

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048488

Facility Name: EMBASSY HEALTH CARE CENTER

Address: 555 KAHLER ROAD WILMINGTON 60481
Number City Zip Code

County: WILL

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax #: (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone #: (217) 782-1630

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

YES ☐ NO ☒

YES ☐ NO ☒

Date started 12/16/06

YES ☒ Date 12/16/06 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 16 and days of care provided 5,293

Medicare Intermediary ADMINISTAR**MODIFIED**

ACCRUAL	☒	CASH*	☐	CASH*	☐
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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.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	92.93%
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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
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,916
	REPAIRS & MAINTENANCE	0
		0
		7,916
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	40,538
	ELECTRICITY	65,982
	WATER	74,035
	CABLE TV - LOBBY	4,275
		0
		184,830
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	63,913
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	0
		0
		0
		0
		0
		63,913
7	OTHER	
	SCAVENGER	26,776
	SECURITY SERVICE	0
		0
		0
		26,776
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	57,401
	LABORATORY & XRAY EXPENSE	2,463
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	8,208
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	5,627
		0
		0
		73,699
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	52,250
	SPEECH THERAPY SERVICES	15,119
	OCCUPATIONAL THERAPY SERVICES	67,143
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	27,020
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	4,240
		165,772
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,146
		2,146
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0

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
	=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					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	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	(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	0	0	0	0	0	0	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	0	0	0	0	0	0	0	(160,459)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,346)	19,161	(116,806)	0	0	0	0	0	0	0	0	(149,991)	29

Summary B

12/31/2011

[illegible]

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:	
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	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.

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

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	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

VIII. ALLOCATION OF INDIRECT COSTS

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

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 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	2
3	17	Administrative	DIRECT ALLOCATION	304,500	3	58,461	58,461	304,500	58,461	3
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	6
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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BRICKYARD BANK		X	MORTGAGE	\$45,218.00	12/06	\$ 5,500,000	\$ 5,159,609	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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 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		
	2007	122,201	9		
	2008	133,468	10		
	2009	118,787	11		
	2010	121,488	12		
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					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

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.

FACILITY NAME	EMBASSY HEALTH CARE CENTER	COUNTY	WILL
---------------	----------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500

B. General Construction Type: Exterior BRICKFrameNumber 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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	40,500	2006	\$ 145,000	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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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.

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	Doorlocks, weatherproofing, magnet locks	04/30/06	\$ 7,073	\$	20	\$ 354	\$ 354	\$ 1,946	37
38	Install to fire alarm sys; trobes & pull stat	07/19/06	2,681		20	134	134	737	38
39	Electric magnet & strike	07/31/06	1,190		20	59	59	326	39
40	Renite zone annunciator & driver	07/31/06	576		20	29	29	159	40
41	Carrir rooftop compressor	11/30/06	2,847		20	142	142	782	41
42	Video monitoring equip	12/21/06	2,000		20	100	100	550	42
43	Water meter	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	☐ YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	☒ NO	IN-HOUSE PROGRAM ☐	IN-HOUSE PROGRAM ☐
		IN OTHER FACILITY ☐	IN OTHER FACILITY ☐
		COMMUNITY COLLEGE ☐	HOURS PER CNA _____
		HOURS PER CNA _____	

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	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.

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.

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	DAY TRAINING	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.

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 175)	
				Employee Meals			Patient Background Checks 237	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
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 87,514	PENSION/PROFIT SHARING PLANS		16,710	MGMT CO ALLOC	
(List each licensed administrator separately.)							TRUST/FRANCHISE/CONTRIB/ETC	0
B. Administrative - Other							Less: Public Relations Expense (	0)
Description			Amount				Non-allowable advertising	(20,628)
MANAGEMENT FEES			\$ 510,250				Yellow page advertising (	0)
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 510,250	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)					\$	676,866		\$ 25,007
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
SEE SCHEDULE ATTACHED			126,708				Entertainment Expense (	)
TOTAL (agree to Schedule V, line 19, column 3)			\$ 126,708	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 benefit: 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