532	12,682	208,214		19
20	Dues, Fees, Subscriptions & Promotions			43,761	43,761		43,761	(16,832)	26,929		20
21	Clerical & General Office Expenses	194,868	31,699	45,358	271,925		271,925	402,181	674,106		21
22	Employee Benefits & Payroll Taxes			492,761	492,761	30,797	523,558	60,992	584,550		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,849	2,849		2,849		2,849		24
25	Other Admin. Staff Transportation			13,293	13,293		13,293	2,508	15,801		25
26	Insurance-Prop.Liab.Malpractice			138,374	138,374		138,374	2,799	141,173		26
27	Other (specify):*										27
28	TOTAL General Administration	273,388	31,699	1,416,668	1,721,755	30,797	1,752,552	(7,410)	1,745,142		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,360,696	585,546	1,955,103	5,901,345		5,901,345	6,123	5,907,468		29

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

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

Facility Name & ID Number

Embassy Holdings LLC

#0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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			219,513	219,513		219,513	(64,736)	154,777			30
31	Amortization of Pre-Op. & Org.			6,279	6,279		6,279		6,279			31
32	Interest			665,636	665,636		665,636	(96,479)	569,157			32
33	Real Estate Taxes			197,868	197,868		197,868	19,327	217,195			33
34	Rent-Facility & Grounds			17,123	17,123		17,123		17,123			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,106,419	1,106,419		1,106,419	(141,888)	964,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		264,394	303,365	567,759		567,759		567,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		264,394	396,988	661,382		661,382		661,382			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,360,696	849,940	3,458,510	7,669,146		7,669,146	(135,765)	7,533,381			45

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

Embassy Holdings LLC

ID# 0038711

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veterans Exp	\$ 29	10	1
2	MarketingExp	(5,513)	20	2
3	Bank Charges	(11,909)	21	3
4	Travel	(11,210)	25	4
5	Restatement of 2008 expenses:			5
6	Insurance	(1,014)	26	6
7	Interest	(34)	32	7
8	Depr R/O adj	6	30	8
9	License (Penalty)	(10,250)	20	9
10	Legal bills:			10
11	Mainzer prior year	(92)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,987)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(287)	0	0	0	0	0	0	0	0	0	0	(287)	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	8,252	0	0	0	0	0	0	0	0	0	8,252	5
6	Maintenance	0	5,539	0	0	0	0	0	0	0	0	0	5,539	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(287)	13,791	0	13,504	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	29	0	0	0	0	0	0	0	0	0	0	29	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	29	0	0	0	0	0	0	0	0	0	0	29	16
	C. General Administration													
17	Administrative	0	(471,740)	0	0	0	0	0	0	0	0	0	(471,740)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(92)	12,774	0	0	0	0	0	0	0	0	0	12,682	19
20	Fees, Subscriptions & Promotions	(17,002)	170	0	0	0	0	0	0	0	0	0	(16,832)	20
21	Clerical & General Office Expenses	(29,910)	432,091	0	0	0	0	0	0	0	0	0	402,181	21
22	Employee Benefits & Payroll Taxes	0	60,992	0	0	0	0	0	0	0	0	0	60,992	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	(11,210)	13,718	0	0	0	0	0	0	0	0	0	2,508	25
26	Insurance-Prop.Liab.Malpractice	(1,014)	3,813	0	0	0	0	0	0	0	0	0	2,799	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(59,228)	51,818	0	(7,410)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(59,486)	65,609	0	6,123	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(81,169)	16,433	0	0	0	0	0	0	0	0	0	(64,736)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(122,534)	26,055	0	0	0	0	0	0	0	0	0	(96,479)	32
33	Real Estate Taxes	0	19,327	0	0	0	0	0	0	0	0	0	19,327	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	(203,703)	61,815	0	(141,888)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(263,189)	127,424	0	0	0	0	0	0	0	0	0	(135,765)	45

Facility Name & ID Number

Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	Chicago	Future Assoc	Skokie	Bkkg; Mgmt Svces
DR Samuel Lipshitz	28%					
Jack Rajchenbach	22%	Peterson Park	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	\$ 471,740	Future Associates		\$	(471,740)	1	
2	V	5 Utilities		Future Associates		8,252	8,252	2	
3	V	6 Maintenance		Future Associates		5,539	5,539	3	
4	V	17 Administrative		Future Associates				4	
5	V	19 Professional Fees		Future Associates		12,774	12,774	5	
6	V	21 Clerical and General		Future Associates		432,091	432,091	6	
7	V	22 Employee Benefits		Future Associates		60,992	60,992	7	
8	V	25 Auto Expense		Future Associates		13,718	13,718	8	
9	V	26 Insurance Expense		Future Associates		3,813	3,813	9	
10	V	30 Depreciation		Future Associates		16,433	16,433	10	
11	V	32 Interest Expense		Future Associates		26,055	26,055	11	
12	V	33 Real Estate Taxes		Future Associates		19,327	19,327	12	
13	V	20 License, Dues, Fees		Future Associates		170	170	13	
14	Total		\$ 471,740			\$ 599,164	\$ *	127,424	14

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

Facility Name & ID Number

Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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 Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	541,740	2	\$ 9,476	\$ 471,740	\$ 8,252	1
2	6	Maintenance	Management Fees	541,740	2	6,361	471,740	5,539	2
3	17	Administrative	Direct allocation	541,740	2		471,740	0	3
4	19	Professional Fees	Management Fees	541,740	2	14,670	471,740	12,774	4
5	21	Clerical and General	Management Fees	541,740	2	375,461	471,740	326,946	5
6	22	Employee Benefits	Management Fees	541,740	2	60,589	471,740	52,760	6
7	25	Auto Expense	Management Fees	541,740	2	15,753	471,740	13,718	7
8	26	Insurance Expense	Management Fees	541,740	2	4,379	471,740	3,813	8
9	30	Depreciation	Management Fees	541,740	2	18,872	471,740	16,433	9
10	32	Interest Expense	Management Fees	541,740	2	29,921	471,740	26,055	10
11	33	Real Estate Taxes	Management Fees	541,740	2	22,195	471,740	19,327	11
12	20	License, Dues, Fees	Management Fees	541,740	2	195	471,740	170	12
13	21	Clerical and General	Per cent	541,740	2	123,062	471,740	123,062	105,144
14	22	Employee Benefits	Per cent	541,740	2	10,401	471,740	8,232	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 691,335	\$ 428,211	\$ 599,163	25

Facility Name & ID Number

Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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										
										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	\$ 5,309,267	12/11	8.7500	\$ 475,953	1							
2	IDPA		X								9,363	2							
3	Related Party Interest	X									122,500	3							
4												4							
5												5							
Working Capital																			
6	Premier		X	Line of Credit		6/11/07	750,000			Var	45,529	6							
7	Brickyard Bank		X	Line of Credit		11/09	250,000			Var	3,672	7							
8	Ins & Vendors		X								8,619	8							
9	TOTAL Facility Related				\$45,218.00		\$ 6,500,000	\$ 5,309,267			\$ 665,636	9							
B. Non-Facility Related*																			
10	Interest Adjustments										(122,534)	10							
11	From FA										26,055	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (96,479)	14							
15	TOTALS (line 9+line14)						\$ 6,500,000	\$ 5,309,267			\$ 569,157	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Holdings LLC 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 2008 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 2008.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-17-36-300-010-0000</u>	<u>Facility</u>	\$ <u>133,468.00</u>	\$ <u>133,468.00</u>
2. <u>10-28-408-025</u>	<u>Management Office</u>	\$ <u>23,535.63</u>	\$ <u>5,517.00</u>
3. <u>10-28-408-026</u>	<u>Management Office</u>	\$ <u>11,524.48</u>	\$ <u>2,701.00</u>
4. <u>10-28-408-027</u>	<u>Management Office</u>	\$ <u>7,407.99</u>	\$ <u>1,737.00</u>
5. <u>10-28-408-028</u>	<u>Management Office</u>	\$ <u>15,027.71</u>	\$ <u>3,523.00</u>
6. <u>10-28-408-029</u>	<u>Management Office</u>	\$ <u>15,027.71</u>	\$ <u>3,523.00</u>
7. <u>10-28-408-030</u>	<u>Management Office</u>	\$ <u>1,803.81</u>	\$ <u>423.00</u>
8. <u>10-28-408-031</u>	<u>Management Office</u>	\$ <u>1,803.81</u>	\$ <u>423.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>209,599.14</u>	\$ <u>151,315.00</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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: 31,395 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 6,279 4. Dates Incurred: Various 2006

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility (prior operator)</u>	<u>40,500</u>	<u>2006</u>	<u>\$ 145,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	40,500		\$ 145,000	3

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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)	\$ 1,143,128	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements		1/1/2007			13,026			(13,026)		9
10	Replace 28 fire dampers		8/10/2007		4,475	112	20	224	112	541	10
11	Roof Repairs		12/30/2007		2,682	67	20	134	67	268	11
12	New York packaged heat/cold rooftop unit		12/8/2007		15,850	396	20	792	396	1,651	12
13	28 fire dampers		12/18/2007		4,686	117	20	235	118	469	13
14	100 gallon hot water heater		2/1/2007		4,108	102	20	205	103	599	14
15	Repair TV Antenna		12/5/2007		3,000	75	20	13	(62)	28	15
16	Satellite TV System		2/28/2009		7,900	173	20	329	156	329	16
17	Various		1993		55,674		20	2,786	2,786	45,831	17
18	Various		1994		144,492		20	7,228	7,228	112,272	18
19	Various		1995		126,250		20	6,317	6,317	91,320	19
20	Various		1996		94,458		20	4,722	4,722	64,034	20
21	Various		1997		13,974		20	700	700	8,975	21
22	Various		1998		13,694		20	682	682	7,807	22
23	Various		1999		29,626		20	1,482	1,482	15,372	23
24	Various		2000		71,797		20	3,760	3,760	33,587	24
25	Various		2001		4,657		20	214	214	1,783	25
26	Various		2002		1,466		20	73	73	574	26
27	Various		2003		67,271		20	3,365	3,365	21,163	27
28	Various		2004		60,965		20	3,048	3,048	16,767	28
29	Various		2005		26,783		20	1,342	1,342	6,028	29
30	Rooftop unit ground wire		1/30/06		2,543		20	127	127	445	30
31	Rooftop unit new solenoid valve		2/27/06		1,287		20	64	64	225	31
32	Video monitoring		3/31/06		1,025		20	51	51	179	32
33	Tilt mag lock		1/1/06		1,818		20	91	91	318	33
34	New doors and frames		4/6/06		4,600		20	230	230	805	34
35	Brickface & Gypsum		4/30/06		601		20	30	30	105	35
36	Brickface & door canopy		4/21/06		863		20	43	21	151	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 Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	Doorlocks, weatherproofing, magnet locks	04/30/06	\$ 7,073	\$	20	\$ 354	\$ 354	\$ 1,238	37
38	Install to fire alarm sys; trobes & pull stat	07/19/06	2,681		20	134	134	469	38
39	Electric magnet & strike	07/31/06	1,190		20	59	59	208	39
40	Renite zone annunciator & driver	07/31/06	576		20	29	29	101	40
41	Carrir rooftop compressor	11/30/06	2,847		20	142	142	498	41
42	Video monitoring equip	12/21/06	2,000		20	100	100	350	42
43	Water meter	09/19/06	1,878		20	94	94	329	43
44									44
45	Allocation From LCF:								45
46	Various	1986	189,255		30	6,309	6,309	145,620	46
47	Various	1987	4,540	145	31.5	145		3,245	47
48	Various	1987	26,047	827	31.5	827		18,464	48
49	Various	1988	1,463	46	31.5	46		991	49
50	Various	1989	544	17	31.5	17		350	50
51	Various	1993	15,129	388	39	388		6,353	51
52	Various	1994	23,070	591	39	591		9,141	52
53	Various	2001	6,425	165	39	165		1,398	53
54	Various	2002	1,574	40	39	40		298	54
55	Various	2003	956	24	39	24		143	55
56	Various blower mtrs, control board	2004	3,741	96	39	96		541	56
57	Parking lot drainage pump	2006	484						57
58	Catch basin	2006	235						58
59	Remove, replace drywalls, studs	2006	738						59
60	10' water guard, sump pump	2006	722						60
61	Carpeting	2006	568	71	39	71		253	61
62	Painting	2007	2,750						62
63	Allocation From Future:	2007	1,978	676	7	676		1,435	63
64	Various								64
65	Various	1987	82,087	2,605	31.5	2,647	42	60,601	65
66		1994	24,009	326	Var	326		16,354	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,534,105	\$ 167,319		\$ 119,081	\$ (48,260)	\$ 1,843,134	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 470,268	\$ 56,434	\$ 22,618	\$ (33,816)	10	\$ 386,992	71
72	Current Year Purchases	9,843	1,593	592	(1,001)	10	592	72
73	Fully Depreciated Assets	545,180		2,470	2,470	10	545,180	73
74								74
75	TOTALS	\$ 1,025,291	\$ 58,027	\$ 25,680	\$ (32,347)		\$ 932,764	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	From FA			\$ 208,347	\$ 7,271	\$ 7,271		5	\$ 136,886	76
77	Emb Holding	Ford Club Wagon	2008	6,356	2,034	1,271	(763)	5	2,542	77
78	Emb Health Care		Var	27,320		1,474	1,474	5	26,583	78
79	Emb Holding				1,301		(1,301)			79
80	TOTALS			\$ 242,023	\$ 10,606	\$ 10,016	\$ (590)		\$ 166,011	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)	\$ 4,946,419	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,777	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (81,175)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,941,909	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ 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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$		\$ 108,818	\$		\$ 108,818	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,761			10,761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			161,789			161,789	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 prescripts				264,394		264,394	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Schedule</u>					21,997			21,997	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 303,365	\$ 264,394		\$ 567,759	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning: 1/1/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 1,441	\$	1
2	Cash-Patient Deposits	65,137		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,588,653		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	189,842		6
7	Other Prepaid Expenses	79,985		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	136,598		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,061,656	\$	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	550,724		15
16	Equipment, at Historical Cost	297,382		16
17	Accumulated Depreciation (book methods)	(686,515)		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):	317,765		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,704,790	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,766,446	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,926,216	\$	26
27	Officer's Accounts Payable	(1,149,438)		27
28	Accounts Payable-Patient Deposits	58,327		28
29	Short-Term Notes Payable	480,000		29
30	Accrued Salaries Payable	206,785		30
31	Accrued Taxes Payable (excluding real estate taxes)	418,907		31
32	Accrued Real Estate Taxes(Sch.IX-B)	292,490		32
33	Accrued Interest Payable	367,991		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)	\$ 2,601,278	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,750,000		39
40	Mortgage Payable	5,309,267		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)	\$ 7,059,267	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,660,545	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (894,099)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,766,446	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 38,589	1
2	Restatements (describe):		2
3	Adjustment to Insurance	1,047	3
4	Round off adj	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 39,633	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(933,732)	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)	\$ (933,732)	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)	\$ (894,099)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 6,663,967	1
2	Discounts and Allowances for all Levels	(483,402)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,180,565	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	290,040	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 290,040	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	231,996	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,014	19
20	Radiology and X-Ray		20
21	Other Medical Services	9,532	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 268,542	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Prior Period Adj</u>	(3,733)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (3,733)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,735,414	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,285,941	31
32	Health Care	2,893,649	32
33	General Administration	1,721,755	33
B. Capital Expense			
34	Ownership	1,106,419	34
C. Ancillary Expense			
35	Special Cost Centers	567,759	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)*	\$ 7,669,146	40
41	Income before Income Taxes (line 30 minus line 40)**	(933,732)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (933,732)	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 Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,810	2,050	\$ 72,701	\$ 35.46	1
2	Assistant Director of Nursing	1,716	1,740	49,368	28.37	2
3	Registered Nurses	5,366	5,684	136,306	23.98	3
4	Licensed Practical Nurses	37,848	40,572	883,659	21.78	4
5	CNAs & Orderlies	71,398	74,264	781,999	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,730	6,263	106,477	17.00	8
9	Activity Director	3,972	4,380	66,448	15.17	9
10	Activity Assistants	17,460	18,384	201,857	10.98	10
11	Social Service Workers	12,628	13,648	174,285	12.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	24,306	26,333	288,079	10.94	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,856	4,129	50,501	12.23	17
18	Housekeepers	23,608	24,817	223,106	8.99	18
19	Laundry	5,775	6,093	52,522	8.62	19
20	Administrator	2,004	2,124	78,520	36.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,195	15,478	194,868	12.59	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)	231,672	245,959	\$ 3,360,696 *	\$ 13.66	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	Monthly	\$ 8,192	1-3	35
36	Medical Director	Monthly	17,950	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	As required	288	10-3	38
39	Pharmacist Consultant	Monthly	1,650	10-3	39
40	Physical Therapy Consultant	Monthly	15,000	10a-3	40
41	Occupational Therapy Consultant	Monthly	150	10a-3	41
42	Respiratory Therapy Consultant	Monthly	14,916	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	As required	6,940	12-3	45
46	Other(specify) <u>ADON Cons</u>	Monthly	103,150	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 168,236		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,024	\$ 68,206	10-3	50
51	Licensed Practical Nurses	918	28,469	10-3	51
52	Certified Nurse Assistants/Aides	1,885	29,424	10-3	52
53	TOTAL (lines 50 - 52)	4,827	\$ 126,099		53

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	
Carolyn Bessette	Administrator	0	\$ 78,520	Workers' Compensation Insurance	\$ 143,817	IDPH License Fee	\$	
				Unemployment Compensation Insurance	59,059	Advertising: Employee Recruitment	13,785	
				FICA Taxes	253,864	Health Care Worker Background Check (Indicate # of checks performed)	4,226	
				Employee Health Insurance	13,485	Patient Background Checks		
				Employee Meals	30,797	Dues & Subs	6,186	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	2,562	
				Employee Benefits	2,197	From FA	170	
				Employee Life Ins	10,225			
				Holiday Expense	10,114			
				From FA	60,992			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,520	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 584,550		\$ 26,929		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Future Associates			\$ 471,740				Out-of-State Travel	\$
Eli Draiman			13,000				In-State Travel	
							Seminar Expense	2,849
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 484,740	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 2,849	
C. Professional Services								
Vendor/Payee	Type		Amount					
LJCohn	Accountant		\$ 23,150					
R Peelo	Med Acct		4,200					
Crowe Chizek	Accountant		3,202					
N Knopf	Accountant		250					
Krupnick, Bokor etc	Accountant		3,000					
James Mainser	Legal		5,029					
Reed Smith	Legal		(2,981)					
A Mandell	Legal		117,500					
Data Processing Exp			18,306					
Personnel Planners	UC Cons		4,693					
Other	Schedule		19,183					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 195,532					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Embassy Holdings LLC

0038711

Report Period Beginning: 1/1/09

Ending: 12/31/09

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? 10Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,168 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. \$ 30,797 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? 90
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? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Embassy Holdings LLC
0038711
COST REPORT RECLASSIFICATIONS
1/1/09
12/31/09

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>30,797</u>
2	FOOD	<u>30,797</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

Embassy Holdings LLC

0038711

1/1/09 to

12/31/09

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

Total

0

Outside Therapies (Column 5- Other)

1 Other Expense

39-3

5616

2 Lab & XRay

39-3

16381

Total

21997

Facility Name & ID Numbe Embassy Holdings LLC

0038711

Report Peri 1/1/09

Ending:

12/31/09

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of12/31/09

OTHER CURRENT ASSETS:

	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	88,775	
Employee Advances	44,042	
Due From Others	2,401	
Repalcement & Repairs Escrows		
Deferred Taxes		
Subs Rec	1,380	
	<u>136,598</u>	<u> </u>

OTHER CURRENT LIAB

	<u>Amount</u>	<u>Amount</u>
Accrued Expenses		
Sale of Assets		
	<u> </u>	<u> </u>

OTHER NON CURRENT ASSETS:

Construction In Progress		
Utility Deposit		
Mortgage Costs - Net	90,558	
Exchange	227,207	
	<u>317,765</u>	<u> </u>

OTHER NON CURRENT LIABILITIES:

	<u> </u>	<u> </u>
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Facility Name & ID Number

Embassy Holdings LLC

0038711

Report Period Beginning:

1/1/09

Ending:

12/31/09

Page 21 Line C

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
DNA Search	Employee Procurement	18,333
Security Service		850
Total		<u>19,183</u>