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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0048488

Facility Name: EMBASSY HEALTH CARE CTR

Address: 555 W 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: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 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) SANFORD BOKOR, 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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	29,280	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,306	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,586	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	1,292		4,044	5,336	8
9	SNF/PED					9
10	ICF	50,466	3,313	24	53,803	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,758	3,313	4,068	59,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.49%

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 12/06/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/06/06 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 4,044

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	302,311	20,235	13,716	336,262		336,262		336,262			1
2	Food Purchase		378,158		378,158		378,158	(2,622)	375,536			2
3	Housekeeping	253,940			253,940		253,940		253,940			3
4	Laundry	67,422	8,898		76,320		76,320		76,320			4
5	Heat and Other Utilities			184,261	184,261		184,261	7,381	191,642			5
6	Maintenance	14,987	62,504	73,465	150,956		150,956	12,978	163,934			6
7	Other (specify):*			29,870	29,870		29,870		29,870			7
8	**TOTAL General Services**	638,660	469,795	301,312	1,409,767		1,409,767	17,737	1,427,504			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	2,248,669	212,031	62,478	2,523,178		2,523,178		2,523,178			10
10a	Therapy	459,498	1,698	91,752	552,948		552,948		552,948			10a
11	Activities	265,147	14,952		280,099		280,099		280,099			11
12	Social Services	94,636		1,563	96,199		96,199		96,199			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,067,950	228,681	169,293	3,465,924		3,465,924		3,465,924			16
	C. General Administration											
17	Administrative	79,338		716,500	795,838		795,838	(619,379)	176,459			17
18	Directors Fees											18
19	Professional Services			170,194	170,194		170,194		170,194			19
20	Dues, Fees, Subscriptions & Promotions			59,898	59,898		59,898	(33,420)	26,478			20
21	Clerical & General Office Expenses	280,456	51,671	73,108	405,235		405,235	219,559	624,794			21
22	Employee Benefits & Payroll Taxes			942,343	942,343		942,343		942,343			22
23	Inservice Training & Education			4,518	4,518		4,518		4,518			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			11,486	11,486		11,486	8,122	19,608			25
26	Insurance-Prop.Liab.Malpractice			119,806	119,806		119,806	329	120,135			26
27	Other (specify):*							63,144	63,144			27
28	**TOTAL General Administration**	359,794	51,671	2,097,853	2,509,318		2,509,318	(361,645)	2,147,673			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,066,404	750,147	2,568,458	7,385,009		7,385,009	(343,908)	7,041,101			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 CTR **#0048488** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	13,716	
	REPAIRS & MAINTENANCE		0	
			0	13,716
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		37,902	
	ELECTRICITY		71,443	
	WATER		70,813	
	CABLE TV - LOBBY		4,103	
			0	184,261
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		73,465	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	73,465
7	**OTHER**			
	SCAVENGER		29,300	
	SECURITY SERVICE		570	
			0	
			0	29,870
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,500	13,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	18,627	
	LABORATORY & XRAY EXPENSE		24,387	
	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	18,473	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	991	
			0	
			0	62,478
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		888	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	57,834	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	33,030	
				91,752
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	1,563	
				1,563
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number EMBASSY HEALTH CARE CTR **#0048488** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	716,500	716,500
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,300	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	144,894	
			0	170,194
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	33,420	
	EMPLOYEE WANT ADS	XIX F	9,053	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	123	
	LICENSES & PERMITS	XIX F	4,184	
	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	7,651	
	PATIENT BACKGROUND CHECKS	XIX F	5,467	
				59,898
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,941	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		4,760	
	PENALTIES / OVERDRAFT CHARGES	VI 18	47,242	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,165	
	MESSENGER SERVICE		0	
			0	73,108

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	302,932	
	UNEMPLOYMENT COMPENSATION	XIX D	188,477	
	WORKERS COMPENSATION INSURANC	XIX D	379,628	
	HOSPITALIZATION INSURANCE	XIX D	39,047	
	EMPLOYEE BENEFITS - OTHER	XIX D	32,259	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	942,343
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,518	
				4,518
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,486	
				11,486
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		119,806	
				119,806
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **2,568,458**

EMBASSY HEALTH CARE CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	378,158
LESS SALES TAX	(2,622)
NET FOOD	375,536
TOTAL PATIENT CENSUS	59,139
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	177,417
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	177,417
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	177,417
NET FOOD	375,536
DIVIDE TOTAL MEALS/YEAR	177,417
COST PER MEAL	2.12
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number EMBASSY HEALTH CARE CTR #0048488 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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			185,238	185,238		185,238	(20,111)	165,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			568,293	568,293		568,293	(57,238)	511,055			32
33	Real Estate Taxes			132,002	132,002		132,002		132,002			33
34	Rent-Facility & Grounds							11,296	11,296			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			885,533	885,533		885,533	(66,053)	819,480			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			674,602	674,602		674,602		674,602			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			674,602	674,602		674,602		674,602			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,066,404	750,147	4,128,593	8,945,144		8,945,144	(409,961)	8,535,183			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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(25,452)	30		9
10	Interest and Other Investment Income	(1,578)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,622)	2		13
14	Non-Care Related Interest	(55,660)	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	(47,242)	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		27		24
25	Fund Raising, Advertising and Promotional	(33,420)	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 SEE PAGE 5A	(31,200)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,174)		$	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)	(212,787)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (212,787)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (409,961)		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

EMBASSY HEALTH CARE CTR

ID# 0048488

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (31,200)	21	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**	(31,200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EMBASSY HEALTH CARE CTR **#** 0048488 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,622)	0	0	0	0	0	0	0	0	0	0	(2,622)	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	7,381	0	0	0	0	0	0	0	0	0	7,381	5
6	Maintenance	0	12,978	0	0	0	0	0	0	0	0	0	12,978	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,622)	20,359	0	0	0	0	0	0	0	0	0	17,737	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	(619,379)	0	0	0	0	0	0	0	0	0	(619,379)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(33,420)	0	0	0	0	0	0	0	0	0	0	(33,420)	20
21	Clerical & General Office Expenses	(78,442)	298,001	0	0	0	0	0	0	0	0	0	219,559	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	8,122	0	0	0	0	0	0	0	0	0	8,122	25
26	Insurance-Prop.Liab.Malpractice	0	329	0	0	0	0	0	0	0	0	0	329	26
27	Other (specify):*	0	63,144	0	0	0	0	0	0	0	0	0	63,144	27
28	**TOTAL General Administration**	(111,862)	(249,783)	0	0	0	0	0	0	0	0	0	(361,645)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,484)	(229,424)	0	0	0	0	0	0	0	0	0	(343,908)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(25,452)	5,341	0	0	0	0	0	0	0	0	0	(20,111)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,238)	0	0	0	0	0	0	0	0	0	0	(57,238)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,296	0	0	0	0	0	0	0	0	0	11,296	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**	(82,690)	16,637	0	0	0	0	0	0	0	0	0	(66,053)	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)**	(197,174)	(212,787)	0	0	0	0	0	0	0	0	0	(409,961)	45

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
SEE PAGE 6-SUPPLEMENTAL		N/A		SEE PAGE 6-SUPPLEMENTAL		

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	$ 703,500	FUTURE VENTURES ASSOCIATES, LLC		$	$ (703,500)	1
2	V	5	UTILITIES				7,381	7,381	2
3	V	6	MAINTENANCE EXPENSE				12,978	12,978	3
4	V	17	ADMINISTRATIVE				84,121	84,121	4
5	V	21	TOTAL OFFICE				298,001	298,001	5
6	V	25	AUTO EXPENSE				8,122	8,122	6
7	V	26	INSURANCE				329	329	7
8	V	27	EMPLOYEE BENEFITS				63,144	63,144	8
9	V	30	DEPRECIATION				5,341	5,341	9
10	V	34	OFFICE RENT				11,296	11,296	10
11	V								11
12	V								12
13	V								13
14	Total			$ 703,500			$ 490,713	$ * (212,787)	14

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

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	NACHSHON DRAIMAN	46.21			FUTURE VENTURES	SKOKIE	MGMT, BKKP	2
3	DR SAMUEL LIPSHITZ, MD	25.78			ASSOCIATES, LLC			3
4	RAJCHENBACH FAMILY TRUST	20.43						4
5	BURIA DRAIMAN FAMILY TRUST	0.69						5
6	BEN FELDMAN	0.06						6
7	J & V VENTURES	0.09						7
8	N DRAIMAN TRUST	0.05						8
9	ND FAMILY TRUST	2.20						9
10	RAE SAITELBACH TRUSTEE	0.15						10
11	ANNA MOSCOVITCH	0.03						11
12	PINKUS ASOWSKY	0.06						12
13	IRVING & LISA WEISS	0.03						13
14	JACKY SCHIESTEL	0.03						14
15	ALLEN HERSHBERG	0.09						15
16	ERWIN KATZ	0.15						16
17	ELI DRAIMAN	3.95						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

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	ELI DRAIMAN	ADMINISTRATIVE	MANAGEMENT	3.90				MGMT FEES	$ 13,000	17-3	1
2											2
3	ALLOCATION FROM FUTURE VENTURES ASSOCIATES, LLC:										3
4	ELI DRAIMAN	ADMINISTRATIVE	ADMINISTRATIV	3.90		60	100.00	SALARY	84,121	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 97,121		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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$46,846.00	12/06	$ 5,500,000	$ 5,059,484	02/13	8.7500	$ 474,839	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BRICKYARD BANK		X	LINE OF CREDIT		11/09	250,000	250,000		7.0000	30,606	6
7				INSURANCE FINANCING							7,188	7
8												8
9	TOTAL Facility Related				$46,846.00		$ 5,750,000	$ 5,309,484			$ 512,633	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							55,660	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 55,660	14
15	TOTALS (line 9+line14)						$ 5,750,000	$ 5,309,484			$ 568,293	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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 132,085	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.)		$ 126,617	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,468)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 137,470	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.		$ 132,002	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	122,201	8
	2008	133,468	9
	2009	118,787	10
	2010	121,488	11
	2011	126,617	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 108% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EMBASSY HEALTH CARE CTR 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 2011 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 2011.

	(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	$ 126,616.68	$ 126,616.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 126,616.68	$ 126,616.68

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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)	$ 1,345,670	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	1,123	10
11	Roof Repairs			12/30/2007	2,682	79	20	134	55	670	11
12	New York packaged heat/cold rooftop unit			12/8/2007	15,850	396	20	792	396	4,027	12
13	28 fire dampers			12/18/2007	4,686	117	20	235	118	1,174	13
14	100 gallon hot water heater			2/1/2007	4,108	102	20	205	103	1,214	14
15	Repair TV Antenna			12/5/2007	3,000	87	20	150	63	204	15
16	Satellite TV System			2/28/2009	7,900	203	20	329	126	1,316	16
17	Various			1993	55,674		20	2,786	2,786	54,189	17
18	Various			1994	144,492		20	7,228	7,228	133,956	18
19	Various			1995	126,250		20	6,317	6,317	110,271	19
20	Various			1996	94,458		20	4,722	4,722	78,200	20
21	Various			1997	13,974		20	700	700	11,075	21
22	Various			1998	13,694		20	682	682	9,853	22
23	Various			1999	29,626		20	1,482	1,482	19,818	23
24	Various			2000	71,797		20	3,760	3,760	44,867	24
25	Various			2001	4,657		20	214	214	2,425	25
26	Various			2002	1,466		20	73	73	793	26
27	Various			2003	67,271		20	3,365	3,365	31,258	27
28	Various			2004	60,965		20	3,048	3,048	25,911	28
29	Various			2005	26,783		20	1,342	1,342	10,054	29
30	Rooftop unit ground wire			1/30/06	2,543		20	127	127	826	30
31	Rooftop unit new solenoid valve			2/27/06	1,287		20	64	64	417	31
32	Video monitoring			3/31/06	1,025		20	51	51	332	32
33	Tilt mag lock			1/1/06	1,818		20	91	91	591	33
34	New doors and frames			4/6/06	4,600		20	230	230	1,495	34
35	Brickface & Gypsum			4/30/06	601		20	30	30	195	35
36				4/21/06	863		20	43		280	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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 2,300	37
38	Install to fire alarm sys; trobes & pull stat	07/19/06	2,681		20	134	134	871	38
39	Electric magnet & strike	07/31/06	1,190		20	59	59	385	39
40	Renite zone annunciator & driver	07/31/06	576		20	29	29	188	40
41	Carrir rooftop compressor	11/30/06	2,847		20	142	142	924	41
42	Video monitoring equip	12/21/06	2,000		20	100	100	650	42
43	Water meter	09/19/06	1,878		20	94	94	611	43
44									44
45	Allocation From LCF:								45
46	Various	1986	189,255		30	6,309	6,309	164,547	46
47	Various	1987	4,540	145	31.5	145		3,680	47
48	Various	1987	26,047	827	31.5	827		20,945	48
49	Various	1988	1,463	46	31.5	46		1,129	49
50	Various	1989	544	17	31.5	17		401	50
51	Various	1993	15,129	388	39	388		7,517	51
52	Various	1994	23,070	591	39	591		10,914	52
53	Various	2001	6,425	165	39	165		1,893	53
54	Various	2002	1,574	40	39	40		418	54
55	Various	2003	956	24	39	24		215	55
56	Various blower mtrs, control board	2004	3,741	96	39	96		829	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		466	61
62	Painting	2007	2,750						62
63	Allocation From Future:	2007	1,978					1,978	63
64	Various								64
65	Various	1987	82,087	2,605	31.5	2,647	42	68,542	65
66		1994	24,009	326	Var	326		17,332	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,534,105	$ 166,697		$ 118,542	$ (48,198)	$ 2,198,939	70

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

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 482,783	$ 17,271	$ 44,783	$ 27,512	10	$ 525,161	71
72	Current Year Purchases	10,598	5,488	530	(4,958)	10	530	72
73	Fully Depreciated Assets	545,180					545,180	73
74								74
75	TOTALS	$ 1,038,561	$ 22,759	$ 45,313	$ 22,554		$ 1,070,871	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	$ 733	$ 1,272	$ 539	5	$ 6,356	76
77			2007	6,777	390		(390)	5	6,777	77
78										78
79										79
80	TOTALS			$ 13,133	$ 1,123	$ 1,272	$ 149		$ 13,133	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)	$ 4,730,799	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,579	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 165,127	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (25,452)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,282,943	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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.		$
13.		$
14.		$

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: $ N/A 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			N/A		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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			N/A				8
9	Pharmacy	39-2	# of prescrpts							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.

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 43,057	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,674,671		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	279,559		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,997,287	$	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	322,083		16
17	Accumulated Depreciation (book methods)	(1,280,096)		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)**	$ 5,818,145	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,815,432	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,957,487	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	257,500		29
30	Accrued Salaries Payable	274,851		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,195,220		31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,470		32
33	Accrued Interest Payable			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)**	$ 4,822,528	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	548,555		39
40	Mortgage Payable	5,059,484		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)**	$ 5,608,039	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,430,567	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,615,135)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,815,432	$	48

***(See instructions.)**

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,473,183)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENTS	776,956	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (696,227)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(918,908)	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)**	$ (918,908)	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)**	$ (1,615,135)	24 *

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

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,024,658	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,024,658	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***	1,578	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,578	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,026,236	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,409,767	31
32	Health Care	3,465,924	32
33	General Administration	2,509,318	33
	B. Capital Expense		
34	Ownership	885,533	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	674,602	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,945,144	40
41	**Income before Income Taxes (line 30 minus line 40)****	(918,908)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (918,908)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,200,941	44
45	Private Pay - Net Inpatient Revenue	1,662,348	45
46	Medicare - Net Inpatient Revenue	1,155,781	46
47	Other-(specify) VETERAN	5,588	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,024,658	49

* **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 CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,984	2,176	$ 73,946	$ 33.98	1
2	Assistant Director of Nursing	2,072	2,160	69,840	32.33	2
3	Registered Nurses	12,545	13,165	328,273	24.94	3
4	Licensed Practical Nurses	30,831	33,628	786,443	23.39	4
5	CNAs & Orderlies	81,894	85,996	915,505	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,818	20,672	459,498	22.23	8
9	Activity Director	3,784	4,160	69,813	16.78	9
10	Activity Assistants	16,602	17,773	195,334	10.99	10
11	Social Service Workers	3,600	4,136	94,636	22.88	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,096	42,057	20.07	13
14	Head Cook	5,626	6,009	62,649	10.43	14
15	Cook Helpers/Assistants	18,245	19,384	197,605	10.19	15
16	Dishwashers					16
17	Maintenance Workers	1,038	1,221	14,987	12.27	17
18	Housekeepers	24,405	25,806	253,940	9.84	18
19	Laundry	6,630	7,090	67,422	9.51	19
20	Administrator	1,984	2,160	79,338	36.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,135	21,777	280,456	12.88	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 C: Quality Assurance	2,728	2,768	74,662	26.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,865	272,177	$ 4,066,404 *	$ 14.94	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	$ 13,716	1-3	35
36	Medical Director	O	13,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	991	10-3	38
39	Pharmacist Consultant	H	18,473	10-3	39
40	Physical Therapy Consultant	L	57,834	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	33,030	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,563	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 139,107		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	56	$ 9,062	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	126	9,565	10-3	52
53	TOTAL (lines 50 - 52)	182	$ 18,627		53

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JODI JUDE	ADMINISTRATOR	0	$ 78,464
CAROLYN BASSETTE	ADMINISTRATOR	0	874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,338

B. Administrative - Other

Description	Amount
FUTURE VENTURES ASSOCIATES MANAGEMENT FEES	$ 703,500
ELI DRAIMAN	13,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 716,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		170,194
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 170,194

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 379,628
Unemployment Compensation Insurance	188,477
FICA Taxes	302,932
Employee Health Insurance	39,047
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	32,259
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 942,343

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	9,053
Health Care Worker Background Check	7,651
(Indicate # of checks performed 396)	
Patient Background Checks 283	5,467
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	33,420
LICENSES/DUES/SUBSCRIPTIONS	2,317
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(33,420)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,478

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)	$

**See instructions.

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number EMBASSY HEALTH CARE CTR # 0048488 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. **N/A**

(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? **N/A**

(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. $ **674,602**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.