

Facility Name & ID Number EMBASSY HEALTH CARE CENTER

0048488 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	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	1,276	78	5,384	6,738	8
9	SNF/PED					9
10	ICF	42,994	3,663	4,609	51,266	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,270	3,741	9,993	58,004	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.93%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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 5,293

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

EMBASSY HEALTH CARE CENTER

0048488

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	304,575	15,097	7,916	327,588		327,588		327,588		1
2	Food Purchase		330,791		330,791		330,791	(1,855)	328,936		2
3	Housekeeping	243,333			243,333		243,333		243,333		3
4	Laundry	40,192	10,305		50,497		50,497		50,497		4
5	Heat and Other Utilities			184,830	184,830		184,830	4,501	189,331		5
6	Maintenance	44,050	58,086	63,913	166,049		166,049	7,822	173,871		6
7	Other (specify):*			26,776	26,776		26,776		26,776		7
8	TOTAL General Services	632,150	414,279	283,435	1,329,864		1,329,864	10,468	1,340,332		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,030,702	388,959	73,699	2,493,360		2,493,360		2,493,360		10
10a	Therapy	265,479		165,772	431,251	3,500	434,751		434,751		10a
11	Activities	287,407	7,671		295,078		295,078		295,078		11
12	Social Services	121,642		2,146	123,788		123,788		123,788		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,705,230	396,630	253,617	3,355,477	3,500	3,358,977		3,358,977		16
	C. General Administration										
17	Administrative	87,514		510,250	597,764		597,764	(388,801)	208,963		17
18	Directors Fees										18
19	Professional Services			126,708	126,708	(3,500)	123,208	50,238	173,446		19
20	Dues, Fees, Subscriptions & Promotions			45,635	45,635		45,635	(20,628)	25,007		20
21	Clerical & General Office Expenses	250,939	37,341	51,262	339,542		339,542	77,174	416,716		21
22	Employee Benefits & Payroll Taxes			676,866	676,866		676,866		676,866		22
23	Inservice Training & Education			3,555	3,555		3,555		3,555		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			24,958	24,958		24,958	27,359	52,317		25
26	Insurance-Prop.Liab.Malpractice			129,540	129,540		129,540	4,358	133,898		26
27	Other (specify):*			29,068	29,068		29,068	89,841	118,909		27
28	TOTAL General Administration	338,453	37,341	1,597,842	1,973,636	(3,500)	1,970,136	(160,459)	1,809,677		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,675,833	848,250	2,134,894	6,658,977		6,658,977	(149,991)	6,508,986		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	510,250
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,302
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	101,406
		0
		126,708
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	20,628
	EMPLOYEE WANT ADS XIX F	5,691
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	152
	LICENSES & PERMITS XIX F	4,730
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	6,139
	PATIENT BACKGROUND CHECKS XIX F	8,295
		45,635
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,927
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	31,163
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,172
	MESSENGER SERVICE	0
		0
		51,262

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	275,952
	UNEMPLOYMENT COMPENSATION XIX D	138,699
	WORKERS COMPENSATION INSURANC XIX D	209,731
	HOSPITALIZATION INSURANCE XIX D	30,549
	EMPLOYEE BENEFITS - OTHER XIX D	5,225
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	16,710
	CHICAGO HEAD TAX XIX D	0
		0
		676,866
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,555
		3,555
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	24,958
		24,958
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	129,540
		129,540
27	OTHER	
	BAD DEBTS VI 24	29,068
		29,068

GRAND TOTAL COLUMN 3 OTHER

2,134,894

**EMBASSY HEALTH CARE CENTER
SCHEDULES
12/31/2011**

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

TOTAL FOOD PURCHASE	330,791
LESS SALES TAX	<u>(1,855)</u>
NET FOOD	328,936
TOTAL PATIENT CENSUS	58,004
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	174,012
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	174,012
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	174,012
NET FOOD	328,936
DIVIDE TOTAL MEALS/YEAR	<u>174,012</u>
COST PER MEAL	1.89
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

EMBASSY HEALTH CARE CENTER

#0048488

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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			198,930	198,930		198,930	(34,471)	164,459			30
31	Amortization of Pre-Op. & Org.			6,279	6,279		6,279		6,279			31
32	Interest			646,849	646,849		646,849	(190,357)	456,492			32
33	Real Estate Taxes			127,562	127,562		127,562		127,562			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			979,620	979,620		979,620	(224,828)	754,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											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			93,623	93,623		93,623		93,623			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,675,833	848,250	3,208,137	7,732,220		7,732,220	(374,819)	7,357,401			45

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

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	(40,488)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,855)	2		13
14	Non-Care Related Interest	(190,357)	32		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	(31,163)	21		18
19	Entertainment				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	(29,068)	27		24
25	Fund Raising, Advertising and Promotional	(20,628)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (313,559)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(91,628)		34
35	Other- Attach Schedule LEGAL	30,368	19	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (61,260)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (374,819)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0048488

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EMBASSY HEALTH CARE CENTER# 0048488

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

	Operating Expenses	PAGES 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	(1,855)	0	0	0	0	0	0	0	0	0	0	(1,855)	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	1,953	2,548	0	0	0	0	0	0	0	0	4,501	5
6	Maintenance	0	4,210	3,612	0	0	0	0	0	0	0	0	7,822	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,855)	6,163	6,160	0	10,468	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(142,762)	(246,039)	0	0	0	0	0	0	0	0	(388,801)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	30,368	13,426	6,444	0	0	0	0	0	0	0	0	50,238	19
20	Fees, Subscriptions & Promotions	(20,628)	0	0	0	0	0	0	0	0	0	0	(20,628)	20
21	Clerical & General Office Expenses	(31,163)	108,204	133	0	0	0	0	0	0	0	0	77,174	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	0	2,744	24,615	0	0	0	0	0	0	0	0	27,359	25
26	Insurance-Prop.Liab.Malpractice	0	1,949	2,409	0	0	0	0	0	0	0	0	4,358	26
27	Other (specify):*	(29,068)	29,437	89,472	0	0	0	0	0	0	0	0	89,841	27
28	TOTAL General Administration	(50,491)	12,998	(122,966)	0	(160,459)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,346)	19,161	(116,806)	0	(149,991)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMBASSY HEALTH CARE CENTER

0048488

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

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

	Capital Expense	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	(40,488)	1,992	4,025	0	0	0	0	0	0	0	0	(34,471)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(190,357)	0	0	0	0	0	0	0	0	0	0	(190,357)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(230,845)	1,992	4,025	0	(224,828)	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)	(283,191)	21,153	(112,781)	0	(374,819)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		PETERSON PARK	CHICAGO	FUTURE ASSOCIAT	SKOKIE	BKKP,MGMT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 178,750	FUTURE ASSOCIATES		\$	(178,750)	1
2	V	5 Utilities				1,953	1,953	2
3	V	6 Maintenance				4,210	4,210	3
4	V	17 Administrative				35,988	35,988	4
5	V	19 Professional Fees				13,426	13,426	5
6	V	21 Clerical and General				108,204	108,204	6
7	V	27 Employee Benefits				29,437	29,437	7
8	V	25 Auto Expense				2,744	2,744	8
9	V	26 Insurance Expense				1,949	1,949	9
10	V	30 Depreciation				1,992	1,992	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 178,750			\$ 199,903	\$ * 21,153	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$ 304,500	FUTURE VENTURE ASSOCIATES, LLC		\$		\$ (304,500) 15
16	V	5	Utilities				2,548		2,548 16
17	V	6	Maintenance				3,612		3,612 17
18	V	17	Administrative				58,461		58,461 18
19	V	19	Professional Fees				6,444		6,444 19
20	V	21	Clerical and General				133		133 20
21	V	27	Employee Benefits				89,472		89,472 21
22	V	25	Auto Expense				24,615		24,615 22
23	V	26	Insurance Expense				2,409		2,409 23
24	V	30	Depreciation				4,025		4,025 24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 304,500			\$ 191,719	\$ *	(112,781) 39

* 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:

01/01/2011

Ending:

12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 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	ELI DRAIMAN	ADMINISTRATIVE	ADMINISTRATIV	3.90	NA	60	100.00	SALARY	\$ 94,449	17-7	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	\$ 94,449		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:

01/01/2011

Ending: **2/31/2011**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	224,750	2	\$ 2,455	\$ 178,750	\$ 1,953	1	
2	6	Maintenance	MANAGEMENT FEES	224,750	2	5,293	4,892	178,750	4,210	2
3	17	Administrative	DIRECT ALLOCATION	178,750	2	35,988	35,988	178,750	35,988	3
4	19	Professional Fees	MANAGEMENT FEES	224,750	2	16,881	178,750	13,426	4	
5	21	Clerical and General	MANAGEMENT FEES	224,750	2	136,049	124,563	178,750	108,204	5
6	27	Employee Benefits	MANAGEMENT FEES	224,750	2	37,013	178,750	29,437	6	
7	25	Auto Expense	MANAGEMENT FEES	224,750	2	3,450	178,750	2,744	7	
8	26	Insurance Expense	MANAGEMENT FEES	224,750	2	2,450	178,750	1,949	8	
9	30	Depreciation	MANAGEMENT FEES	224,750	2	2,500	178,750	1,992	9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 242,079	\$ 165,443	\$ 199,903	25	

Facility Name & ID Number **EMBASSY HEALTH CARE CENTER**

0048488

Report Period Beginning:

01/01/2011

Ending: **2/31/2011**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization FUTURE VENTURE ASSOCIATES, LLC
 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 FEE	709,500	3	\$ 5,937	\$ 304,500	\$ 2,548	1
2	6	Maintenance	MANAGEMENT FEE	709,500	3	8,417	7,952	304,500	3,612
3	17	Administrative	DIRECT ALLOCATION	304,500	3	58,461	58,461	304,500	58,461
4	19	Professional Fees	MANAGEMENT FEE	709,500	3	15,015	304,500	6,444	4
5	20	License, Dues, Fees	MANAGEMENT FEE	709,500	3	309	304,500	133	5
6	21	Clerical and General	MANAGEMENT FEE	709,500	3	208,474	184,619	304,500	89,472
7	27	Employee Benefits	MANAGEMENT FEE	709,500	3	57,355	304,500	24,615	7
8	25	Auto Expense	MANAGEMENT FEE	709,500	3	5,613	304,500	2,409	8
9	26	Insurance Expense	MANAGEMENT FEE	709,500	3	1,621	304,500	696	9
10	30	Depreciation	MANAGEMENT FEE	709,500	3	9,375	304,500	4,025	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 370,577	\$ 251,032	\$ 192,415	25

Facility Name & ID Number

EMBASSY HEALTH CARE CENTER

0048488

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	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	\$ 5,159,609	12/11	8.7500	\$ 421,734	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	BRICKYARD BANK		X	LINE OF CREDIT		11/09	250,000	250,000			19,010	6						
7				INSURANCE FINANCING							15,748	7						
8												8						
9	TOTAL Facility Related				\$45,218.00		\$ 5,750,000	\$ 5,409,609			\$ 456,492	9						
B. Non-Facility Related*																		
10	PAYROLL TAX										56,183	10						
11	REAL ESTATE TAX										11,674	11						
12	RELATED PARTY										122,500	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 190,357	14						
15	TOTALS (line 9+line14)						\$ 5,750,000	\$ 5,409,609			\$ 646,849	15						

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	320,580	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.)		\$	316,057			2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,523)			3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	132,085			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.		\$	127,562			7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2006	75,288	8	FOR BHF USE ONLY			
	2007	122,201	9	13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
	2008	133,468	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2009	118,787	11	15	LESS REFUND FROM LINE 6	\$	15
	2010	121,488	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 105% OF THE PRIOR YEAR REAL ESTATE TAX BILL							
THE PAYMENT ON LINE 2 APPLIES TO 1 INSTALLMENT OF THE 2007 TAX BILL AND THE 2008 AND 2010 TAX BILL							

NOTES:

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

2010 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-17-36-300-010-0000</u>	<u>NURSING HOME</u>	\$ <u>121,488.06</u>	\$ <u>121,488.06</u>
2. <u>03-17-36-300-010-0000</u>	<u>NURSING HOME</u>	\$ <u>133,468.48</u>	\$ <u>133,468.48</u>
3. <u>03-17-36-300-010-0000</u>	<u>NURSING HOME</u>	\$ <u>61,100.39</u>	\$ <u>61,100.39</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>316,056.93</u></u>	\$ <u><u>316,056.93</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 31,395 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 5,279 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>40,500</u>	<u>2006</u>	<u>\$ 145,000</u>	1
2					2
3	TOTALS	40,500		\$ 145,000	3

Facility Name & ID Number EMBASSY HEALTH CARE CENTER# 0048488

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

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

1	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			\$ 2,363,000	\$ 147,234	35	\$ 67,514	\$ (79,720)	\$ 1,278,156	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	899	10
11	Roof Repairs		12/30/2007	2,682	79	20	134	55	536	11
12	New York packaged heat/cold rooftop unit		12/8/2007	15,850	396	20	792	396	3,235	12
13	28 fire dampers		12/18/2007	4,686	117	20	235	118	939	13
14	100 gallon hot water heater		2/1/2007	4,108	102	20	205	103	1,009	14
15	Repair TV Antenna		12/5/2007	3,000	87	20	13	(74)	54	15
16	Satellite TV System		2/28/2009	7,900	203	20	329	126	987	16
17	Various		1993	55,674		20	2,786	2,786	51,403	17
18	Various		1994	144,492		20	7,228	7,228	126,728	18
19	Various		1995	126,250		20	6,317	6,317	103,954	19
20	Various		1996	94,458		20	4,722	4,722	73,478	20
21	Various		1997	13,974		20	700	700	10,375	21
22	Various		1998	13,694		20	682	682	9,171	22
23	Various		1999	29,626		20	1,482	1,482	18,336	23
24	Various		2000	71,797		20	3,760	3,760	41,107	24
25	Various		2001	4,657		20	214	214	2,211	25
26	Various		2002	1,466		20	73	73	720	26
27	Various		2003	67,271		20	3,365	3,365	27,893	27
28	Various		2004	60,965		20	3,048	3,048	22,863	28
29	Various		2005	26,783		20	1,342	1,342	8,712	29
30	Rooftop unit ground wire		1/30/06	2,543		20	127	127	699	30
31	Rooftop unit new solenoid valve		2/27/06	1,287		20	64	64	353	31
32	Video monitoring		3/31/06	1,025		20	51	51	281	32
33	Tilt mag lock		1/1/06	1,818		20	91	91	500	33
34	New doors and frames		4/6/06	4,600		20	230	230	1,265	34
35	Brickface & Gypsum		4/30/06	601		20	30	30	165	35
36			4/21/06	863		20	43		237	36

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

See Page 12A, Line 70 for total

**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:

01/01/2011 Ending: 12/31/2011

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

1	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	04/30/06	\$ 7,073	\$	20	\$ 354	\$ 354	\$ 1,946	37	
38	07/19/06	2,681		20	134	134	737	38	
39	07/31/06	1,190		20	59	59	326	39	
40	07/31/06	576		20	29	29	159	40	
41	11/30/06	2,847		20	142	142	782	41	
42	12/21/06	2,000		20	100	100	550	42	
43	09/19/06	1,878		20	94	94	517	43	
44								44	
45	Allocation From LCF:							45	
46	Various	1986	189,255		30	6,309	6,309	158,238	46
47	Various	1987	4,540	145	31.5	145		3,535	47
48	Various	1987	26,047	827	31.5	827		20,118	48
49	Various	1988	1,463	46	31.5	46		1,083	49
50	Various	1989	544	17	31.5	17		384	50
51	Various	1993	15,129	388	39	388		7,129	51
52	Various	1994	23,070	591	39	591		10,323	52
53	Various	2001	6,425	165	39	165		1,728	53
54	Various	2002	1,574	40	39	40		378	54
55	Various	2003	956	24	39	24		191	55
56	Various blower mtrs, control board	2004	3,741	96	39	96		733	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		395	61
62	Painting	2007	2,750						62
63	Allocation From Future:	2007	1,978	676	7		(676)	1,978	63
64	Various								64
65	Various	1987	82,087	2,605	31.5	2,647	42	65,895	65
66		1994	24,009	326	Var	326		17,006	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,534,105	\$ 167,373		\$ 118,405	\$ (49,011)	\$ 2,080,397	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 480,111	\$ 33,389	\$ 44,516	\$ 11,127	10	\$ 480,111	71
72	Current Year Purchases	2,672	2,672	267	(2,405)	10	267	72
73	Fully Depreciated Assets	545,180					545,180	73
74								74
75	TOTALS	\$ 1,027,963	\$ 36,061	\$ 44,783	\$ 8,722		\$ 1,025,558	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FROD CLUB WAGON	2008	\$ 6,356	\$ 781	\$ 1,271	\$ 490	5	\$ 5,084	76
77				6,777	732		(732)	5	6,777	77
78										78
79										79
80	TOTALS			\$ 13,133	\$ 1,513	\$ 1,271	\$ (242)		\$ 11,861	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,720,201	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,947	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,459	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (40,488)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,117,816	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: NA

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: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* 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?</p> <p><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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs							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							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2011**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 12,093	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,766,552		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	203,327		6
7	Other Prepaid Expenses	27,000		7
8	Accounts Receivable (owners or related parties)	1,585,542		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,594,514	\$	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	311,485		16
17	Accumulated Depreciation (book methods)	(1,094,858)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,992,785	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,587,299	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,683,181	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000		29
30	Accrued Salaries Payable	238,258		30
31	Accrued Taxes Payable (excluding real estate taxes)	681,294		31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,085		32
33	Accrued Interest Payable	612,500		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)	\$ 4,597,318	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,303,555		39
40	Mortgage Payable	5,159,609		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)	\$ 7,463,164	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,060,482	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,473,183)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,587,299	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,819,216)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,819,216)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,033	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)	\$ 346,033	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)	\$ (1,473,183)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number EMBASSY HEALTH CARE CENTER

0048488

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,077,681	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,077,681	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DAY TRAINING</u>	572	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 572	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,078,253	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,329,864	31
32	Health Care	3,355,477	32
33	General Administration	1,973,636	33
B. Capital Expense			
34	Ownership	979,620	34
C. Ancillary Expense			
35	Special Cost Centers		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)*	\$ 7,732,220	40
41	Income before Income Taxes (line 30 minus line 40)**	346,033	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 346,033	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **EMBASSY HEALTH CARE CENTER**

0048488

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,944	2,080	\$ 69,787	\$ 33.55	1
2	Assistant Director of Nursing	1,888	1,936	59,365	30.66	2
3	Registered Nurses	8,426	9,159	214,303	23.40	3
4	Licensed Practical Nurses	33,461	36,430	818,604	22.47	4
5	CNAs & Orderlies	80,429	84,246	868,643	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,453	16,974	265,479	15.64	8
9	Activity Director	3,848	4,160	69,006	16.59	9
10	Activity Assistants	17,580	18,552	218,401	11.77	10
11	Social Service Workers	5,144	6,040	121,642	20.14	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,056	49,817	24.23	13
14	Head Cook	5,749	6,056	61,510	10.16	14
15	Cook Helpers/Assistants	17,935	19,191	193,248	10.07	15
16	Dishwashers					16
17	Maintenance Workers	3,131	3,398	44,050	12.96	17
18	Housekeepers	24,276	25,438	243,333	9.57	18
19	Laundry	3,663	3,974	40,192	10.11	19
20	Administrator	2,241	2,421	87,514	36.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,436	19,943	250,939	12.58	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)	245,460	262,054	\$ 3,675,833 *	\$ 14.03	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	M	\$ 7,916	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	5,627	10-3	38
39	Pharmacist Consultant	H	8,208	10-3	39
40	Physical Therapy Consultant	L	27,020	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	4,240	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,146	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 67,157		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	2,592	57,401	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	2,592	\$ 57,401		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 BASSETTE	ADMINISTRATOR		\$ 30,352	Workers' Compensation Insurance	\$ 209,731	IDPH License Fee	\$	
JODI JUDE	ADMINISTRATOR		57,162	Unemployment Compensation Insurance	138,699	Advertising: Employee Recruitment	5,691	
			0	FICA Taxes	275,952	Health Care Worker Background Check	6,139	
				Employee Health Insurance	30,549	(Indicate # of checks performed <u>175</u>)		
				Employee Meals		Patient Background Checks <u>237</u>	8,295	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	5,225	MARKETING/ADV/PROMO	20,628	
						LICENSES/DUES/SUBSCRIPTIONS	4,882	
						MGMT CO ALLOC		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TRUST/FRANCHISE/CONTRIB/ETC	0	
			\$ 87,514	PENSION/PROFIT SHARING PLANS	16,710	Less: Public Relations Expense	(0)	
B. Administrative - Other						Non-allowable advertising	(20,628)	
Description			Amount			Yellow page advertising	(0)	
MANAGEMENT FEES			\$ 510,250					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 510,250	TOTAL (agree to Schedule V, line 22, col.8)			\$ 676,866	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			126,708					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$	TOTAL	\$
			\$ 126,708	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NA	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number EMBASSY HEALTH CARE CENTER# 0048488Report Period Beginning: 01/01/2011Ending: 12/31/2011**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 93,623
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees