

		FOR BHF USE					

LL1

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0049924</u></p> <p><b>Facility Name:</b> <u>Ambassador Nsg &amp; Rehab Ctr</u></p> <p><b>Address:</b> <u>4900 N Bernard</u> <u>Chicago</u> <u>60625</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>773-583-7130</u> <b>Fax #</b> <u>773-583-3929</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/01/2008</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Alan Sorscher</u> <b>Telephone Number:</b> <u>(708)-449-1900</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Alan Sorscher</u>            (Title) <u>CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) _____ Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Sorscher</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Sorscher</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ( ) _____							

Facility Name & ID Number Ambassador Nsg & Rehab Ctr

# 0049924 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 N/A

	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	69,540	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	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	46,181	1,136	4,592	51,909	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,181	1,136	4,592	51,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.65%

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 04/01/2008

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 4,592

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

Ambassador Nsg &amp; Rehab Ctr

# 0049924

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 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
	<b>A. General Services</b>										
1	Dietary	295,454	22,181	15,000	332,635		332,635	(4,676)	327,959		1
2	Food Purchase		222,146		222,146		222,146		222,146		2
3	Housekeeping	185,193	34,449		219,642		219,642		219,642		3
4	Laundry	61,468	13,164		74,632		74,632		74,632		4
5	Heat and Other Utilities			217,520	217,520		217,520	684	218,204		5
6	Maintenance	71,667	31,593	48,596	151,856		151,856	603	152,459		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	613,782	323,533	281,116	1,218,431		1,218,431	(3,389)	1,215,042		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,883,969	476,177	32,025	3,392,171		3,392,171	16,988	3,409,159		10
10a	Therapy			482,042	482,042		482,042		482,042		10a
11	Activities	111,523			111,523		111,523		111,523		11
12	Social Services	46,709		2,773	49,482		49,482		49,482		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			12,870	12,870		12,870		12,870		15
16	<b>TOTAL Health Care and Programs</b>	3,042,201	476,177	553,710	4,072,088		4,072,088	16,988	4,089,076		16
	<b>C. General Administration</b>										
17	Administrative	101,944			101,944		101,944		101,944		17
18	Directors Fees										18
19	Professional Services			312,093	312,093		312,093	(258,981)	53,112		19
20	Dues, Fees, Subscriptions & Promotions			13,946	13,946		13,946		13,946		20
21	Clerical & General Office Expenses	252,093	64,329	27,762	344,184		344,184	75,138	419,322		21
22	Employee Benefits & Payroll Taxes			571,108	571,108		571,108	76,050	647,158		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,487	18,487		18,487	280	18,767		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			188,893	188,893		188,893	131,018	319,911		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	354,037	64,329	1,132,289	1,550,655		1,550,655	23,505	1,574,160		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,010,020	864,039	1,967,115	6,841,174		6,841,174	37,104	6,878,278		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 &amp; ID Number

Ambassador Nsg &amp; Rehab Ctr

#0049924

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

## 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	
	<b>D. Ownership</b>											
30	Depreciation			40,634	40,634		40,634	98,872	139,506			30
31	Amortization of Pre-Op. & Org.							351,088	351,088			31
32	Interest			149,769	149,769		149,769	347,558	497,327			32
33	Real Estate Taxes							243,338	243,338			33
34	Rent-Facility & Grounds			1,140,000	1,140,000		1,140,000	(1,132,835)	7,165			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,330,403	1,330,403		1,330,403	(91,979)	1,238,424			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation		15,140		15,140		15,140		15,140			38
39	Ancillary Service Centers		202,332		202,332		202,332		202,332			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			615,779	615,779		615,779		615,779			42
43	Other (specify):* <b>Bad Debt</b>			640,000	640,000		640,000	(640,000)				43
44	<b>TOTAL Special Cost Centers</b>		217,472	1,255,779	1,473,251		1,473,251	(640,000)	833,251			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,010,020	1,081,511	4,553,297	9,644,828		9,644,828	(694,875)	8,949,953			45

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(75,300)	30		9
10	Interest and Other Investment Income	(423)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	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	(4,333)	21		18
19	Entertainment				19
20	Contributions	(300)	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	(640,000)	43		24
25	Fund Raising, Advertising and Promotional	(23,439)	21		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	(9,284)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (753,122)		\$	30

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)	58,247	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 58,247		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (694,875)		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		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Ambassador Nsg & Rehab Ctr

ID# 0049924

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Misc Income	\$ (9,284)	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	<b>Total</b>		(9,284)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nsg & Rehab Ctr# 0049924

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)	
	<b>A. General Services</b>													
1	Dietary	(43)	(4,633)	0	0	0	0	0	0	0	0	0	(4,676)	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	684	0	0	0	0	0	0	0	0	0	684	5
6	Maintenance	0	603	0	0	0	0	0	0	0	0	0	603	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(43)</b>	<b>(3,346)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,389)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	16,988	0	0	0	0	0	0	0	0	0	16,988	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>16,988</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16,988</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(274,863)	15,882	0	0	0	0	0	0	0	0	(258,981)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(37,356)	77,211	35,283	0	0	0	0	0	0	0	0	75,138	21
22	Employee Benefits & Payroll Taxes	0	76,050	0	0	0	0	0	0	0	0	0	76,050	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	280	0	0	0	0	0	0	0	0	0	280	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	464	130,554	0	0	0	0	0	0	0	0	131,018	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(37,356)</b>	<b>(120,858)</b>	<b>181,719</b>	<b>0</b>	<b>23,505</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(37,399)</b>	<b>(107,216)</b>	<b>181,719</b>	<b>0</b>	<b>37,104</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ambassador Nsg & Rehab Ctr# 0049924

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	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)	
	<b>D. Ownership</b>													
30	Depreciation	(75,300)	176	173,996	0	0	0	0	0	0	0	0	98,872	30
31	Amortization of Pre-Op. & Org.	0	0	351,088	0	0	0	0	0	0	0	0	351,088	31
32	Interest	(423)	0	347,981	0	0	0	0	0	0	0	0	347,558	32
33	Real Estate Taxes	0	0	243,338	0	0	0	0	0	0	0	0	243,338	33
34	Rent-Facility & Grounds	0	7,165	(1,140,000)	0	0	0	0	0	0	0	0	(1,132,835)	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	<b>TOTAL Ownership</b>	<b>(75,723)</b>	<b>7,341</b>	<b>(23,597)</b>	<b>0</b>	<b>(91,979)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(640,000)	0	0	0	0	0	0	0	0	0	0	(640,000)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(640,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(640,000)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(753,122)	(99,875)	158,122	0	0	0	0	0	0	0	0	(694,875)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL BLISKO	37.5			Infinity Healthcare	Hillside	Management Co.
MOISHE GUBIN	37.5					
A & F REALTY	5.0					
B & N INVESTMENTS	20.0					

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	1 Dietary	\$ 15,329	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		\$ 10,696	\$ (4,633)	1
2	V	6 Maintenance		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		3,098	3,098	2
3	V	10 Nursing	25,200	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		42,188	16,988	3
4	V	21 Office Wages		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		90,849	90,849	4
5	V	5 Utilities		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		684	684	5
6	V	6 Maintenance	3,713	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		1,218	(2,495)	6
7	V	19 Professional Fees	276,000	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		1,137	(274,863)	7
8	V	21 Office Expense	18,845	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		5,207	(13,638)	8
9	V	22 Employee Benefits	4,164	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		80,214	76,050	9
10	V	24 Travel		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		280	280	10
11	V	26 insurance		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		464	464	11
12	V	30 Depreciation		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		176	176	12
13	V	34 Rent		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		7,165	7,165	13
14	Total		\$ 343,251			\$ 243,376	\$ * (99,875)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent	\$ 1,140,000	Ambassador Realty, LLC		\$	\$ (1,140,000)
16	V	21 Office Expense		Ambassador Realty, LLC		35,283	35,283
17	V	30 Depreciation		Ambassador Realty, LLC		173,996	173,996
18	V	31 Amortization		Ambassador Realty, LLC		351,088	351,088
19	V	26 Insurance		Ambassador Realty, LLC		130,554	130,554
20	V	32 Interest	789	Ambassador Realty, LLC		348,770	347,981
21	V	19 Professional Fees		Ambassador Realty, LLC		15,882	15,882
22	V	33 Property Taxes		Ambassador Realty, LLC		243,338	243,338
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,140,789			\$ 1,298,911	\$ * 158,122

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

Facility Name & ID Number

Ambassador Nsg & Rehab Ctr

# 0049924

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								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

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr

# 0049924

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	HUD		x	Mortgage	\$55,697.00	9/28/12	\$ 10,160,000	\$ 9,866,070	9/27/37	2.5400	\$ 124,385	1						
2	Meisels Limited Partnership		x	Mortgage	\$14,590.00	4/1/08	1,945,447		4/1/12	9.0000	43,804	2						
3	First Bank		x	Mortgage	Interest Only	4/1/08	8,020,000		4/1/33	3+LIBOR	180,582	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	First Merit Bank			Working Capital	none	06/30/11	1,050,500		06/30/12	5.5000	132,295	6						
7	Capital One			Working Capital	none	08/31/12	5,000,000	1,601,248	08/31/15	2.9590	17,474	7						
8												8						
9	<b>TOTAL Facility Related</b>				<b>\$70,287.00</b>		<b>\$ 26,175,947</b>	<b>\$ 11,467,318</b>			<b>\$ 498,540</b>	<b>9</b>						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 26,175,947</b>	<b>\$ 11,467,318</b>			<b>\$ 498,540</b>	<b>15</b>						

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.)

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2011 report.		\$	<u>176,357</u>		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.)		\$	<u>188,497</u>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>12,140</u>		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>231,198</u>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>243,338</u>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	<u>199,000</u>	8	<b>FOR BHF USE ONLY</b>		
	2008	<u>176,347</u>	9			
	2009	<u>205,841</u>	10			
	2010	<u>189,254</u>	11			
	2011	<u>188,497</u>	12			
				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 Ambassador Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE (708)-449-1900 FAX #: ( )

**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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-11-418-033-0000</u>	<u>Nursing Home</u>	\$ <u>4,968.96</u>	\$ <u>4,968.96</u>
2. <u>13-11-418-028-0000</u>	<u>Nursing Home</u>	\$ <u>29,957.66</u>	\$ <u>29,957.66</u>
3. <u>13-11-418-026-0000</u>	<u>Nursing Home</u>	\$ <u>76,760.36</u>	\$ <u>76,760.36</u>
4. <u>13-11-418-022-0000</u>	<u>Nursing Home</u>	\$ <u>60,405.18</u>	\$ <u>60,405.18</u>
5. <u>13-11-418-021-0000</u>	<u>Nursing Home</u>	\$ <u>16,404.77</u>	\$ <u>16,404.77</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>188,496.93</u></u>	\$ <u><u>188,496.93</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

**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: 183,166 2. Number of Years Over Which it is Being Amortized: 20 Years  
 3. Current Period Amortization: 6,732 4. Dates Incurred: 4/1/08-12/31/10

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190	2008		\$ 4,000,000	\$ 102,564	39	\$ 102,564	\$	\$ 487,179	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	BEARINGS		2008	1,148	29	39	29		147	9
10	PATIO		2008	950	24	39	24		122	10
11	PATIO		2008	63	2	39	2		8	11
12	PUMP		2008	796	20	39	20		102	12
13	PATIO		2008	650	17	39	17		83	13
14	DIGITAL TV SYSTEM		2008	15,000	385	39	385		1,923	14
15						39				15
16	CURTAINS AND LIGHTS		2009	1,165	30	39	30		119	16
17	DOORS		2009	1,210	31	39	31		124	17
18	WARDROBES		2009	8,125	208	39	208		833	18
19	BEDSPREADS, CURTAINS, WARDROBES		2009	16,147	414	39	414		1,656	19
20	PHONE WIRING		2009	3,000	77	39	77		308	20
21	PHONE CONTROL CABINET		2009	2,200	56	39	56		226	21
22	COMPUTER WIRING		2009	680	17	39	17		70	22
23	PAINT		2009	504	13	39	13		52	23
24	PAINT		2009	594	15	39	15		61	24
25	REFRIGERATOR		2009	2,331	60	39	60		239	25
26						39				26
27	CUBICLE CURTAINS		2010	4,526	116	39	116		348	27
28	WHEELCHAIR RAMP		2010	20,975	538	39	538		1,613	28
29	MASONRY		2010	11,175	287	39	287		860	29
30	DOORS		2010	1,498	38	39	38		115	30
31	DOORS		2010	1,162	30	39	30		89	31
32	BOILER		2010	7,879	202	39	202		606	32
33	FREEZER REPAIR		2010	1,400	36	39	36		108	33
34	CIRCUIT BREAKER REPAIR		2010	850	22	39	22		65	34
35	PATIO RAILINGS		2010	2,980	76	39	76		229	35
36			2010	2,100	54	39	54		162	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	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	\$ 711	\$	\$ 2,015	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	60		119	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	481		961	40
41	Clean Chiller Barrells, Filter, Heat Exhanger	2011	5,871	151	39	151		301	41
42	Lighting	2011	15,156	389	39	389		777	42
43	Waterproofing North Patio	2011	3,402	87	39	87		174	43
44	Waterproofing North Patio	2011	3,402	87	39	87		174	44
45	Custom Cabinets	2011	1,628	42	39	42		83	45
46	Cement	2011	4,100	105	39	105		210	46
47									47
48	Cooling Tower	2012	5,068	130	39	43	(87)	130	48
49	New Boiler Burners	2012	5,170	133	39	22	(111)	133	49
50	Patch Basement Hallway Floors/Tiles	2012	2,450	63	39	42	(21)	63	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)		\$ 4,204,161	\$ 107,799		\$ 107,581	\$ (218)	\$ 502,590	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 671,771	\$ 73,680	\$ 28,397	\$ (45,283)	5	\$ 511,271	71
72	Current Year Purchases	33,151	33,151	3,528	(29,623)	5	33,151	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 704,922	\$ 106,831	\$ 31,925	\$ (74,906)		\$ 544,422	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				\$	\$	\$	\$		\$	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)	\$ 5,209,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 214,630	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,506	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (75,124)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,047,012	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2013                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	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 Ambassador Nsg & Rehab Ctr # 0049924 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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8	
			Staff		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	10a-3	hrs	\$		\$	180,025	\$			\$	180,025	1
2	Licensed Speech and Language Development Therapist		hrs				96,028					96,028	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist		hrs				205,989					205,989	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy		# of prescripts						195,073			195,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):								7,259			7,259	12
13	Other (specify): <u>Lab &amp; xray</u>												13
14	<b>TOTAL</b>			\$		\$	482,042	\$	202,332		\$	684,374	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 Ambassador Nsg & Rehab Ctr# 0049924Report 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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 126,373	\$ 127,962	1
2	Cash-Patient Deposits	(18,439)	(18,439)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,750,607	2,750,607	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	(31,937)	(31,937)	6
7	Other Prepaid Expenses		2,098	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,826,604	\$ 2,830,291	10
	<b>B. Long-Term Assets</b>			
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	204,161	204,161	15
16	Equipment, at Historical Cost	206,270	706,270	16
17	Accumulated Depreciation (book methods)	(220,556)	(1,047,012)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,348,613	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,667,684)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Financing Reserves/Escrows</u>		327,575	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 189,875	\$ 8,171,923	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,016,479	\$ 11,002,214	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 744,330	\$ 893,700	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,111,836	1,111,836	30
31	Accrued Taxes Payable (excluding real estate taxes)			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
	<b>Other Current Liabilities(specify):</b>			
36	<u>working capital note</u>	1,601,248	1,601,248	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,457,414	\$ 3,606,784	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,866,070	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,866,070	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,457,414	\$ 13,472,854	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (440,935)	\$ (2,470,640)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,016,479	\$ 11,002,214	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>153,755</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>153,755</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(94,690)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(500,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(594,690)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(440,935)</b>	<b>24</b> *

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr# 0049924Report Period Beginning: 01/01/2012Ending: 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.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,393,853	1
2	Discounts and Allowances for all Levels	(137,592)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,256,261</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,256	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 146,256</b>	8
<b>C. Other Operating Revenue</b>			
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	124,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,614	19
20	Radiology and X-Ray	2,639	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 137,914</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	423	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 423</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous Income</u>	9,284	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 9,284</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 9,550,138</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,218,431	31
32	Health Care	4,072,088	32
33	General Administration	1,550,655	33
<b>B. Capital Expense</b>			
34	Ownership	1,330,403	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	217,472	35
36	Provider Participation Fee	615,779	36
<b>D. Other Expenses (specify):</b>			
37	<u>Bad Debt</u>	640,000	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 9,644,828</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(94,690)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (94,690)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,931,413	44
45	Private Pay - Net Inpatient Revenue	99,279	45
46	Medicare - Net Inpatient Revenue	2,225,569	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 9,256,261</b>	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 **Ambassador Nsg & Rehab Ctr**

# **0049924**

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,824	2,130	\$ 93,807	\$ 44.04	1
2	Assistant Director of Nursing	1,448	1,773	56,455	31.84	2
3	Registered Nurses	28,211	30,263	939,287	31.04	3
4	Licensed Practical Nurses	26,706	28,880	703,297	24.35	4
5	CNAs & Orderlies	74,004	82,197	983,063	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,476	5,225	78,160	14.96	8
9	Activity Director	8,674	9,580	111,523	11.64	9
10	Activity Assistants					10
11	Social Service Workers	1,968	2,267	46,709	20.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,056	22,482	295,454	13.14	15
16	Dishwashers					16
17	Maintenance Workers	3,737	4,145	71,667	17.29	17
18	Housekeepers	15,648	17,091	185,193	10.84	18
19	Laundry	5,646	6,253	61,468	9.83	19
20	Administrator	2,000	2,281	101,944	44.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,099	13,319	252,093	18.93	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	2,016	2,420	29,900	12.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,513	230,306	\$ 4,010,020 *	\$ 17.41	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	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant	640	32,025	10-3	38
39	Pharmacist Consultant	257	12,870	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	80	2,773	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	977	\$ 47,668		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Joseph Javier	Admin		\$ 30,998	Workers' Compensation Insurance	\$ 74,972	IDPH License Fee	\$		
Konstant Stavropoulos	Admin		16,894	Unemployment Compensation Insurance	61,233	Advertising: Employee Recruitment			
Juivenal Gonzalez	Admin		54,052	FICA Taxes	301,078	Health Care Worker Background Check			
				Employee Health Insurance	133,455	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees		13,946	
				Pension Expense	27,104				
				employee expenses	49,316				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,944						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Bradley & Associates	Accounting		\$ 6,702			\$	Out-of-State Travel	\$	
Johnson, Goldberg & Brown	Accounting		2,500						
Law offices of Evelyn Hoffman	Legal		1,851						
Universal International Health	Legal		10,000				In-State Travel		
Life Saftey Resources	Maint		5,089				Auto Allowance	11,597	
Michael Feldman	Professional		500				Mileage	4,574	
Infinity Healthcare	Professional		276,000				Travel & Ent.	149	
Capital One	Legal		9,451				Seminar Expense		
							Seminar expense	2,447	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 312,093	TOTAL		\$	Entertainment Expense	(	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$	18,767

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr# 0049924Report 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? yes  
If YES, give association name and amount. Illinois Council on Long Term Care 9510
- (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. \$ 42,208 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.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 603,154  
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? yes  
Attach invoices and a summary of services for all architect and appraisal fees.