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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0049924

Facility Name: Ambassador Nsg & Rehab Ctr

Address: 4900 N Bernard (Number) Chicago (City) 60625 (Zip Code)

County: Cook

Telephone Number: 709-449-1900 **Fax #** 708-449-1500

HFS ID Number:

Date of Initial License for Current Owners: 4/01/2008

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 1/1/16 to 12/31/16 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, 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**

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	69,540	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	47,404	410	4,755	52,569	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,404	410	4,755	52,569	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.60%

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 04/08/2008

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

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 1,925

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	326,293		35,684	361,977		361,977	(2,278)	359,699			1
2	Food Purchase		257,453		257,453		257,453	715	258,168			2
3	Housekeeping	180,800	31,325		212,125		212,125	452	212,577			3
4	Laundry	77,825	16,333		94,158		94,158		94,158			4
5	Heat and Other Utilities			228,683	228,683		228,683	610	229,293			5
6	Maintenance	74,533	32,666	53,002	160,201		160,201	1,096	161,297			6
7	Other (specify):*											7
8	TOTAL General Services	659,451	337,777	317,369	1,314,597		1,314,597	595	1,315,192			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	3,202,956	313,819	47,683	3,564,458		3,564,458	(30,459)	3,533,999			10
10a	Therapy			786,733	786,733		786,733		786,733			10a
11	Activities	116,834	17,032		133,866		133,866	2,874	136,740			11
12	Social Services	60,816		6,343	67,159		67,159		67,159			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX consultant			15,435	15,435		15,435		15,435			15
16	TOTAL Health Care and Programs	3,380,606	330,851	890,694	4,602,151		4,602,151	(27,585)	4,574,566			16
	C. General Administration											
17	Administrative	126,255			126,255		126,255		126,255			17
18	Directors Fees											18
19	Professional Services			411,832	411,832		411,832	(155,676)	256,156			19
20	Dues, Fees, Subscriptions & Promotions			8,156	8,156		8,156	(198)	7,958			20
21	Clerical & General Office Expenses	240,966	81,509	77,282	399,757		399,757	121,685	521,442			21
22	Employee Benefits & Payroll Taxes			911,450	911,450		911,450	52,978	964,428			22
23	Inservice Training & Education											23
24	Travel and Seminar			719	719		719	1,445	2,164			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			374,296	374,296		374,296	55,397	429,693			26
27	Other (specify):*											27
28	TOTAL General Administration	367,221	81,509	1,783,735	2,232,465		2,232,465	75,631	2,308,096			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,407,278	750,137	2,991,798	8,149,213		8,149,213	48,641	8,197,854			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Ambassador Nsg & Rehab Ctr #0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			45,764	45,764		45,764	256,016	301,780			30
31	Amortization of Pre-Op. & Org.							384,943	384,943			31
32	Interest			55,638	55,638		55,638	199,462	255,100			32
33	Real Estate Taxes			220,000	220,000		220,000	66,435	286,435			33
34	Rent-Facility & Grounds			873,105	873,105		873,105	(866,865)	6,240			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Replacement Tax**			4,044	4,044		4,044		4,044			36
37	**TOTAL Ownership**			1,198,551	1,198,551		1,198,551	39,991	1,238,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			16,030	16,030		16,030		16,030			38
39	Ancillary Service Centers		173,935		173,935		173,935		173,935			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			408,256	408,256		408,256		408,256			42
43	Other (specify):*			702,317	702,317		702,317	(702,317)				43
44	**TOTAL Special Cost Centers**		173,935	1,126,603	1,300,538		1,300,538	(702,317)	598,221			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,407,278	924,072	5,316,952	10,648,302		10,648,302	(613,685)	10,034,617			45

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	69,100	30		9
10	Interest and Other Investment Income	(27,717)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(702,317)	43		24
25	Fund Raising, Advertising and Promotional	(19,609)	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	(1,894)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (682,447)		$	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)			34
35	Other- Attach Schedule	68,762	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 68,762		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (613,685)		37

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

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

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

Ambassador Nsg & Rehab Ctr

ID# 0049924

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc, Income	$ (1,379)	21	1
2	Lobbying	(515)	20	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
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24				24
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26				26
27				27
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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**	(1,894)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(10)	(2,268)	0	0	0	0	0	0	0	0	0	(2,278)	1
2	Food Purchase	0	715	0	0	0	0	0	0	0	0	0	715	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	610	0	0	0	0	0	0	0	0	0	610	5
6	Maintenance	0	1,096	0	0	0	0	0	0	0	0	0	1,096	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10)	605	0	0	0	0	0	0	0	0	0	595	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(30,459)	0	0	0	0	0	0	0	0	0	(30,459)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,874	0	0	0	0	0	0	0	0	0	2,874	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(27,585)	0	0	0	0	0	0	0	0	0	(27,585)	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	(186,344)	30,668	0	0	0	0	0	0	0	0	(155,676)	19
20	Fees, Subscriptions & Promotions	(515)	317	0	0	0	0	0	0	0	0	0	(198)	20
21	Clerical & General Office Expenses	(20,988)	141,904	769	0	0	0	0	0	0	0	0	121,685	21
22	Employee Benefits & Payroll Taxes	0	52,978	0	0	0	0	0	0	0	0	0	52,978	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,445	0	0	0	0	0	0	0	0	0	1,445	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	374	55,023	0	0	0	0	0	0	0	0	55,397	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,503)	10,674	86,460	0	0	0	0	0	0	0	0	75,631	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,513)	(16,306)	86,460	0	0	0	0	0	0	0	0	48,641	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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	69,100	0	186,916	0	0	0	0	0	0	0	0	256,016	30
31	Amortization of Pre-Op. & Org.	0	0	384,943	0	0	0	0	0	0	0	0	384,943	31
32	Interest	(27,717)	0	227,179	0	0	0	0	0	0	0	0	199,462	32
33	Real Estate Taxes	0	0	66,435	0	0	0	0	0	0	0	0	66,435	33
34	Rent-Facility & Grounds	0	0	(866,865)	0	0	0	0	0	0	0	0	(866,865)	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	41,383	0	(1,392)	0	0	0	0	0	0	0	0	39,991	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):*	(702,317)	0	0	0	0	0	0	0	0	0	0	(702,317)	43
44	TOTAL Special Cost Centers	(702,317)	0	0	0	0	0	0	0	0	0	0	(702,317)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(682,447)	(16,306)	85,068	0	0	0	0	0	0	0	0	(613,685)	45

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Rebab 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. [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	$ 14,710	Infinity Healthcare Management		$ 12,442	$ (2,268)	1
2	V	2	Food Purchases		Infinity Healthcare Management		715	715	2
3	V	3	Housekeeping		Infinity Healthcare Management		452	452	3
4	V	5	Utilities		Infinity Healthcare Management		610	610	4
5	V	6	Maintenance		Infinity Healthcare Management		1,096	1,096	5
6	V	10	Nursing	47,683	Infinity Healthcare Management		17,224	(30,459)	6
7	V	11	Activities		Infinity Healthcare Management		2,874	2,874	7
8	V	19	Professional Fees	320,517	Infinity Healthcare Management		134,173	(186,344)	8
9	V	20	Dues, Fees, Subs, & Promotions		Infinity Healthcare Management		317	317	9
10	V	21	Office Expense	94,021	Infinity Healthcare Management		235,925	141,904	10
11	V	22	Employee Benefits		Infinity Healthcare Management		52,978	52,978	11
12	V	24	Travel & Seminar	146	Infinity Healthcare Management		1,591	1,445	12
13	V	26	Insurance		Infinity Healthcare Management		374	374	13
14	Total			$ 477,077			$ 460,771	$ * (16,306)	14

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	30	Depreciation	$	Infinity Healthcare Mangement		$ 265	$ 265	15
16	V	32	Interest		Infinity Healthcare Mangement		3,432	3,432	16
17	V	34	Rent		Infinity Healthcare Mangement		6,240	6,240	17
18	V								18
19	V	33	Property Tax		Ambassador Realty, LLC		66,435	66,435	19
20	V	26	Insurance		Ambassador Realty, LLC		55,023	55,023	20
21	V	31	Amortization		Ambassador Realty, LLC		384,943	384,943	21
22	V	19	Professional Services		Ambassador Realty, LLC		30,668	30,668	22
23	V	21	Office Expense		Ambassador Realty, LLC		769	769	23
24	V	30	Depreciation		Ambassador Realty, LLC		186,651	186,651	24
25	V	32	Interest		Ambassador Realty, LLC		223,747	223,747	25
26	V	34	Rent	873,105	Ambassador Realty, LLC			(873,105)	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			$ 873,105			$ 958,173	$ * 85,068	39

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Bloomingdale				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 Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	mortgage	$44,674.00	9/28/12	$ 9,913,500	$ 8,948,257	9/28/42	2.5400	$ 227,179	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/12	26,000,000	349,143	8/31/18	2.9590	55,638	6
7												7
8												8
9	TOTAL Facility Related				$44,674.00		$ 35,913,500	$ 9,297,400			$ 282,817	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	$ 9,297,400			$ 282,817	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 45,327 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.)**

Facility Name & ID Number Ambassador Nsg & Rehab Ctr **#** 0049924 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 219,210	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.)		$ 254,113	2
3. Under or (over) accrual (line 2 minus line 1).		$ 34,903	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 251,532	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.		$ 286,435	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	188,497	8
	2012	136,872	9
	2013	240,956	10
	2014	245,813	11
	2015	254,113	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-021-0000	Nursing Home	$ 22,239.74	$ 22,239.74
2.	13-11-418-022-000	Nursing Home	$ 81,834.42	$ 81,834.42
3.	13-11-418-026-001	Nursing Home	$ 103,983.88	$ 103,983.88
4.	13-11-418-028-002	Nursing Home	$ 40,437.90	$ 40,437.90
5.	13-11-418-033-003	Nursing Home	$ 5,617.54	$ 5,617.54
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 254,113.48	$ 254,113.48

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2008	$ 1,545,000	1
2					2
3	TOTALS			$ 1,545,000	3

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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		$ 1,847,237	$ 139,286	39	$ 139,286	$	$ 725,794	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARINGS			2008	1,148	29	39	29	0	263	9
10	PATIO			2008	950	24	39	24	0	218	10
11	PATIO			2008	63	2	39	2	(0)	16	11
12	PUMP			2008	796	20	39	20	0	182	12
13	PATIO			2008	650	17	39	17	(0)	151	13
14	DIGITAL TV SYSTEM			2008	15,000	385	39	385	(0)	3,344	14
15											15
16	CURTAINS AND LIGHTS			2009	1,165	30	39	30	(0)	209	16
17	DOORS			2009	1,210	31	39	31	0	248	17
18	WARDROBES			2009	8,125	208	39	208	0	1,665	18
19	BEDSPREADS, CURTAINS, WARDROBES			2009	16,147	414	39	414	0	3,312	19
20	PHONE WIRING			2009	3,000	77	39	77	(0)	616	20
21	PHONE CONTROL CABINET			2009	2,200	56	39	56	0	450	21
22	COMPUTER WIRING			2009	680	17	39	17	0	138	22
23	PAINT			2009	504	13	39	13	(0)	104	23
24	PAINT			2009	594	15	39	15	0	121	24
25	REFRIGERATOR			2009	2,331	60	39	60	(0)	479	25
26											26
27	CUBICLE CURTAINS			2010	4,526	116	39	116	0	812	27
28	WHEELCHAIR RAMP			2010	20,975	538	39	538	(0)	3,765	28
29	MASONRY			2010	11,175	287	39	287	(0)	2,008	29
30	DOORS			2010	1,498	38	39	38	0	267	30
31	DOORS			2010	1,162	30	39	30	(0)	209	31
32	BOILER			2010	7,879	202	39	202	0	1,414	32
33	FREEZER REPAIR			2010	1,400	36	39	36	(0)	252	33
34	CIRCUIT BREAKER REPAIR			2010	850	22	39	22	(0)	153	34
35	PATIO RAILINGS			2010	2,980	76	39	76	0	533	35
36	PY ADDITION			2010	2,100	54	39	54	(0)	378	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 & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 0	$ 4,978	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	60	(0)	359	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	481	(0)	2,885	40
41	Clean Chiller Barrells, Filter, Heat Exhanger	2011	5,871	151	39	151	(0)	905	41
42	Lighting	2011	15,156	389	39	389	(0)	2,333	42
43	Waterproofing North Patio	2011	3,402	87	39	87	0	522	43
44	Waterproofing North Patio	2011	3,402	87	39	87	0	522	44
45	Custom Cabinets	2011	1,628	42	39	42	(0)	251	45
46	Cement	2011	4,100	105	39	105	0	630	46
47									47
48	Cooling Tower	2012	5,068	130	39	130	(0)	650	48
49	New Boiler Burners	2012	5,170	133	39	133	(0)	665	49
50	Patch Basement Hallway Floors/Tiles	2012	2,450	63	39	63	(0)	315	50
51									51
52	Fire Dampers	2013	7,725	198	39	198	0	693	52
53	Ceiling tiles, 2nd floor	2013	94,133	2,414	39	2,414	(0)	8,449	53
54	Build closets, 2nd & 3rd floors	2013	7,450	191	39	191	0	669	54
55	80 ton water cooler	2013	110,843	2,842	39	2,842	0	9,947	55
56	Plumbing for installation of sinks in beauty shop	2013	1,800	46	39	46	0	161	56
57	Santelli Custom Cabinet - Nurse station	2013	13,500	346	39	346	0	1,211	57
58	Closets, Shelving 3rd floor	2013	18,714	480	39	480	(0)	1,680	58
59									59
60	Generator Repairs	2014	2,877	74	39	74	(0)	290	60
61	Install Cove Base in Second Floor Corridor	2014	8,211	211	39	211	(0)	533	61
62	Sprinkler Head Replacement	2014	4,407	113	39	113		305	62
63	Run Pipe to Shut-Off Valve	2014	1,563	40	39	40	0	107	63
64	Install Remote Annunciator	2014	2,758	71	39	71	(0)	192	64
65	Leaking Cooling Tower	2014	28,800	738	39	738	0	2,502	65
66	Hot Water Boiler Leak	2014	3,249	83	39	83	0	239	66
67	Winterize and Clean Tower	2014	2,409	62	39	62	(0)	155	67
68	Install Boiler	2014	8,850	227	39	227	(0)	533	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,368,687	$ 152,658		$ 152,657	$ (1)	$ 789,782	70

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 12A, Carried Forward		$ 2,368,687	$ 152,658		$ 152,657	$ (1)	$ 789,782	1
2	2nd Floor Artwork	2014	4,257	109	39	109	0	218	2
3	Storage Tank Repair	2015	2,941	75	39	75	0	150	3
4	Chiller Maintenance	2015	3,370	86	39	86	0	172	4
5	Wallcoverings in lobby, 2nd Floor Dining Room, Handrails and	2015	45,880	1,176	39	1,176	0	2,352	5
6	Guards, Lights, Cove Base, Tile								6
7	Painted Therapy Room	2015	9,934	255	39	255	(0)	510	7
8	Hot Water Boiler Repair	2015	3,995	102	39	102	0	204	8
9	CC TV System	2015	4,978	128	39	128	(0)	256	9
10	Remodeling / Tiling	2015	2,787	71	39	71	0	142	10
11	3rd Floor - New Flooring, Cove Base, Nurse Station Countertops	2015	147,124	3,772	39	3,772	0	7,544	11
12	Wall Coverings, Drop Ceiling								12
13	Fire Sprinkler Survey	2015	2,880	74	39	74	(0)	148	13
14	Masonry Wall and Concrete Work	2015	13,100	336	39	336	(0)	672	14
15									15
16	Replace faulty booster pump on chiler	2016	3,943	578	39	101	(477)	578	16
17	Exterior awnings	2016	10,615	1,555	39	272	(1,283)	1,555	17
18	Install 20 amp 120v outlet from generator to computer outlet	2016	2,075	304	39	53	(251)	304	18
19	3rd floor dining room labor to complete	2016	1,510	221	39	39	(182)	221	19
20	Replacement of 80 ton chiller	2016	5,000	733	39	128	(605)	733	20
21	conference room shade, 3rd floor cove base	2016	25,203	3,692	39	646	(3,046)	3,692	21
22	Concrete work for stairwell, plat survey and masonary work	2016	8,625	1,264	39	221	(1,043)	1,264	22
23	Repack AC 500 gpm pump and packing glands	2016	6,698	981	39	172	(809)	981	23
24	Basement back door repair	2016	1,723	252	39	44	(208)	252	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)		$ 2,675,324	$ 168,422		$ 160,519	$ (7,903)	$ 811,730	34

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 975,000	$ 47,365	$ 139,286	$ 91,921		$ 668,786	71
72	Current Year Purchases	38,955	16,893	1,975	(14,918)		16,656	72
73	Fully Depreciated Assets	315,070					315,070	73
74								74
75	TOTALS	$ 1,329,025	$ 64,258	$ 141,261	$ 77,003		$ 1,000,512	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)	$ 5,549,349	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 232,680	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 301,780	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 69,100	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,812,242	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 & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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.

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,613	$ 317,954	$	4,613	$ 317,954	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,991	83,232		1,991	83,232	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,452	295,547		4,452	295,547	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				167,333		#REF!	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Xray	39-2					1,956		1,956	12
13	Other (specify): Lab	39-2					4,646		4,646	13
14	TOTAL			$	11,056	$ 696,733	$ 173,935	11,056	$ #REF!	14

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr **#** 0049924 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ (104,406)	$ 171,936	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,442,538	3,442,538	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,365	221,365	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		172,333	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,559,497	$ 4,008,172	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	857,107	857,107	15
16	Equipment, at Historical Cost	354,024	1,329,024	16
17	Accumulated Depreciation (book methods)	(417,671)	(1,812,242)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,791,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,223,252)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	297,700	521,013	22
23	Other(specify):		146,413	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,091,160	$ 7,001,752	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,650,657	$ 11,009,924	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,401,527	$ 2,712,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,337	39,337	28
29	Short-Term Notes Payable		319,686	29
30	Accrued Salaries Payable	150,611	150,611	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,022	17,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		18,342	33
34	Deferred Compensation	495	495	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital Note	349,143		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,958,135	$ 3,258,404	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,345,754	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)**	$	$ 8,345,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,958,135	$ 11,604,158	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,692,522	$ (594,734)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,650,657	$ 11,009,424	48

***(See instructions.)**

Facility Name & ID Number Ambassador Nsg & Rehab Ctr **#** 0049924 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 909,436	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 909,436	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,063,086	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	(280,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Related Party Co. Net Income**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 783,086	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,692,522	24 *

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,743,322	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,743,322	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	914,287	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 914,287	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	34,867	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,376	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,243	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,158	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,158	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc. Revenue	1,379	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,379	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,711,389	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,314,598	31
32	Health Care	4,602,150	32
33	General Administration	2,232,466	33
	B. Capital Expense		
34	Ownership	1,198,551	34
	C. Ancillary Expense		
35	Special Cost Centers	173,935	35
36	Provider Participation Fee	408,256	36
	D. Other Expenses (specify):		
37	Bad Debt Exp	702,317	37
38	Medically Necessary Transportation	16,030	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,648,303	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,063,086	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,063,086	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,997,527	44
45	Private Pay - Net Inpatient Revenue	39,505	45
46	Medicare - Net Inpatient Revenue	552,233	46
47	Other-(specify) net inpatient revenue	1,154,057	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,743,322	49

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

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

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

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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	2,108	2,158	$ 97,052	$ 44.97	1
2	Assistant Director of Nursing	4,468	4,761	159,534	33.51	2
3	Registered Nurses	18,805	20,892	626,641	29.99	3
4	Licensed Practical Nurses	32,060	34,920	903,575	25.88	4
5	CNAs & Orderlies	89,567	97,208	1,277,122	13.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,671	8,678	116,834	13.46	9
10	Activity Assistants					10
11	Social Service Workers	2,945	3,297	60,816	18.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,509	22,060	326,293	14.79	15
16	Dishwashers					16
17	Maintenance Workers	3,346	3,855	74,533	19.33	17
18	Housekeepers	12,601	14,017	180,800	12.90	18
19	Laundry	6,472	7,243	77,825	10.74	19
20	Administrator	2,093	2,154	126,255	58.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,585	18,699	348,496	18.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,061	2,152	31,502	14.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,291	242,094	$ 4,407,278 *	$ 18.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	420	$ 14,710	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,362	47,683	10-3	38
39	Pharmacist Consultant	309	15,435	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1,800	90,000	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	181	6,343	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,072	$ 174,171		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

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aaron Cohen	Administrator		$ 126,255
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,255

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
MTS Consulting	Professional Fee	$ 3,341
Infinity Healthcare Mgmt	Prof./ Mgmt fee	154
Pinnacle Quality Mgmt	Prof./ Mgmt fee	2,369
Various	Mgmt	326,058
Bradley Associates	Accounting	7,818
Johnson& Goldberg	Accounting	2,900
Legal Fees (Capital One)	Accounting	4,985
Infinity Funding	legal	2,499
Lewis, Brisbois, Bisgaard and Smith	legal	6,207
Infinity Funding/ Sedgwick	legal	27,361
Global Recovery	legal	12,198
Various	legal	15,942
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 411,832

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,559
Unemployment Compensation Insurance	23,544
FICA Taxes	352,750
Employee Health Insurance	323,010
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Exp.	136,324
Employee Exp	12,506
Uniform	8,791
Workers Comp Settlement	1,520
Employee Background Check	914
Resident Back Ground Check	510
TOTAL (agree to Schedule V, line 22, col.8)	$ 964,428

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)	
City of Chicago	340
IHCA	7,301
IHCA PAC	515
Home Office Permits	317
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,473

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	1,071
	1,567
Seminar Expense	
Education and Seminars	(352)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,286

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ambassador Nsg & Rehab Ctr # 0049924 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 ($7301)**

(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. $ **58,239** 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. $ **408,256**
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