FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048488

Facility Name: EMBASSY HEALTH CARE CENTER

Address: 555 WEST KAHLER (Number) WILMINGTON (City) 60481 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 01/01/2010 to 12/31/2010 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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,980	5,980	8
9	SNF/PED					9
10	ICF	46,014	3,314	266	49,594	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,014	3,314	6,246	55,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.04%

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 [X]

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

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 [X] Date 12/16/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 5,980

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,133	12,302	9,433	329,868		329,868		329,868			1
2	Food Purchase		360,378		360,378	(31,865)	328,513	(4,592)	323,921			2
3	Housekeeping	236,396			236,396		236,396		236,396			3
4	Laundry	40,283	11,110		51,393		51,393		51,393			4
5	Heat and Other Utilities			177,201	177,201		177,201	5,822	183,023			5
6	Maintenance	51,711	36,162	59,192	147,065		147,065	11,278	158,343			6
7	Other (specify):*			24,829	24,829		24,829		24,829			7
8	**TOTAL General Services**	636,523	419,952	270,655	1,327,130	(31,865)	1,295,265	12,508	1,307,773			8
	B. Health Care and Programs											
9	Medical Director			47,156	47,156		47,156		47,156			9
10	Nursing and Medical Records	2,011,903	192,351	95,200	2,299,454		2,299,454		2,299,454			10
10a	Therapy	250,499		18,847	269,346		269,346		269,346			10a
11	Activities	319,052	4,709		323,761		323,761		323,761			11
12	Social Services	107,514		3,973	111,487		111,487		111,487			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,688,968	197,060	165,176	3,051,204		3,051,204		3,051,204			16
	C. General Administration											
17	Administrative	90,418		553,850	644,268		644,268	(459,433)	184,835			17
18	Directors Fees											18
19	Professional Services			197,472	197,472		197,472	22,970	220,442			19
20	Dues, Fees, Subscriptions & Promotions			37,727	37,727		37,727	(5,011)	32,716			20
21	Clerical & General Office Expenses	202,653	35,998	226,027	464,678		464,678	74,592	539,270			21
22	Employee Benefits & Payroll Taxes			714,320	714,320	31,865	746,185		746,185			22
23	Inservice Training & Education			1,899	1,899		1,899		1,899			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,385	8,385		8,385	8,362	16,747			25
26	Insurance-Prop.Liab.Malpractice			128,896	128,896		128,896	3,043	131,939			26
27	Other (specify):*			7,572	7,572		7,572	55,064	62,636			27
28	**TOTAL General Administration**	293,071	35,998	1,876,148	2,205,217	31,865	2,237,082	(300,413)	1,936,669			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,618,562	653,010	2,311,979	6,583,551		6,583,551	(287,905)	6,295,646			29

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

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

Facility Name & ID#: EMBASSY HEALTH CARE CENTER #0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,433	
	REPAIRS & MAINTENANCE		0	
			0	9,433
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		52,078	
	ELECTRICITY		71,957	
	WATER		49,113	
	CABLE TV - LOBBY		4,053	
			0	177,201
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		59,192	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	59,192
7	**OTHER**			
	SCAVENGER		24,829	
	SECURITY SERVICE		0	
			0	
			0	24,829
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	47,156	47,156

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	75,000	
	LABORATORY & XRAY EXPENSE		8,744	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	8,506	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,950	
			0	
			0	95,200
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	14,375	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,472	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				18,847
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,973	
			0	3,973
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number EMBASSY HEALTH CARE CENTER **#0048488** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	553,850	553,850
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,729	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	172,743	
			0	197,472
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,125	
	EMPLOYEE WANT ADS	XIX F	10,022	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	12,289	
	LICENSES & PERMITS	XIX F	3,309	
	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	4,542	
	PATIENT BACKGROUND CHECKS	XIX F	2,440	
				37,727
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	212,041	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,986	
	MESSENGER SERVICE		0	
			0	226,027

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	271,522	
	UNEMPLOYMENT COMPENSATION	XIX D	78,301	
	WORKERS COMPENSATION INSURANC	XIX D	318,003	
	HOSPITALIZATION INSURANCE	XIX D	6,289	
	EMPLOYEE BENEFITS - OTHER	XIX D	24,820	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	15,385	
	CHICAGO HEAD TAX	XIX D	0	
			0	714,320
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,899	
				1,899
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,385	
				8,385
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		128,896	
				128,896
27	**OTHER**			
	BAD DEBTS	VI 24	7,572	
				7,572

GRAND TOTAL COLUMN 3 OTHER **2,311,979**

EMBASSY HEALTH CARE CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	360,378
LESS SALES TAX	(4,592)
NET FOOD	355,786
TOTAL PATIENT CENSUS	55,574
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	166,722
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	16,425
PATIENT MEALS	166,722
ADD EMPLOYEE MEALS	16,425
TOTAL MEALS/YEAR	183,147
NET FOOD	355,786
DIVIDE TOTAL MEALS/YEAR	183,147
COST PER MEAL	1.94
TIME EMPLOYEE MEALS	16,425
EMPLOYEE MEAL RECLASSIFICATION	**31,865**
	========

Facility Name & ID Number EMBASSY HEALTH CARE CENTER #0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			209,413	209,413		209,413	(33,175)	176,238			30
31	Amortization of Pre-Op. & Org.			6,279	6,279		6,279		6,279			31
32	Interest			686,436	686,436		686,436	(64,807)	621,629			32
33	Real Estate Taxes			146,876	146,876		146,876		146,876			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,049,004	1,049,004		1,049,004	(97,982)	951,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,588	290,802	612,390		612,390		612,390			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**		321,588	384,425	706,013		706,013		706,013			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,618,562	974,598	3,745,408	8,338,568		8,338,568	(385,887)	7,952,681			45

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Reference	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	(37,970)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,592)	2		13
14	Non-Care Related Interest	(64,807)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(212,041)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,572)	27		24
25	Fund Raising, Advertising and Promotional	(5,125)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (332,107)		$	30

BHF USE ONLY								
48		49		50		51		52	

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)	(53,780)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (53,780)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (385,887)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

EMBASSY HEALTH CARE CENTER

ID# 0048488

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	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:** 01/01/2010 **Ending:** 12/31/2010

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	(4,592)	0	0	0	0	0	0	0	0	0	0	(4,592)	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	5,822	0	0	0	0	0	0	0	0	0	5,822	5
6	Maintenance	0	11,278	0	0	0	0	0	0	0	0	0	11,278	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,592)	17,100	0	0	0	0	0	0	0	0	0	12,508	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	(459,433)	0	0	0	0	0	0	0	0	0	(459,433)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,970	0	0	0	0	0	0	0	0	0	22,970	19
20	Fees, Subscriptions & Promotions	(5,125)	114	0	0	0	0	0	0	0	0	0	(5,011)	20
21	Clerical & General Office Expenses	(212,041)	286,633	0	0	0	0	0	0	0	0	0	74,592	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	8,362	0	0	0	0	0	0	0	0	0	8,362	25
26	Insurance-Prop.Liab.Malpractice	0	3,043	0	0	0	0	0	0	0	0	0	3,043	26
27	Other (specify):*	(7,572)	62,636	0	0	0	0	0	0	0	0	0	55,064	27
28	**TOTAL General Administration**	(224,738)	(75,675)	0	0	0	0	0	0	0	0	0	(300,413)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(229,330)	(58,575)	0	0	0	0	0	0	0	0	0	(287,905)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,970)	4,795	0	0	0	0	0	0	0	0	0	(33,175)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(64,807)	0	0	0	0	0	0	0	0	0	0	(64,807)	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	(102,777)	4,795	0	0	0	0	0	0	0	0	0	(97,982)	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)	(332,107)	(53,780)	0	0	0	0	0	0	0	0	0	(385,887)	45

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule attached		Peterson Park	Chicago	Future Assoc	Skokie	Bkkg; Mgmt Svces

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 553,850	Future Associates		$	$ (553,850)	1
2	V	5	Utilities		Future Associates		5,822	5,822	2
3	V	6	Maintenance		Future Associates		11,278	11,278	3
4	V	17	Administrative		Future Associates		94,417	94,417	4
5	V	19	Professional Fees		Future Associates		22,970	22,970	5
6	V	20	License, Dues, Fees		Future Associates		114	114	6
7	V	21	Clerical and General		Future Associates		286,633	286,633	7
8	V	27	Employee Benefits		Future Associates		62,636	62,636	8
9	V	25	Auto Expense		Future Associates		8,362	8,362	9
10	V	26	Insurance Expense		Future Associates		3,043	3,043	10
11	V	30	Depreciation		Future Associates		4,795	4,795	11
12	V								12
13	V								13
14	Total			$ 553,850			$ 500,070	$ * (53,780)	14

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nachshon Draiman	Director	Administrative	0.50		15	25.00		$		1
2	Eli Draiman		Administrative	0.00				Salary	94,417	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,417		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	649839	2	$ 7,306	$	517,850	$ 5,822	1
2	6	Maintenance	Management Fees	649839	2	14,152	12,844	517,850	11,278	2
3	17	Administrative	Direct allocation	517850	1	94,417		517,850	94,417	3
4	19	Professional Fees	Management Fees	649839	2	28,825		517,850	22,970	4
5	20	License, Dues, Fees	Management Fees	649839	2	143		517,850	114	5
6	21	Clerical and General	Management Fees	649839	2	359,690	306,644	517,850	286,633	6
7	27	Employee Benefits	Management Fees	649839	2	78,600		517,850	62,636	7
8	25	Auto Expense	Management Fees	649839	2	10,493		517,850	8,362	8
9	26	Insurance Expense	Management Fees	649839	2	3,818		517,850	3,043	9
10	30	Depreciation	Management Fees	649839	2	6,017		517,850	4,795	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					$ 603,461	$ 319,488		$ 500,070	25

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Brickyard Bank		X	Mortgage	$45,218.00	12/06	$ 5,500,000	$ 5,234,751	12/11	8.7500	$ 467,608	1
2												2
3	Related Party Interest	X						2,010,000			124,219	3
4												4
5												5
	Working Capital											
6	Brickyard Bank		X	Line of Credit		11/09	250,000	250,000		Var	18,850	6
7												7
8	Insurance Financing		X								10,952	8
9	TOTAL Facility Related				$45,218.00		$ 5,750,000	$ 7,494,751			$ 621,629	9
	B. Non-Facility Related*											
10	IRS & RE Tax & Vendors		x								64,807	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 64,807	14
15	TOTALS (line 9+line14)						$ 5,750,000	$ 7,494,751			$ 686,436	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.)**

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 292,490	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.)		$ 118,787	2
3. Under or (over) accrual (line 2 minus line 1).		$ (173,703)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 320,579	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.		$ 146,876	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	67,638	8
	2006	75,288	9
	2007	122,201	10
	2008	133,468	11
	2009	118,787	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010-0000	NURSING HOME	$ 118,786.92	$ 118,786.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,786.92	$ 118,786.92

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$ 2,363,000	$ 147,234	35	$ 67,514	$ (79,720)	$ 1,210,642	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	675	10
11	Roof Repairs			12/30/2007	2,682	79	20	134	55	402	11
12	New York packaged heat/cold rooftop unit			12/8/2007	15,850	396	20	792	396	2,443	12
13	28 fire dampers			12/18/2007	4,686	117	20	235	118	704	13
14	100 gallon hot water heater			2/1/2007	4,108	102	20	205	103	804	14
15	Repair TV Antenna			12/5/2007	3,000	87	20	13	(74)	41	15
16	Satellite TV System			2/28/2009	7,900	203	20	329	126	658	16
17	Various			1993	55,674		20	2,786	2,786	48,617	17
18	Various			1994	144,492		20	7,228	7,228	119,500	18
19	Various			1995	126,250		20	6,317	6,317	97,637	19
20	Various			1996	94,458		20	4,722	4,722	68,756	20
21	Various			1997	13,974		20	700	700	9,675	21
22	Various			1998	13,694		20	682	682	8,489	22
23	Various			1999	29,626		20	1,482	1,482	16,854	23
24	Various			2000	71,797		20	3,760	3,760	37,347	24
25	Various			2001	4,657		20	214	214	1,997	25
26	Various			2002	1,466		20	73	73	647	26
27	Various			2003	67,271		20	3,365	3,365	24,528	27
28	Various			2004	60,965		20	3,048	3,048	19,815	28
29	Various			2005	26,783		20	1,342	1,342	7,370	29
30	Rooftop unit ground wire			1/30/06	2,543		20	127	127	572	30
31	Rooftop unit new solenoid valve			2/27/06	1,287		20	64	64	289	31
32	Video monitoring			3/31/06	1,025		20	51	51	230	32
33	Tilt mag lock			1/1/06	1,818		20	91	91	409	33
34	New doors and frames			4/6/06	4,600		20	230	230	1,035	34
35	Brickface & Gypsum			4/30/06	601		20	30	30	135	35
36				4/21/06	863		20	43		194	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doorlocks, weatherproofing, magnet locks	04/30/06	$ 7,073	$	20	$ 354	$ 354	$ 1,592	37
38	Install to fire alarm sys; trobes & pull stat	07/19/06	2,681		20	134	134	603	38
39	Electric magnet & strike	07/31/06	1,190		20	59	59	267	39
40	Renite zone annunciator & driver	07/31/06	576		20	29	29	130	40
41	Carrir rooftop compressor	11/30/06	2,847		20	142	142	640	41
42	Video monitoring equip	12/21/06	2,000		20	100	100	450	42
43	Water meter	09/19/06	1,878		20	94	94	423	43
44									44
45	Allocation From LCF:								45
46	Various	1986	189,255		30	6,309	6,309	151,929	46
47	Various	1987	4,540	145	31.5	145		3,390	47
48	Various	1987	26,047	827	31.5	827		19,291	48
49	Various	1988	1,463	46	31.5	46		1,037	49
50	Various	1989	544	17	31.5	17		367	50
51	Various	1993	15,129	388	39	388		6,741	51
52	Various	1994	23,070	591	39	591		9,732	52
53	Various	2001	6,425	165	39	165		1,563	53
54	Various	2002	1,574	40	39	40		338	54
55	Various	2003	956	24	39	24		167	55
56	Various blower mtrs, control board	2004	3,741	96	39	96		637	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		324	61
62	Painting	2007	2,750						62
63	Allocation From Future:	2007	1,978	676	7	543	(133)	1,978	63
64	Various								64
65	Various	1987	82,087	2,605	31.5	2,647	42	63,248	65
66		1994	24,009	326	Var	326		16,680	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,534,105	$ 167,373		$ 118,948	$ (48,468)	$ 1,961,992	70

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 480,111	$ 45,615	$ 48,011	$ 2,396	10	$ 435,595	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	545,180				10	545,180	73
74								74
75	TOTALS	$ 1,025,291	$ 45,615	$ 48,011	$ 2,396		$ 980,775	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	From FA			$ 208,347	$	$ 7,271	$ 7,271	5	$ 144,157	76
77	Emb Holding	Ford Club Wagon	2008	6,356	1,220	1,271	51	5	3,813	77
78	Emb Health Care		Var	27,320		737	737	5	27,320	78
79	Emb Holding									79
80	TOTALS			$ 242,023	$ 1,220	$ 9,279	$ 8,059		$ 175,290	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,946,419	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,208	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 176,238	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,970)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,118,057	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.

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
   - [X] NO

   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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

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.

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$		$ 153,397	$		$ 153,397	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,919			13,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			123,486			123,486	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				321,588		321,588	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			$		$ 290,802	$ 321,588		$ 612,390	14

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,490	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,441,115		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	189,842		6
7	Other Prepaid Expenses	18,037		7
8	Accounts Receivable (owners or related parties)	1,587,943		8
9	Other(specify): RE TAX ESCROW	38,335		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,342,762	$	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	308,813		16
17	Accumulated Depreciation (book methods)	(895,928)		17
18	Deferred Charges	6,279		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)**	$ 6,195,322	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,538,084	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,183,934	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	592,550		29
30	Accrued Salaries Payable	222,797		30
31	Accrued Taxes Payable (excluding real estate taxes)	519,858		31
32	Accrued Real Estate Taxes(Sch.IX-B)	320,579		32
33	Accrued Interest Payable	532,834		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)**	$ 4,372,552	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,750,000		39
40	Mortgage Payable	5,234,751		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)**	$ 6,984,751	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,357,303	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,819,219)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,538,084	$	48

***(See instructions.)**

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (821,008)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (821,008)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(998,211)	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)**	$ (998,211)	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)**	$ (1,819,219)	24 *

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,340,056	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,340,056	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	301	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 301	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,340,357	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,327,130	31
32	Health Care	3,051,204	32
33	General Administration	2,205,217	33
	B. Capital Expense		
34	Ownership	1,049,004	34
	C. Ancillary Expense		
35	Special Cost Centers	612,390	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)***	$ 8,338,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	(998,211)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (998,211)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 76,936	$ 36.99	1
2	Assistant Director of Nursing	2,008	2,080	61,439	29.54	2
3	Registered Nurses	7,823	8,166	199,313	24.41	3
4	Licensed Practical Nurses	35,051	37,926	842,867	22.22	4
5	CNAs & Orderlies	76,155	79,627	831,348	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,212	18,513	250,499	13.53	8
9	Activity Director	5,112	5,448	85,435	15.68	9
10	Activity Assistants	17,626	18,436	233,617	12.67	10
11	Social Service Workers	5,592	6,240	107,514	17.23	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,080	50,398	24.23	13
14	Head Cook	4,923	5,138	53,225	10.36	14
15	Cook Helpers/Assistants	19,487	20,408	204,510	10.02	15
16	Dishwashers					16
17	Maintenance Workers	3,811	4,138	51,711	12.50	17
18	Housekeepers	23,801	25,083	236,396	9.42	18
19	Laundry	4,148	4,614	40,283	8.73	19
20	Administrator	1,984	2,160	90,418	41.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,810	16,118	202,653	12.57	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)	243,375	258,255	$ 3,618,562 *	$ 14.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,433	1-3	35
36	Medical Director	O	47,156	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,950	10-3	38
39	Pharmacist Consultant	H	8,506	10-3	39
40	Physical Therapy Consultant	L	14,375	10a-3	40
41	Occupational Therapy Consultant	Y	4,472	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,973	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 90,865		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	2,418	75,000	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	2,418	$ 75,000		53

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn Bessette	ADMINISTRATOR		$ 90,418
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,418

B. Administrative - Other

Description	Amount
Home Office Expense	$ 517,850
Management Fees	36,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 553,850
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		197,472
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 197,472

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 318,003
Unemployment Compensation Insurance	78,301
FICA Taxes	271,522
Employee Health Insurance	6,289
Employee Meals	31,865
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	24,820
PENSION/PROFIT SHARING PLANS	15,385
TOTAL (agree to Schedule V, line 22, col.8)	$ 746,185

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,022
Health Care Worker Background Check	4,542
(Indicate # of checks performed 454)	
Patient Background Checks 244	2,440
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	5,125
LICENSES/DUES/SUBSCRIPTIONS	15,598
MGMT CO ALLOC	114
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,125)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,716

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EMBASSY HEALTH CARE CENTER # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
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 # 0048488 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
EMBASSY CARE CENTER 36-3863655-001

(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. $ **31,865** 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? **90**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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 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.