

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER

0049924 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	37,300	3,527	6,896	47,723	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,300	3,527	6,896	47,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.81%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 4/1/08

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 190 and days of care provided 5,208

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

AMBASSADOR NURSING & REHAB CEN]

0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	274,547	200,936	15,000	490,483		490,483	(3,219)	487,264		1
2	Food Purchase										2
3	Housekeeping	172,265	35,817		208,082		208,082		208,082		3
4	Laundry	68,354	10,540		78,894		78,894		78,894		4
5	Heat and Other Utilities			210,918	210,918		210,918		210,918		5
6	Maintenance	63,982	20,905	48,303	133,190		133,190	(1,164)	132,026		6
7	Other (specify):*										7
8	TOTAL General Services	579,148	268,198	274,221	1,121,567		1,121,567	(4,383)	1,117,184		8
	B. Health Care and Programs										
9	Medical Director			40,000	40,000		40,000		40,000		9
10	Nursing and Medical Records	2,551,033	380,990	48,721	2,980,744		2,980,744	15,107	2,995,851		10
10a	Therapy			543,517	543,517		543,517		543,517		10a
11	Activities	95,316	13,668		108,984		108,984		108,984		11
12	Social Services	40,444		2,640	43,084		43,084		43,084		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,686,793	394,658	634,878	3,716,329		3,716,329	15,107	3,731,436		16
	C. General Administration										
17	Administrative	98,965			98,965		98,965		98,965		17
18	Directors Fees										18
19	Professional Services			275,160	275,160		275,160	(262,192)	12,968		19
20	Dues, Fees, Subscriptions & Promotions			2,794	2,794		2,794	226	3,020		20
21	Clerical & General Office Expenses	149,462	68,793	110,286	328,541		328,541	(56,413)	272,128		21
22	Employee Benefits & Payroll Taxes			624,273	624,273		624,273	26,340	650,613		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,100	2,100		2,100	367	2,467		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			118,794	118,794		118,794	7,522	126,316		26
27	Other (specify):*										27
28	TOTAL General Administration	248,427	68,793	1,133,407	1,450,627		1,450,627	(284,150)	1,166,477		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,514,368	731,649	2,042,506	6,288,523		6,288,523	(273,426)	6,015,097		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

AMBASSADOR NURSING & REHAB CENTER

#0049924

Report Period Beginning:

1/1/10

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			66,846	66,846		66,846	155,504	222,350			30
31	Amortization of Pre-Op. & Org.							351,088	351,088			31
32	Interest			53,015	53,015		53,015	420,913	473,928			32
33	Real Estate Taxes							205,841	205,841			33
34	Rent-Facility & Grounds			1,140,000	1,140,000		1,140,000	(1,139,255)	745			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,259,861	1,259,861		1,259,861	(5,909)	1,253,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		317,029		317,029		317,029		317,029			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		317,029	104,025	421,054		421,054		421,054			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,514,368	1,048,678	3,406,392	7,969,438		7,969,438	(279,335)	7,690,103			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,489)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(101,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(75,179)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (195,235)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(84,100)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (84,100)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (279,335)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0049924

Report Period Beginning: 1/1/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VENDING INCOME	\$ (1,230)	6	1
2	MEDICAL RECORDS	(826)	10	2
3	MARKETING WAGES	(21,584)	21	3
4	PROMOTIONS	(31,709)	21	4
5	PENALTIES REFUND	2,120	21	5
6	MISCELLANEOUS INCOME	(21,950)	21	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	(75,179)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER

0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	(67)	(3,152)	0	0	0	0	0	0	0	0	0	(3,219)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,230)	66	0	0	0	0	0	0	0	0	0	(1,164)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,297)	(3,086)	0	0	0	0	0	0	0	0	0	(4,383)	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	(826)	15,933	0	0	0	0	0	0	0	0	0	15,107	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	(826)	15,933	0	0	0	0	0	0	0	0	0	15,107	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(263,514)	1,322	0	0	0	0	0	0	0	0	(262,192)	19
20	Fees, Subscriptions & Promotions	0	226	0	0	0	0	0	0	0	0	0	226	20
21	Clerical & General Office Expenses	(174,623)	117,717	493	0	0	0	0	0	0	0	0	(56,413)	21
22	Employee Benefits & Payroll Taxes	0	26,340	0	0	0	0	0	0	0	0	0	26,340	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	367	0	0	0	0	0	0	0	0	0	367	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	456	7,066	0	0	0	0	0	0	0	0	7,522	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(174,623)	(118,408)	8,881	0	(284,150)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(176,746)	(105,561)	8,881	0	(273,426)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER

0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(18,489)	0	173,993	0	0	0	0	0	0	0	0	155,504	30
31	Amortization of Pre-Op. & Org.	0	0	351,088	0	0	0	0	0	0	0	0	351,088	31
32	Interest	0	0	420,913	0	0	0	0	0	0	0	0	420,913	32
33	Real Estate Taxes	0	0	205,841	0	0	0	0	0	0	0	0	205,841	33
34	Rent-Facility & Grounds	0	(1,139,255)	0	0	0	0	0	0	0	0	0	(1,139,255)	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	(18,489)	(1,139,255)	1,151,835	0	(5,909)	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)	(195,235)	(1,244,816)	1,160,716	0	(279,335)	45							

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
SEE ATTACHMENT #1						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	19 PROFESSIONAL FEES	\$ 264,000	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS	46.25%	\$ 486	\$	(263,514)	1
2	V	10 NURSING & MED REC	25,200	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		41,133		15,933	2
3	V	21 ADMIN WAGES		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		116,006		116,006	3
4	V	21 OTHER ADMIN EXP	6,691	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		8,402		1,711	4
5	V	22 FRINGE BENEFITS	3,315	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		29,655		26,340	5
6	V	24 TRAVEL	372	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		739		367	6
7	V	1 DIETARY	15,000	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		11,848		(3,152)	7
8	V	26 LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		456		456	8
9	V	34 RENT		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		745		745	9
10	V	20 CLASSIFIED ADS		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		226		226	10
11	V	6 GROUNDS MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		66		66	11
12	V								12
13	V	34 RENT	1,140,000	AMBASSADOR NURSING REALTY, LLC				(1,140,000)	13
14	Total		\$ 1,454,578			\$ 209,762	\$ *	(1,244,816)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32	INTEREST EXPENSE	\$	AMBASSADOR REALTY, LLC		\$ 420,913	\$	420,913	15
16	V	30	DEPRECIATION		AMBASSADOR REALTY, LLC		173,993		173,993	16
17	V	31	AMORTIZATION		AMBASSADOR REALTY, LLC		351,088		351,088	17
18	V	26	LIABILITY INSURANCE		AMBASSADOR REALTY, LLC		7,066		7,066	18
19	V	21	OTHER ADMIN EXP		AMBASSADOR REALTY, LLC		493		493	19
20	V	19	LEGAL FEES		AMBASSADOR REALTY, LLC		1,322		1,322	20
21	V	33	REAL ESTATE TAXES		AMBASSADOR REALTY, LLC		205,841		205,841	21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 1,160,716	\$ *	1,160,716	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

<u>OWNERS</u>		<u>OTHER RELATED BUSINESS ENTITIES</u>		
NAME	OWNERSHIP %	NAME	CITY	TYPE OF BUSINESS
MICHAEL BLISKO	37.500%	INFINITY HEALTHCARE MANAGEMENT	Hillside, IL	MANAGEMENT CO.
MOISHE GUBIN	37.500%			
A&F GENERAL REALTY	5.000%			
B&N REALTY INVESTMENT	<u>20.000%</u>			
	<u><u>100.000%</u></u>			

NOTE: INFINITY HEALTHCARE MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1								\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER

0049924

Report Period Beginning:

1/1/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	FIRST BANK		X	MORTGAGE	INTEREST ON	4/1/08	\$ 8,020,000	\$ 8,020,000	4/1/2033	3+LIBOR	\$ 248,638	1								
2	MEISELS LIMITED PARTNERSHIP	X		MORTGAGE	\$14,590.00	4/1/08	1,945,447	1,770,000	4/1/12	9.0000	172,276	2								
3												3								
4												4								
5												5								
Working Capital																				
6	FIRST BANK		X	WORKING CAPITAL	NONE	4/1/08	750,000	750,000		PRIME	53,014	6								
7												7								
8												8								
9	TOTAL Facility Related				\$14,590.00		\$ 10,715,447	\$ 10,540,000			\$ 473,928	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 10,715,447	\$ 10,540,000			\$ 473,928	15								

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	176,347	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.)		\$	205,836	2
3. Under or (over) accrual (line 2 minus line 1).		\$	29,489	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	176,352	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.		\$	205,841	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	212,421	8
	2006	199,523	9
	2007	190,000	10
	2008	176,347	11
	2009	205,841	12

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBASSADOR NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-418-033-0000</u>	<u>NURSING HOME</u>	\$ <u>4,808.24</u>	\$ <u>4,808.24</u>
2. <u>13-11-418-028-0000</u>	<u>NURSING HOME</u>	\$ <u>32,739.87</u>	\$ <u>32,739.87</u>
3. <u>13-11-418-026-0000</u>	<u>NURSING HOME</u>	\$ <u>84,105.95</u>	\$ <u>84,105.95</u>
4. <u>13-11-418-022-0000</u>	<u>NURSING HOME</u>	\$ <u>66,195.62</u>	\$ <u>66,195.62</u>
5. <u>13-11-418-021-0000</u>	<u>NURSING HOME</u>	\$ <u>17,986.58</u>	\$ <u>17,986.58</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>205,836.26</u></u>	\$ <u><u>205,836.26</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 **AMBASSADOR NURSING & REHAB CENTER**

0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,497 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 3

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

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

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

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

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

NONE

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

1. Total Amount Incurred: 100,881 2. Number of Years Over Which it is Being Amortized: 20 YEARS

3. Current Period Amortization: 6,725 4. Dates Incurred: 4/1/08 - 12/31/09

Nature of Costs: ORGINIZATIONAL COSTS

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>2008</u>	<u>\$ 300,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>			<u>\$ 300,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER# 0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190		2008		\$ 4,000,000	\$ 102,564	39	\$ 102,564	\$	\$ 282,051	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARINGS		2008		1,148	29	39	29		63	9
10	PATIO		2008		950	24	39	24		58	10
11	PATIO		2008		63	2	39	2		5	11
12	PUMP		2008		796	20	39	20		43	12
13	PATIO		2008		650	17	39	17		41	13
14	DIGITAL TV SYSTEM		2008		15,000	385	39	385		898	14
15											15
16	CURTAINS AND LIGHTS		2009		1,165	30	39	30		65	16
17	DOORS		2009		1,210	31	39	31		65	17
18	WARDROBES		2009		8,125	208	39	208		347	18
19	BEDSPREADS, CURTAINS, WARDROBES		2009		16,147	414	39	414		449	19
20	PHONE WIRING		2009		3,000	77	39	77		96	20
21	PHONE CONTROL CABINET		2009		2,200	56	39	56		70	21
22	COMPUTER WIRING		2009		680	17	39	17		21	22
23	PAINT		2009		504	13	39	13		25	23
24	PAINT		2009		594	15	39	15		19	24
25	REFRIGERATOR		2009		2,331	60	39	60		75	25
26											26
27	CUBICLE CURTAINS		2010		4,526	116	39	106	(10)	106	27
28	WHEELCHAIR RAMP		2010		20,975	538	39	314	(224)	314	28
29	MASONRY		2010		11,175	287	39	143	(144)	143	29
30	DOORS		2010		1,498	38	39	19	(19)	19	30
31	DOORS		2010		1,162	30	39	7	(23)	7	31
32	BOILER		2010		7,879	202	39	34	(168)	34	32
33	FREEZER REPAIR		2010		1,400	36	39	18	(18)	18	33
34	CIRCUIT BREAKER REPAIR		2010		850	22	39	11	(11)	11	34
35	PATIO RAILINGS		2010		2,980	76	39	32	(44)	32	35
36	RAILINGS		2010		2,100	54	39	22	(32)	22	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 REPLACE PAVEMENT	2010	\$ 27,735	\$ 711	39	\$ 178	\$ (533)	\$ 178	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,136,843	\$ 106,072		\$ 104,846	\$ (1,226)	\$ 285,275	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	\$ 553,585	\$ 127,981	\$ 110,718	\$ (17,263)	5	\$ 294,276	71
72	Current Year Purchases	61,089	6,786	6,786		5	6,786	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 614,674	\$ 134,767	\$ 117,504	\$ (17,263)		\$ 301,062	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,051,517	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 240,839	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,350	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,489)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 586,337	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER

0049924

Report Period Beginning: 1/1/10

Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

**

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 220,016	\$		\$ 220,016	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			92,806			92,806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			230,695			230,695	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				306,446		306,446	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): LAB & X-RAY	39-2					10,583		10,583	13
14	TOTAL			\$		\$ 543,517	\$ 317,029		\$ 860,546	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **AMBASSADOR NURSING & REHAB CENTER**

0049924

Report Period Beginning: **1/1/10**

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/10**

(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	\$ 114,820	\$ 475,779	1
2	Cash-Patient Deposits	(1,834)	(1,834)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,268,070	3,004,164	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,848	86,848	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)	\$ 2,467,904	\$ 3,564,957	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	136,843	136,843	15
16	Equipment, at Historical Cost	114,674	614,674	16
17	Accumulated Depreciation (book methods)	(114,320)	(592,800)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,266,329	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(965,492)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Security deposit		22,500	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 137,197	\$ 8,782,054	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,605,101	\$ 12,347,011	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,411,515	\$ 1,411,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	428,288	428,288	30
31	Accrued Taxes Payable (excluding real estate taxes)		149,371	31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 1,839,803	\$ 1,989,174	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	750,000	750,000	39
40	Mortgage Payable		9,790,000	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)	\$ 750,000	\$ 10,540,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,589,803	\$ 12,529,174	46
47	TOTAL EQUITY(page 18, line 24)	\$ 15,298	\$ (182,163)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,605,101	\$ 12,347,011	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 44,413	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 44,413	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	454,884	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	(483,999)	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)	\$ (29,115)	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)	\$ 15,298	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,827,319	1
2	Discounts and Allowances for all Levels	(826,738)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,000,581	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,089,490	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,089,490	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	282,539	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,048	19
20	Radiology and X-Ray	3,182	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 301,769	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,208	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,208	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	1,230	28
28a	MISCELLANEOUS	29,044	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,274	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,424,322	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,121,568	31
32	Health Care	3,716,329	32
33	General Administration	1,450,627	33
B. Capital Expense			
34	Ownership	1,259,861	34
C. Ancillary Expense			
35	Special Cost Centers	317,029	35
36	Provider Participation Fee	104,024	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,969,438	40
41	Income before Income Taxes (line 30 minus line 40)**	454,884	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 454,884	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **AMBASSADOR NURSING & REHAB CENTER**

0049924

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,046	2,166	\$ 90,250	\$ 41.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,941	28,810	868,997	30.16	3
4	Licensed Practical Nurses	27,950	29,311	704,697	24.04	4
5	CNAs & Orderlies	68,302	74,874	861,248	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,936	8,703	95,316	10.95	9
10	Activity Assistants					10
11	Social Service Workers	1,901	2,176	40,444	18.59	11
12	Dietician	18,872	21,746	274,547	12.63	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,722	3,950	63,982	16.20	17
18	Housekeepers	14,919	16,792	172,265	10.26	18
19	Laundry	6,872	7,573	68,354	9.03	19
20	Administrator	2,101	2,317	98,965	42.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,358	10,848	149,462	13.78	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	2,104	2,192	25,841	11.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,024	211,458	\$ 3,514,368 *	\$ 16.62	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	429	\$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	605	30,328	10-3	38
39	Pharmacist Consultant	370	18,483	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	2,640	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,479	\$ 66,451		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
PATRICIA CORREA	ADMIN	0%	\$ 98,965	Workers' Compensation Insurance	\$ 86,694	IDPH License Fee	\$		
				Unemployment Compensation Insurance	49,140	Advertising: Employee Recruitment			
				FICA Taxes	267,015	Health Care Worker Background Check			
				Employee Health Insurance	153,009	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		LICENSES & FEES	3,020		
				PENSION	30,710				
				PHYSICALS	64,045				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 98,965	TOTAL (agree to Schedule V, line 22, col.8)		\$ 650,613			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							MILEAGE	2,019	
							Seminar Expense	448	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Entertainment Expense	()	
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
C. Professional Services							TOTAL		\$ 2,467
Vendor/Payee	Type	Amount							
INFINITY	MGMT CO	\$ 264,000							
BRADLEY & ASSOCIATES	ACCOUNTING	8,410							
JOHNSON, GOLDBERG	ACCOUNTING	2,750							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 275,160						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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? 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? N/A
- (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? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,959 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 104,025
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. \$ N/A
- (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. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0%
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - 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: N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT