FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0049924

Facility Name: AMBASSADOR NURSING & REHAB CENTER

Address: 4900 N. BERNARD (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773)5837130 **Fax #** (773)583-3929

HFS ID Number:

Date of Initial License for Current Owners: 4/1/08

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MOSHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	45,043	737	6,329	52,109	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,043	737	6,329	52,109	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.14%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 4/1/08

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 190 and days of care provided 6,429

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CEN # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,806	21,008	15,000	326,814		326,814	(5,353)	321,461			1
2	Food Purchase		219,948		219,948		219,948		219,948			2
3	Housekeeping	181,761	36,092		217,853		217,853		217,853			3
4	Laundry	66,711	12,590		79,301		79,301		79,301			4
5	Heat and Other Utilities			219,546	219,546		219,546	462	220,008			5
6	Maintenance	67,691	19,399	27,874	114,964		114,964	(30)	114,934			6
7	Other (specify):*											7
8	TOTAL General Services	606,969	309,037	262,420	1,178,426		1,178,426	(4,921)	1,173,505			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	2,716,577	345,703	32,650	3,094,930		3,094,930	17,952	3,112,882			10
10a	Therapy			495,093	495,093		495,093		495,093			10a
11	Activities	98,988	18,461		117,449		117,449		117,449			11
12	Social Services	43,052		2,898	45,950		45,950		45,950			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			9,243	9,243		9,243		9,243			15
16	TOTAL Health Care and Programs	2,858,617	364,164	564,884	3,787,665		3,787,665	17,952	3,805,617			16
	C. General Administration											
17	Administrative	98,948			98,948		98,948		98,948			17
18	Directors Fees											18
19	Professional Services			292,032	292,032		292,032	(260,345)	31,687			19
20	Dues, Fees, Subscriptions & Promotions			4,902	4,902		4,902	350	5,252			20
21	Clerical & General Office Expenses	234,140	71,714	20,508	326,362		326,362	166,591	492,953			21
22	Employee Benefits & Payroll Taxes			644,963	644,963		644,963	7,542	652,505			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,125	14,125		14,125	524	14,649			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			156,385	156,385		156,385	14,278	170,663			26
27	Other (specify):*											27
28	TOTAL General Administration	333,088	71,714	1,132,915	1,537,717		1,537,717	(71,060)	1,466,657			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,798,674	744,915	1,960,219	6,503,808		6,503,808	(58,029)	6,445,779			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER #0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,602	65,602		65,602	69,769	135,371			30
31	Amortization of Pre-Op. & Org.							351,088	351,088			31
32	Interest			47,748	47,748		47,748	412,878	460,626			32
33	Real Estate Taxes							189,259	189,259			33
34	Rent-Facility & Grounds			1,140,000	1,140,000		1,140,000	(1,126,678)	13,322			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Replacement Tax**			5,102	5,102		5,102	5,102	10,204			36
37	**TOTAL Ownership**			1,258,452	1,258,452		1,258,452	(98,582)	1,159,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		290,877		290,877		290,877		290,877			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		290,877	104,025	394,902		394,902		394,902			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,798,674	1,035,792	3,322,696	8,157,162		8,157,162	(156,611)	8,000,551			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(104,227)	30		9
10	Interest and Other Investment Income	(1,288)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(2,167)	21		18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,714)	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	(8,400)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (126,311)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,300)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,300)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (156,611)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

AMBASSADOR NURSING & REHAB CENTER

ID# 0049924

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (861)	6	1
2	Misc Income	(6,425)	21	2
3	Medical Records	(1,114)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	(15)	(5,338)	0	0	0	0	0	0	0	0	0	(5,353)	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	462	0	0	0	0	0	0	0	0	0	462	5
6	Maintenance	(861)	831	0	0	0	0	0	0	0	0	0	(30)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(876)	(4,045)	0	0	0	0	0	0	0	0	0	(4,921)	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	(1,114)	19,066	0	0	0	0	0	0	0	0	0	17,952	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,114)	19,066	0	0	0	0	0	0	0	0	0	17,952	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(275,731)	15,386	0	0	0	0	0	0	0	0	(260,345)	19
20	Fees, Subscriptions & Promotions	0	0	350	0	0	0	0	0	0	0	0	350	20
21	Clerical & General Office Expenses	(18,806)	184,444	953	0	0	0	0	0	0	0	0	166,591	21
22	Employee Benefits & Payroll Taxes	0	7,542	0	0	0	0	0	0	0	0	0	7,542	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	524	0	0	0	0	0	0	0	0	0	524	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	456	13,822	0	0	0	0	0	0	0	0	14,278	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18,806)	(82,765)	30,511	0	0	0	0	0	0	0	0	(71,060)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,796)	(67,744)	30,511	0	0	0	0	0	0	0	0	(58,029)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(104,227)	0	173,996	0	0	0	0	0	0	0	0	69,769	30
31	Amortization of Pre-Op. & Org.	0	0	351,088	0	0	0	0	0	0	0	0	351,088	31
32	Interest	(1,288)	0	414,166	0	0	0	0	0	0	0	0	412,878	32
33	Real Estate Taxes	0	0	189,259	0	0	0	0	0	0	0	0	189,259	33
34	Rent-Facility & Grounds	0	13,322	(1,140,000)	0	0	0	0	0	0	0	0	(1,126,678)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	5,102	0	0	0	0	0	0	0	0	5,102	36
37	**TOTAL Ownership**	(105,515)	13,322	(6,389)	0	0	0	0	0	0	0	0	(98,582)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,311)	(54,422)	24,122	0	0	0	0	0	0	0	0	(156,611)	45

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 REALTY INVESTMENT	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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 15,479	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		$ 10,141	$ (5,338)	1
2	V	6	Maintenance Wages		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		410	410	2
3	V	10	Nursing	25,200	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		44,266	19,066	3
4	V	21	Office Wages		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		193,265	193,265	4
5	V	5	Utilities	73	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		535	462	5
6	V	6	Maintenance		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		421	421	6
7	V	19	Professional Fees	276,000	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		269	(275,731)	7
8	V	21	Office Expense	29,820	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		20,999	(8,821)	8
9	V	22	Employee Benefits	2,601	INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		10,143	7,542	9
10	V	24	Travel		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		524	524	10
11	V	26	Insurance		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		456	456	11
12	V	34	Rent		INFINITY HEALTHCARE MANAGEMENT OF ILLINOIS		13,322	13,322	12
13	V								13
14	Total			$ 349,173			$ 294,751	$ * (54,422)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 1,140,000	Ambassador Realty , LLC		$	$ (1,140,000)	15
16	V	21	Office Expense		Ambassador Realty , LLC		953	953	16
17	V	30	Depreciation		Ambassador Realty , LLC		173,996	173,996	17
18	V	31	Amortization		Ambassador Realty , LLC		351,088	351,088	18
19	V	20	Filing Fees		Ambassador Realty , LLC		350	350	19
20	V	26	Insurance		Ambassador Realty , LLC		13,822	13,822	20
21	V	32	Interest	1,347	Ambassador Realty , LLC		415,513	414,166	21
22	V	19	Professional Fees		Ambassador Realty , LLC		15,386	15,386	22
23	V	33	Property Taxes		Ambassador Realty , LLC		189,259	189,259	23
24	V	36	Replacement Tax		Ambassador Realty , LLC		5,102	5,102	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,141,347			$ 1,165,469	$ * 24,122	39

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CEN # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/2011 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENT # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Bank		X	Mortgage	Interest Only	4/1/08	$ 8,020,000	$ 8,020,000	4/1/33	3+Libor	$ 151,613	1
2	Meisels Limited Partnership		X	Mortgage	$14,590.00	4/1/08	1,945,447	1,525,000	4/1/12	9.0000	263,900	2
3												3
4												4
5												5
	Working Capital											
6	First Merit Bank		X	Working Capital	None	6/30/11	1,050,500	1,050,500	6/30/12	5.5000	47,748	6
7												7
8												8
9	TOTAL Facility Related				$14,590.00		$ 11,015,947	$ 10,595,500			$ 463,261	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,015,947	$ 10,595,500			$ 463,261	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 176,352	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.)		$ 189,254	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,902	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 176,357	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.		$ 189,259	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	199,523	8
	2007	199,000	9
	2008	176,347	10
	2009	205,841	11
	2010	189,254	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBASSADOR NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-033-0000	NURSING HOME	$ 4,989.73	$ 4,989.73
2.	13-11-418-028-0000	NURSING HOME	$ 30,082.75	$ 30,082.75
3.	13-11-418-026-0000	NURSING HOME	$ 77,050.82	$ 77,050.82
4.	13-11-418-022-0000	NURSING HOME	$ 60,657.46	$ 60,657.46
5.	13-11-418-021-0000	NURSING HOME	$ 16,473.29	$ 16,473.29
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 189,254.05	$ 189,254.05

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 [X] (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 [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 100,881
2. Number of Years Over Which it is Being Amortized: 20 YEARS
3. Current Period Amortization: 6,732
4. Dates Incurred: 4/1/08-12/31/10

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		2008	$ 300,000	1
2					2
3	TOTALS			$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		2008		$ 4,000,000	$ 102,564	39	$ 102,564	$	$ 384,615	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARINGS			2008	1,148	29	39	29		118	9
10	PATIO			2008	950	24	39	24		97	10
11	PATIO			2008	63	2	39	2		6	11
12	PUMP			2008	796	20	39	20		82	12
13	PATIO			2008	650	17	39	17		67	13
14	DIGITAL TV SYSTEM			2008	15,000	385	39	385		1,538	14
15							39				15
16	CURTAINS AND LIGHTS			2009	1,165	30	39	30		90	16
17	DOORS			2009	1,210	31	39	31		93	17
18	WARDROBES			2009	8,125	208	39	208		625	18
19	BEDSPREADS, CURTAINS, WARDROBES			2009	16,147	414	39	414		1,242	19
20	PHONE WIRING			2009	3,000	77	39	77		231	20
21	PHONE CONTROL CABINET			2009	2,200	56	39	56		169	21
22	COMPUTER WIRING			2009	680	17	39	17		52	22
23	PAINT			2009	504	13	39	13		39	23
24	PAINT			2009	594	15	39	15		46	24
25	REFRIGERATOR			2009	2,331	60	39	60		179	25
26							39				26
27	CUBICLE CURTAINS			2010	4,526	116	39	116		232	27
28	WHEELCHAIR RAMP			2010	20,975	538	39	538		1,076	28
29	MASONRY			2010	11,175	287	39	287		573	29
30	DOORS			2010	1,498	38	39	38		77	30
31	DOORS			2010	1,162	30	39	30		60	31
32	BOILER			2010	7,879	202	39	202		404	32
33	FREEZER REPAIR			2010	1,400	36	39	36		72	33
34	CIRCUIT BREAKER REPAIR			2010	850	22	39	22		44	34
35	PATIO RAILINGS			2010	2,980	76	39	76		153	35
36				2010	2,100	54	39	54		108	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPLACE PAVEMENT	2010	$ 27,735	$ 711	39	$ 711	$	$ 1,304	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	15	(45)	60	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	401	(80)	481	40
41	Clean Chiller Barrells, Filter, Heat Exhanger	2011	5,871	151	39	100	(51)	151	41
42	Retrofitting	2011	15,156	389	39	259	(130)	389	42
43	Waterproofing North Patio	2011	3,402	87	39	58	(29)	87	43
44	Waterproofing North Patio	2011	3,402	87	39	36	(51)	87	44
45	Custom Cabinets	2011	1,628	42	39	14	(28)	42	45
46	Cement	2011	4,100	105	39	18	(87)	105	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,191,472	$ 107,474		$ 106,974	$ (500)	$ 394,791	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 614,674	$ 75,027	$ 22,937	$ (52,090)	5	$ 380,502	71
72	Current Year Purchases	57,097	57,097	5,460	(51,637)	5	57,097	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 671,771	$ 132,124	$ 28,397	$ (103,727)		$ 437,599	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)	$ 5,163,243	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 239,598	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,371	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (104,227)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 832,390	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 NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 195,072	$		$ 195,072	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			84,866			84,866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			215,155			215,155	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				277,324		277,324	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray	39-2					13,553		13,553	12
13	Other (specify):									13
14	TOTAL			$		$ 495,093	$ 290,877		$ 785,970	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER **#** 0049924 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of ######## **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (662,178)	$ (205,353)	1
2	Cash-Patient Deposits	(1,958)	(1,958)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,234,662	3,240,372	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,217	32,217	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,602,743	$ 3,065,278	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	191,472	191,472	15
16	Equipment, at Historical Cost	173,118	673,118	16
17	Accumulated Depreciation (book methods)	(179,922)	(832,390)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,266,329	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,316,588)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Security Deposit**		30,480	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 184,668	$ 8,312,420	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,787,410	$ 11,377,698	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,108,491	$ 1,257,861	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	476,937	476,937	30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,273)	(2,273)	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Working Capitol Note**	1,050,500	1,050,500	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,633,655	$ 2,783,025	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,545,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,545,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,633,655	$ 12,328,025	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 153,755	$ (950,327)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,787,410	$ 11,377,698	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,298	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,298	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,118,457	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	(980,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 138,457	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)**	$ 153,755	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,614,776	1
2	Discounts and Allowances for all Levels	(647,086)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,967,690	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	982,851	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 982,851	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	284,142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,606	19
20	Radiology and X-Ray	2,529	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 309,277	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,288	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,288	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	861	28
28a	MISCELLANEOUS	13,652	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,513	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,275,619	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,178,426	31
32	Health Care	3,787,665	32
33	General Administration	1,537,717	33
	B. Capital Expense		
34	Ownership	1,258,452	34
	C. Ancillary Expense		
35	Special Cost Centers	290,877	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,157,162	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,118,457	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,118,457	43

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

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

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

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

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,964	2,150	$ 94,269	$ 43.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,385	26,855	812,290	30.25	3
4	Licensed Practical Nurses	31,549	33,532	799,500	23.84	4
5	CNAs & Orderlies	76,902	84,082	984,036	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,928	8,664	98,988	11.43	9
10	Activity Assistants					10
11	Social Service Workers	1,893	2,131	43,052	20.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,134	22,559	290,806	12.89	15
16	Dishwashers					16
17	Maintenance Workers	3,947	4,236	67,691	15.98	17
18	Housekeepers	15,376	17,275	181,761	10.52	18
19	Laundry	6,521	7,177	66,711	9.30	19
20	Administrator	1,600	2,130	98,948	46.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,897	12,790	234,142	18.31	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	1,861	2,085	26,480	12.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,957	225,666	$ 3,798,674 *	$ 16.83	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	149	7,450	10-3	38
39	Pharmacist Consultant	185	9,243	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	83	2,898	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	417	$ 19,591		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Correa	Admin		$ 60,509
Konstant Stavropoulos	Admin		38,439
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,948

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

Vendor/Payee	Type	Amount
Bradley Associates	Accounting	$ 11,732
Johnson, Goldberg & Brown	Accounting	2,500
Ira I. Silverstein	Legal	1,800
Infinity Healthcare	Professional	276,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 292,032

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,276
Unemployment Compensation Insurance	83,464
FICA Taxes	291,860
Employee Health Insurance	165,253
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	24,135
Employee Expense	17,517
TOTAL (agree to Schedule V, line 22, col.8)	$ 652,505

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
License & Fees	4,902
Filing Fees	350
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	11,029
Mileage	2,110
Seminar Expense	1,510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,649

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER # 0049924 Report Period Beginning: 1/1/2010 Ending: #######

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING & REHAB CENTER **#** 0049924 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,335** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **104,025**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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