

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	69,350	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	45,763	830	7,791	54,384	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,763	830	7,791	54,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.42%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 4/8/08

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 2,407

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Ambassador Nsg & Reha Center # 0049924 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	354,464	21,001	12,672	388,137		388,137	(801)	387,336		1
2	Food Purchase		299,293		299,293		299,293	1,496	300,789		2
3	Housekeeping	221,740	39,710		261,450		261,450	452	261,902		3
4	Laundry	67,925	18,632		86,557		86,557		86,557		4
5	Heat and Other Utilities			220,233	220,233		220,233	611	220,844		5
6	Maintenance	57,143	32,932	75,973	166,048		166,048	514	166,562		6
7	Other (specify):*										7
8	TOTAL General Services	701,272	411,568	308,878	1,421,718		1,421,718	2,272	1,423,990		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,528,893	251,994	55,668	3,836,555		3,836,555	(4,960)	3,831,595		10
10a	Therapy			690,650	690,650		690,650		690,650		10a
11	Activities	125,868	20,421		146,289		146,289		146,289		11
12	Social Services	119,314		6,927	126,241		126,241		126,241		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			16,074	16,074		16,074	(351)	15,723		15
16	TOTAL Health Care and Programs	3,774,075	272,415	799,319	4,845,809		4,845,809	(5,311)	4,840,498		16
	C. General Administration										
17	Administrative	135,338			135,338		135,338	(46,218)	89,120		17
18	Directors Fees										18
19	Professional Services			478,648	478,648		478,648	(199,185)	279,463		19
20	Dues, Fees, Subscriptions & Promotions			13,842	13,842		13,842	162	14,004		20
21	Clerical & General Office Expenses	275,009	74,704	141,141	490,854		490,854	99,425	590,279		21
22	Employee Benefits & Payroll Taxes			896,999	896,999		896,999	35,865	932,864		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,467	3,467		3,467	4,383	7,850		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			326,578	326,578		326,578	56,102	382,680		26
27	Other (specify):*										27
28	TOTAL General Administration	410,347	74,704	1,860,675	2,345,726		2,345,726	(49,466)	2,296,260		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,885,694	758,687	2,968,872	8,613,253		8,613,253	(52,505)	8,560,748		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			74,812	74,812		74,812	204,139	278,951		30
31	Amortization of Pre-Op. & Org.							384,943	384,943		31
32	Interest			7,064	7,064		7,064	181,157	188,221		32
33	Real Estate Taxes			280,160	280,160		280,160		280,160		33
34	Rent-Facility & Grounds			803,748	803,748		803,748	(797,931)	5,817		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Replacement Tax			5,988	5,988		5,988		5,988		36
37	TOTAL Ownership			1,171,772	1,171,772		1,171,772	(27,692)	1,144,080		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			24,722	24,722		24,722		24,722		38
39	Ancillary Service Centers		149,789		149,789		149,789	(2,954)	146,835		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			414,838	414,838		414,838		414,838		42
43	Other (specify):* Bad Debt Expense			327,454	327,454		327,454	(327,454)			43
44	TOTAL Special Cost Centers		149,789	767,014	916,803		916,803	(330,408)	586,395		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,885,694	908,476	4,907,658	10,701,828		10,701,828	(410,605)	10,291,223		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	17,326	30		9
10	Interest and Other Investment Income	(34,508)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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	(25,540)	21		18
19	Entertainment				19
20	Contributions	(7,142)	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	(327,454)	43		24
25	Fund Raising, Advertising and Promotional	(15,267)	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	(4,844)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (397,450)		\$	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)	(13,155)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (13,155)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (410,605)		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

BHF USE ONLY							
48		49		50		51	

Ambassador Nsg & Reha Center

ID# 0049924

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical records income	\$ (673)	10	1
2	Lobbying	(629)	20	2
3	RP Profit	(163)	10	3
4	RP Profit	(351)	15	4
5	RP Profit	(2,954)	39	5
6	Interest income	(73)	32	6
7	Misc income	(1)	21	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
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26				26
27				27
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30				30
31				31
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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	(4,844)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	(21)	(780)	0	0	0	0	0	0	0	0	0	(801)	1
2	Food Purchase	0	1,496	0	0	0	0	0	0	0	0	0	1,496	2
3	Housekeeping	0	452	0	0	0	0	0	0	0	0	0	452	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	611	0	0	0	0	0	0	0	0	0	611	5
6	Maintenance	0	514	0	0	0	0	0	0	0	0	0	514	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21)	2,293	0	0	0	0	0	0	0	0	0	2,272	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	(836)	(4,124)	0	0	0	0	0	0	0	0	0	(4,960)	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):*	(351)	0	0	0	0	0	0	0	0	0	0	(351)	15
16	TOTAL Health Care and Programs	(1,187)	(4,124)	0	0	0	0	0	0	0	0	0	(5,311)	16
	C. General Administration													
17	Administrative	0	0	(46,218)	0	0	0	0	0	0	0	0	(46,218)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(202,885)	3,700	0	0	0	0	0	0	0	0	(199,185)	19
20	Fees, Subscriptions & Promotions	(629)	791	0	0	0	0	0	0	0	0	0	162	20
21	Clerical & General Office Expenses	(47,950)	147,068	307	0	0	0	0	0	0	0	0	99,425	21
22	Employee Benefits & Payroll Taxes	0	35,865	0	0	0	0	0	0	0	0	0	35,865	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,383	0	0	0	0	0	0	0	0	0	4,383	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	736	55,366	0	0	0	0	0	0	0	0	56,102	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(48,579)	(14,042)	13,155	0	(49,466)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,787)	(15,873)	13,155	0	(52,505)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	17,326	162	186,651	0	0	0	0	0	0	0	0	204,139	30
31	Amortization of Pre-Op. & Org.	0	0	384,943	0	0	0	0	0	0	0	0	384,943	31
32	Interest	(34,581)	0	215,738	0	0	0	0	0	0	0	0	181,157	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(797,931)	0	0	0	0	0	0	0	0	(797,931)	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	(17,255)	162	(10,599)	0	(27,692)	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	(2,954)	0	0	0	0	0	0	0	0	0	0	(2,954)	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):*	(327,454)	0	0	0	0	0	0	0	0	0	0	(327,454)	43
44	TOTAL Special Cost Centers	(330,408)	0	0	0	0	0	0	0	0	0	0	(330,408)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(397,450)	(15,711)	2,556	0	(410,605)	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	37.50	Ambassador Nursing & rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	37.50	Belhaven Nursing and Rehab Center	Chicago	Ambassador Realty, LLC		Realty Co.
A & F Realty	5.00	City View Nusring and Rehabe Center	Cierro			
B & N Investments	20.00	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	\$ 3,686	Infinity Healthcare Management		\$ 2,906	\$ (780)	1
2	V	2 Food Purchases		Infinity Healthcare Management		1,496	1,496	2
3	V	3 Housekeeping		Infinity Healthcare Management		452	452	3
4	V	5 Utilities		Infinity Healthcare Management		611	611	4
5	V	6 Maintenance		Infinity Healthcare Management		514	514	5
6	V	10 Nursing	55,668	Infinity Healthcare Management		51,544	(4,124)	6
7	V	19 Professional Fees	335,480	Infinity Healthcare Management		132,595	(202,885)	7
8	V	20 Dues, Fees, Subs, & Promotions		Infinity Healthcare Management		791	791	8
9	V	21 Office Expense	116,426	Infinity Healthcare Management		263,494	147,068	9
10	V	22 Employee Benefits		Infinity Healthcare Management		35,865	35,865	10
11	V	24 Travel & Seminar		Infinity Healthcare Management		4,383	4,383	11
12	V	26 Insurance		Infinity Healthcare Management		736	736	12
13	V	30 Depreciation		Infinity Healthcare Management		162	162	13
14	Total		\$ 511,260			\$ 495,549	\$ * (15,711)	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	32 Interest	\$	Infinity Healthcare Mangement		\$ 17	\$	17	15
16	V	34 Rent		Infinity Healthcare Mangement		5,817		5,817	16
17	V	17 Adminstration	46,218	Infinity Healthcare Mangement				(46,218)	17
18	V	19 Professional Services		Ambassador Realty, LLC		3,700		3,700	18
19	V	21 Office Expense		Ambassador Realty, LLC		307		307	19
20	V	26 Insurance		Ambassador Realty, LLC		55,366		55,366	20
21	V	30 Depreciation		Ambassador Realty, LLC		186,651		186,651	21
22	V	31 Amortization		Ambassador Realty, LLC		384,943		384,943	22
23	V	32 Interest		Ambassador Realty, LLC		215,721		215,721	23
24	V	34 Rent	803,748	Ambassador Realty, LLC				(803,748)	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		\$ 849,966			\$ 852,522	\$ *	2,556	39

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

Facility Name & ID Number

Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
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19								19
20								20
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Ambassador Nsg & Reha Center # 0049924 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending: 12/31/17

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

Facility Name & ID Number

Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	HUD		X	Mortgage	\$44,674.00	9/28/12	\$ 9,913,500	\$ 8,345,754	9/28/42	2.5400	\$ 215,721	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Capital One		X	Working Capital	None	8/31/12	26,000,000		8/31/18	3.9800	7,081	6						
7												7						
8												8						
9	TOTAL Facility Related				\$44,674.00		\$ 35,913,500	\$ 8,345,754			\$ 222,802	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 35,913,500	\$ 8,345,754			\$ 222,802	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,304 Line # 26

* 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

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 2016 report.		\$	251,532	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.)		\$	277,710	2
3. Under or (over) accrual (line 2 minus line 1).		\$	26,178	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	253,982	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.		\$	280,160	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	136,872	8
	2013	240,956	9
	2014	245,813	10
	2015	254,113	11
	2016	277,710	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nsg & Reha Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(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>13-11-418-021-0000</u>	<u>Nursing Home</u>	\$ <u>24,304.85</u>	\$ <u>24,304.85</u>
2. <u>13-11-418-022-000</u>	<u>Nursing Home</u>	\$ <u>89,433.28</u>	\$ <u>89,433.28</u>
3. <u>13-11-418-026-001</u>	<u>Nursing Home</u>	\$ <u>113,639.48</u>	\$ <u>113,639.48</u>
4. <u>13-11-418-028-002</u>	<u>Nursing Home</u>	\$ <u>44,192.80</u>	\$ <u>44,192.80</u>
5. <u>13-11-418-033-003</u>	<u>Nursing Home</u>	\$ <u>6,139.17</u>	\$ <u>6,139.17</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>277,709.58</u></u>	\$ <u><u>277,709.58</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

1. Total Amount Incurred: 183,166 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 12,211 4. Dates Incurred: 4/8/08 - 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Facility, 2008, \$1,545,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), \$1,545,000, 3.

Facility Name & ID Number Ambassador Nsg & Reha Center# 0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17**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		\$ 1,847,237	\$ 139,287	39	\$ 47,365	\$ (91,922)	\$ 865,081	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARINGS		2008		1,148	29	39	29	0	292	9
10	PATIO		2008		950	24	39	24	0	242	10
11	PATIO		2008		63	2	39	2	(0)	18	11
12	PUMP		2008		796	20	39	20	0	202	12
13	PATIO		2008		650	17	39	17	(0)	168	13
14	DIGITAL TV SYSTEM		2008		15,000	385	39	385	(0)	3,729	14
15											15
16	CURTAINS AND LIGHTS		2009		1,165	30	39	30	(0)	239	16
17	DOORS		2009		1,210	31	39	31	0	279	17
18	WARDROBES		2009		8,125	208	39	208	0	1,873	18
19	BEDSPREADS, CURTAINS, WARDROBES		2009		16,147	414	39	414	0	3,726	19
20	PHONE WIRING		2009		3,000	77	39	77	(0)	693	20
21	PHONE CONTROL CABINET		2009		2,200	56	39	56	0	506	21
22	COMPUTER WIRING		2009		680	17	39	17	0	155	22
23	PAINT		2009		504	13	39	13	(0)	117	23
24	PAINT		2009		594	15	39	15	0	136	24
25	REFRIGERATOR		2009		2,331	60	39	60	(0)	539	25
26											26
27	CUBICLE CURTAINS		2010		4,526	116	39	116	0	928	27
28	WHEELCHAIR RAMP		2010		20,975	538	39	538	(0)	4,303	28
29	MASONRY		2010		11,175	287	39	287	(0)	2,295	29
30	DOORS		2010		1,498	38	39	38	0	305	30
31	DOORS		2010		1,162	30	39	30	(0)	239	31
32	BOILER		2010		7,879	202	39	202	0	1,616	32
33	FREEZER REPAIR		2010		1,400	36	39	36	(0)	288	33
34	CIRCUIT BREAKER REPAIR		2010		850	22	39	22	(0)	175	34
35	PATIO RAILINGS		2010		2,980	76	39	76	0	609	35
36	PY ADDITION		2010		2,100	54	39	54	(0)	432	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	\$ 0	\$ 5,689	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	60	(0)	419	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	481	(0)	3,366	40
41	Clean Chiller Barrells, Filter, Heat Exhanger	2011	5,871	151	39	151	(0)	1,056	41
42	Lighting	2011	15,156	389	39	389	(0)	2,722	42
43	Waterproofing North Patio	2011	3,402	87	39	87	0	609	43
44	Waterproofing North Patio	2011	3,402	87	39	87	0	609	44
45	Custom Cabinets	2011	1,628	42	39	42	(0)	293	45
46	Cement	2011	4,100	105	39	105	0	735	46
47									47
48	Cooling Tower	2012	5,068	130	39	130	(0)	780	48
49	New Boiler Burners	2012	5,170	133	39	133	(0)	798	49
50	Patch Basement Hallway Floors/Tiles	2012	2,450	63	39	63	(0)	378	50
51									51
52	Fire Dampers	2013	7,725	198	39	198	0	891	52
53	Ceiling tiles, 2nd floor	2013	94,133	2,414	39	2,414	(0)	10,863	53
54	Build closets, 2nd & 3rd floors	2013	7,450	191	39	191	0	860	54
55	80 ton water cooler	2013	110,843	2,842	39	2,842	0	12,789	55
56	Plumbing for installation of sinks in beauty shop	2013	1,800	46	39	46	0	207	56
57	Santelli Custom Cabinet - Nurse station	2013	13,500	346	39	346	0	1,557	57
58	Closets, Shelving 3rd floor	2013	18,714	480	39	480	(0)	2,160	58
59									59
60	Generator Repairs	2014	2,877	74	39	74	(0)	364	60
61	Install Cove Base in Second Floor Corridor	2014	8,211	211	39	211	(0)	744	61
62	Sprinkler Head Replacement	2014	4,407	113	39	113		418	62
63	Run Pipe to Shut-Off Valve	2014	1,563	40	39	40	0	147	63
64	Install Remote Annunciator	2014	2,758	71	39	71	(0)	263	64
65	Leaking Cooling Tower	2014	28,800	738	39	738	0	3,240	65
66	Hot Water Boiler Leak	2014	3,249	83	39	83	0	322	66
67	Winterize and Clean Tower	2014	2,409	62	39	62	(0)	217	67
68	Install Boiler	2014	8,850	227	39	227	(0)	760	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,368,687	\$ 152,659		\$ 60,736	\$ (91,923)	\$ 942,441	70

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

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	
1	Totals from Page 12A, Carried Forward		\$ 2,368,687	\$ 152,659		\$ 60,736	\$ (91,923)	\$ 942,441	1
2	2nd Floor Artwork	2014	4,257	109	39	109	0	327	2
3	Storage Tank Repair	2015	2,941	75	39	75	0	225	3
4	Chiller Maintenance	2015	3,370	86	39	86	0	258	4
5	Wallcoverings in lobby, 2nd Floor Dining Room, Handrails and	2015	45,880	1,176	39	1,176	0	3,528	5
6	Guards, Lights, Cove Base, Tile								6
7	Painted Therapy Room	2015	9,934	255	39	255	(0)	765	7
8	Hot Water Boiler Repair	2015	3,995	102	39	102	0	306	8
9	CC TV System	2015	4,978	128	39	128	(0)	384	9
10	Remodeling / Tiling	2015	2,787	71	39	71	0	213	10
11	3rd Floor - New Flooring, Cove Base, Nurse Station Countertops	2015	147,124	3,772	39	3,772	0	11,316	11
12	Wall Coverings, Drop Ceiling								12
13	Fire Sprinkler Survey	2015	2,880	74	39	74	(0)	222	13
14	Masonry Wall and Concrete Work	2015	13,100	336	39	336	(0)	1,008	14
15									15
16	Replace faulty booster pump on chiler	2016	3,943		39	101	101	578	16
17	Exterior awnings	2016	10,615		39	272	272	1,555	17
18	Install 20 amp 120v outlet from generator to computer outlet	2016	2,075		39	53	53	304	18
19	3rd floor dining room labor to complete	2016	1,510		39	39	39	221	19
20	Replacement of 80 ton chiller	2016	5,000		39	128	128	733	20
21	conference room shade, 3rd floor cove base	2016	25,203		39	646	646	3,692	21
22	Concrete work for stairwell, plat survey and masonry work	2016	8,625		39	221	221	1,264	22
23	Repack AC 500 gpm pump and packing glands	2016	6,698		39	172	172	981	23
24	Basement back door repair	2016	1,723		39	44	44	252	24
25									25
26	Repair and paint - Rms 201-211, kitchen ceiling,	2017	13,916	178	39	357	179	178	26
27	1st Floor Admissions Office, Shower Rooms,								27
28	Bathrooms & Janitor Closets on 1st, 2nd, 3rd Floors								28
29									29
30									30
31	Labor & Materials to fix Pipes in Basement & Laundry Room	2017	1,800	23	39	46	23	23	31
32	Eight New Exhaust Fans	2017	6,045	77	39	155	78	77	32
33	Hot Water Boilers	2017	26,800	343	39	687	344	343	33
34	TOTAL (lines 1 thru 33)		\$ 2,723,885	\$ 159,464		\$ 69,843	\$ (89,621)	\$ 971,194	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,723,885	\$ 159,464		\$ 69,843	\$ (89,621)	\$ 971,194	1
2	90 New Closet Doors	2017	9,322	119	39	239	120	119	2
3	Wall Repairs to 1st & 2nd Floor Shower Rooms	2017	2,573	33	39	66	33	33	3
4	New Carpet in Administrator Office room, Conference Room & R	2017	3,946	51	39	101	50	51	4
5	New Doors for Kitchen	2017	5,953	76	39	153	77	76	5
6	Hot Water Energy Management Controller	2017	2,450	31	39	63	32	31	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	TOTAL (lines 1 thru 33)		\$ 2,748,129	\$ 159,774		\$ 70,465	\$ (89,309)	\$ 971,504	34

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

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	\$ 1,013,955	\$ 79,296	\$ 202,955	\$ 123,659	5-7	\$ 764,574	71
72	Current Year Purchases	27,649	22,554	5,530	(17,024)	5	22,554	72
73	Fully Depreciated Assets	315,070					315,070	73
74								74
75	TOTALS	\$ 1,356,674	\$ 101,850	\$ 208,485	\$ 106,635		\$ 1,102,198	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)	\$ 5,649,803	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,624	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 278,950	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,326	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,073,702	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Ambassador Nsg & Reha Center

0049924

Report Period Beginning: 1/1/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	4,621	\$ 313,257	\$	4,621	\$ 313,257	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,205	92,958		2,205	92,958	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,258	284,435		4,258	284,435	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				141,809		141,809	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray</u>	39-2					6,853		6,853	12
13	Other (specify): <u>Lab</u>	39-2					1,127		1,127	13
14	TOTAL			\$	11,084	\$ 690,650	\$ 149,789	11,084	\$ 840,439	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (156,072)	\$ 148,755	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,143,376	3,143,376	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	220,530	220,530	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	357,571	508,370	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,565,405	\$ 4,021,031	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,545,000	13
14	Buildings, at Historical Cost		1,847,236	14
15	Leasehold Improvements, at Historical Cost	900,891	900,891	15
16	Equipment, at Historical Cost	381,674	1,356,674	16
17	Accumulated Depreciation (book methods)	(492,484)	(2,073,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	17,301	5,791,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,608,195)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	196,000	565,739	22
23	Other(specify):		146,413	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,003,382	\$ 6,471,506	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,568,787	\$ 10,492,537	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,169,366	\$ 2,653,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,350	45,350	28
29	Short-Term Notes Payable		327,901	29
30	Accrued Salaries Payable	192,238	192,238	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,395	20,395	31
32	Accrued Real Estate Taxes(Sch.IX-B)	407,217	407,217	32
33	Accrued Interest Payable		17,665	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Capital One Note</u>	(1,082,974)	(1,082,974)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,751,592	\$ 2,581,346	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,017,853	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)	\$	\$ 8,017,853	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,751,592	\$ 10,599,199	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,817,195	\$ (106,662)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,568,787	\$ 10,492,537	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,692,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,692,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,462,811	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	(58,138)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Prior year distribution	(280,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,124,673	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)	\$ 2,817,195	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,802,235	1
2	Discounts and Allowances for all Levels	743,871	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,546,106	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	504,490	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 504,490	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	50,541	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,859	19
20	Radiology and X-Ray	125	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 54,525	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33,803	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,803	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Revenue	25,715	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,715	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,164,639	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,421,718	31
32	Health Care	4,845,809	32
33	General Administration	2,345,725	33
B. Capital Expense			
34	Ownership	1,171,773	34
C. Ancillary Expense			
35	Special Cost Centers	149,789	35
36	Provider Participation Fee	414,838	36
D. Other Expenses (specify):			
37	<u>Bad Debt Expense</u>	327,454	37
38	<u>Medically Necessary Transportation</u>	24,722	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,701,828	40
41	Income before Income Taxes (line 30 minus line 40)**	1,462,811	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,462,811	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,867,845	44
45	Private Pay - Net Inpatient Revenue	166,265	45
46	Medicare - Net Inpatient Revenue	1,228,035	46
47	Other-(specify) <u>Net Inpatient revenue</u>	1,283,961	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,546,106	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 & Reha Center**

0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	2,127	2,248	\$ 106,722	\$ 47.47	1
2	Assistant Director of Nursing	4,456	5,075	173,037	34.10	2
3	Registered Nurses	17,621	19,407	626,747	32.29	3
4	Licensed Practical Nurses	37,634	40,586	1,140,582	28.10	4
5	CNAs & Orderlies	85,239	92,688	1,383,657	14.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,240	9,018	125,868	13.96	9
10	Activity Assistants					10
11	Social Service Workers	4,800	5,290	119,314	22.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,376	23,200	354,464	15.28	15
16	Dishwashers					16
17	Maintenance Workers	2,341	2,485	57,143	23.00	17
18	Housekeepers	14,741	16,277	221,740	13.62	18
19	Laundry	5,218	5,895	67,925	11.52	19
20	Administrator	1,859	1,998	135,338	67.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,512	15,802	275,009	17.40	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	1,920	2,238	34,363	15.35	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	2,213	2,244	63,786	28.43	33
34	TOTAL (lines 1 - 33)	223,297	244,451	\$ 4,885,695 *	\$ 19.99	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	270	\$ 12,672	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,591	55,668	10-3	38
39	Pharmacist Consultant	321	16,074	15-3	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	84	5,212	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,266	\$ 89,626		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	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Aaron Cohen	Administrator		\$ 80,412	Workers' Compensation Insurance	\$ 156,555	IDPH License Fee	\$		
Michael Elkes	Administrator		10,356	Unemployment Compensation Insurance	33,204	Advertising: Employee Recruitment			
Jim Kouzios	Administrator		44,570	FICA Taxes	371,611	Health Care Worker Background Check			
				Employee Health Insurance	210,637	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		IDPH License	1,244		
				Pension	135,283	IHCA	10,127		
				Uniforms	3,999	Illinois Dept Of Public Health	1,990		
				Background Checks	828	City of Chicago	210		
				Employee Expense	20,747	Other License and Dues	433		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,338	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,004	
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		
							Auto allowance	4,383	
							Mileage	2,501	
							Seminar Expense		
							Education and Seminars	966	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 7,850
C. Professional Services									
Vendor/Payee	Type		Amount						
Infinity Funding/Sedgwick	Legal		\$ 104,860						
Lewis Brisbois Bisgaard & Smith	Legal		3,643						
US Courts	Legal		177						
Cook County Sheriffs Office	Legal		60						
Mark Epstein	Legal		2,000						
Bradley Associates	Accounting		11,423						
Johnson Goldburg	Accounting		3,900						
MTS Consulting	Consulting		5,101						
Infinity Healthcare	Mgmt		335,480						
Empire Risk	Mgmt		12,350						
Various	Legal		(346)						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 478,648						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ambassador Nsg & Reha Center# 0049924

Report Period Beginning:

1/1/17

Ending:

12/31/17**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 \$10,127
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,838 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. \$ 414,838
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees