FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0049924

Facility Name: Ambassador Nsg & Rehab Center, LLC

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2008

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 1/1/18 to 12/31/18 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) Paresh Vipani
(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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	47,501	1,104	4,822	53,427	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,501	1,104	4,822	53,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.04%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 4/8/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/8/08 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 2,389

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	367,376	27,813	11,280	406,469		406,469	(29)	406,440			1
2	Food Purchase		280,427		280,427		280,427	1,524	281,951			2
3	Housekeeping	208,275	31,633		239,908		239,908	16	239,924			3
4	Laundry	77,391	15,303		92,694		92,694		92,694			4
5	Heat and Other Utilities			254,215	254,215		254,215	2,517	256,732			5
6	Maintenance	63,284	19,254	106,755	189,293		189,293	1,380	190,673			6
7	Other (specify):*											7
8	TOTAL General Services	716,326	374,430	372,250	1,463,006		1,463,006	5,408	1,468,414			8
	B. Health Care and Programs											
9	Medical Director			27,500	27,500		27,500		27,500			9
10	Nursing and Medical Records	3,701,153	245,871	55,668	4,002,692		4,002,692	(5,074)	3,997,618			10
10a	Therapy			702,353	702,353		702,353		702,353			10a
11	Activities	143,553	20,280		163,833		163,833	(130)	163,703			11
12	Social Services	111,603		6,820	118,423		118,423		118,423			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			14,805	14,805		14,805	(317)	14,488			15
16	TOTAL Health Care and Programs	3,956,309	266,151	807,146	5,029,606		5,029,606	(5,521)	5,024,085			16
	C. General Administration											
17	Administrative	127,978			127,978		127,978	(5,986)	121,992			17
18	Directors Fees											18
19	Professional Services			578,181	578,181		578,181	(400,039)	178,142			19
20	Dues, Fees, Subscriptions & Promotions			4,783	4,783		4,783	(130)	4,653			20
21	Clerical & General Office Expenses	214,447	66,069	182,961	463,477		463,477	95,868	559,345			21
22	Employee Benefits & Payroll Taxes			963,690	963,690		963,690	33,445	997,135			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,952	8,952		8,952	(1,748)	7,204			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			335,705	335,705		335,705	56,673	392,378			26
27	Other (specify):*											27
28	TOTAL General Administration	342,425	66,069	2,074,272	2,482,766		2,482,766	(221,917)	2,260,849			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,015,060	706,650	3,253,668	8,975,378		8,975,378	(222,030)	8,753,348			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 Center, LLC #0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			62,179	62,179		62,179	214,899	277,078			30
31	Amortization of Pre-Op. & Org.							384,943	384,943			31
32	Interest			(162,406)	(162,406)		(162,406)	352,636	190,230			32
33	Real Estate Taxes			274,740	274,740		274,740		274,740			33
34	Rent-Facility & Grounds			830,385	830,385		830,385	(825,402)	4,983			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			8,262	8,262		8,262		8,262			36
37	**TOTAL Ownership**			1,013,160	1,013,160		1,013,160	127,076	1,140,236			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			32,594	32,594		32,594		32,594			38
39	Ancillary Service Centers		139,027		139,027		139,027	(2,848)	136,179			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			411,386	411,386		411,386		411,386			42
43	Other (specify):*			138,128	138,128		138,128	(138,128)				43
44	**TOTAL Special Cost Centers**		139,027	582,108	721,135		721,135	(140,976)	580,159			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,015,060	845,677	4,848,936	10,709,673		10,709,673	(235,930)	10,473,743			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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	28,248	30		9
10	Interest and Other Investment Income	(21,612)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29)	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	(138,128)	43		24
25	Fund Raising, Advertising and Promotional	(23,516)	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	157,934	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,897		$	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)	(238,827)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (238,827)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (235,930)		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 Center, LLC
ID# 0049924
Report Period Beginning: 1/1/18
Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying	$ (114)	20	1
2	Medical Records Income	(511)	10	2
3	Various Misc Income	(447)	21	3
4	RP Profit	(207)	10	4
5	RP Profit	(317)	15	5
6	RP Profit	(28)	17	6
7	RP Profit	(2,848)	39	7
8	Interest Expense	162,406	32	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**	157,934		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(29)	0	0	0	0	0	0	0	0	0	0	(29)	1
2	Food Purchase	0	1,524	0	0	0	0	0	0	0	0	0	1,524	2
3	Housekeeping	0	16	0	0	0	0	0	0	0	0	0	16	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,517	0	0	0	0	0	0	0	0	0	2,517	5
6	Maintenance	0	1,380	0	0	0	0	0	0	0	0	0	1,380	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29)	5,437	0	0	0	0	0	0	0	0	0	5,408	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	(718)	(4,356)	0	0	0	0	0	0	0	0	0	(5,074)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	(130)	0	0	0	0	0	0	0	0	(130)	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):*	(317)	0	0	0	0	0	0	0	0	0	0	(317)	15
16	**TOTAL Health Care and Programs**	(1,035)	(4,356)	(130)	0	0	0	0	0	0	0	0	(5,521)	16
	C. General Administration													
17	Administrative	(28)	0	(5,958)	0	0	0	0	0	0	0	0	(5,986)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(403,739)	3,700	0	0	0	0	0	0	0	0	(400,039)	19
20	Fees, Subscriptions & Promotions	(114)	(16)	0	0	0	0	0	0	0	0	0	(130)	20
21	Clerical & General Office Expenses	(23,963)	119,703	128	0	0	0	0	0	0	0	0	95,868	21
22	Employee Benefits & Payroll Taxes	0	33,445	0	0	0	0	0	0	0	0	0	33,445	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(1,748)	0	0	0	0	0	0	0	0	0	(1,748)	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	1,343	55,330	0	0	0	0	0	0	0	0	56,673	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,105)	(251,012)	53,200	0	0	0	0	0	0	0	0	(221,917)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,169)	(249,931)	53,070	0	0	0	0	0	0	0	0	(222,030)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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	28,248	0	186,651	0	0	0	0	0	0	0	0	214,899	30
31	Amortization of Pre-Op. & Org.	0	0	384,943	0	0	0	0	0	0	0	0	384,943	31
32	Interest	140,794	0	211,842	0	0	0	0	0	0	0	0	352,636	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(825,402)	0	0	0	0	0	0	0	0	(825,402)	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**	169,042	0	(41,966)	0	0	0	0	0	0	0	0	127,076	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,848)	0	0	0	0	0	0	0	0	0	0	(2,848)	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):*	(138,128)	0	0	0	0	0	0	0	0	0	0	(138,128)	43
44	**TOTAL Special Cost Centers**	(140,976)	0	0	0	0	0	0	0	0	0	0	(140,976)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,897	(249,931)	11,104	0	0	0	0	0	0	0	0	(235,930)	45

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 & Rehab Center	Chicago	Ambassador Realty, LLC		Realty Co.
A& F Realty	5.00	City View Nursing & Rehab Center	Cierro			
B & N Investments	20.00	Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab 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	$	Infinity Healthcare Management		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management		1,524	1,524	2
3	V	3	Housekeeping		Infinity Healthcare Management		16	16	3
4	V	5	Utilities		Infinity Healthcare Management		2,517	2,517	4
5	V	6	Maintenance		Infinity Healthcare Management		1,380	1,380	5
6	V	10	Nursing	51,120	Infinity Healthcare Management		46,764	(4,356)	6
7	V	19	Professional Fees	405,873	Infinity Healthcare Management		2,134	(403,739)	7
8	V	20	Dues, Fees, Subs, & Promotions	164	Infinity Healthcare Management		148	(16)	8
9	V	21	Office Expense	141,207	Infinity Healthcare Management		260,910	119,703	9
10	V	22	Employee Benefits	6,272	Infinity Healthcare Management		39,717	33,445	10
11	V	24	Travel & Seminar	6,472	Infinity Healthcare Management		4,724	(1,748)	11
12	V	26	Insurance		Infinity Healthcare Management		1,343	1,343	12
13	V	30	Depreciation		Infinity Healthcare Management				13
14	Total			$ 611,108			$ 361,177	$ * (249,931)	14

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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	32	Interest	$	Infinity Healthcare Management		$ 4,354	$ 4,354	15
16	V	34	Rent		Infinity Healthcare Management		4,983	4,983	16
17	V	17	Administration	5,958	Infinity Healthcare Management			(5,958)	17
18	V	11	Activities	130	Infinity Healthcare Management			(130)	18
19	V	19	Professional Services		Ambassador Realty, LLC		3,700	3,700	19
20	V	21	Office Expense		Ambassador Realty, LLC		128	128	20
21	V	26	Insurance		Ambassador Realty, LLC		55,330	55,330	21
22	V	30	Depreciation		Ambassador Realty, LLC		186,651	186,651	22
23	V	31	Amortization		Ambassador Realty, LLC		384,943	384,943	23
24	V	32	Interest		Ambassador Realty, LLC		207,488	207,488	24
25	V	34	Rent	830,385	Ambassador Realty, LLC			(830,385)	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			$ 836,473			$ 847,577	$ * 11,104	39

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			Landmark of Des Plaines	Des Plaines				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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 8,017,854	9/28/42	2.5400	$ 211,842	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,674.00		$ 9,913,500	$ 8,017,854			$ 211,842	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,913,500	$ 8,017,854			$ 211,842	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 43,773 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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	253,982	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.)	$	298,465	2
3. Under or (over) accrual (line 2 minus line 1).	$	44,483	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	230,257	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.	$	274,740	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	240,956	8
2014	245,813	9
2015	254,113	10
2016	277,710	11
2017	298,465	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nsg & Rehab Center, LLC 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-021-0000	Nursing Home	$ 26,121.38	$ 26,121.38
2.	13-11-418-022-0000	Nursing Home	$ 96,117.26	$ 96,117.26
3.	13-11-418-026-0000	Nursing Home	$ 122,132.65	$ 122,132.65
4.	13-11-418-028-0000	Nursing Home	$ 47,495.66	$ 47,495.66
5.	13-11-418-033-0000	Nursing Home	$ 6,598.03	$ 6,598.03
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 298,464.98	$ 298,464.98

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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).

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: 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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 47,365	$ (91,921)	$ 1,004,367	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARINGS			2008	1,148	29	39	29	0	321	9
10	PATIO			2008	950	24	39	24	0	266	10
11	PATIO			2008	63	2	39	2	(0)	20	11
12	PUMP			2008	796	20	39	20	0	222	12
13	PATIO			2008	650	17	39	17	(0)	185	13
14	DIGITAL TV SYSTEM			2008	15,000	385	39	385	(0)	4,114	14
15											15
16	CURTAINS AND LIGHTS			2009	1,165	30	39	30	(0)	270	16
17	DOORS			2009	1,210	31	39	31	0	311	17
18	WARDROBES			2009	8,125	208	39	208	0	2,089	18
19	BEDSPREADS, CURTAINS, WARDROBES			2009	16,147	414	39	414	0	4,157	19
20	PHONE WIRING			2009	3,000	77	39	77	(0)	773	20
21	PHONE CONTROL CABINET			2009	2,200	56	39	56	0	564	21
22	COMPUTER WIRING			2009	680	17	39	17	0	173	22
23	PAINT			2009	504	13	39	13	(0)	130	23
24	PAINT			2009	594	15	39	15	0	152	24
25	REFRIGERATOR			2009	2,331	60	39	60	(0)	601	25
26											26
27	CUBICLE CURTAINS			2010	4,526	116	39	116	0	1,044	27
28	WHEELCHAIR RAMP			2010	20,975	538	39	538	(0)	4,841	28
29	MASONRY			2010	11,175	287	39	287	(0)	2,582	29
30	DOORS			2010	1,498	38	39	38	0	343	30
31	DOORS			2010	1,162	30	39	30	(0)	269	31
32	BOILER			2010	7,879	202	39	202	0	1,818	32
33	FREEZER REPAIR			2010	1,400	36	39	36	(0)	324	33
34	CIRCUIT BREAKER REPAIR			2010	850	22	39	22	(0)	197	34
35	PATIO RAILINGS			2010	2,980	76	39	76	0	685	35
36				2010	2,100	54	39	54	(0)	486	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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 6,400	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	60	(0)	479	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	481	(0)	3,846	40
41	Clean Chiller Barrells, Filter, Heat Exhanger	2011	5,871	151	39	151	(0)	1,207	41
42	Lighting	2011	15,156	389	39	389	(0)	3,111	42
43	Waterproofing North Patio	2011	3,402	87	39	87	0	696	43
44	Waterproofing North Patio	2011	3,402	87	39	87	0	696	44
45	Custom Cabinets	2011	1,628	42	39	42	(0)	335	45
46	Cement	2011	4,100	105	39	105	0	840	46
47									47
48	Cooling Tower	2012	5,068	130	39	130	(0)	907	48
49	New Boiler Burners	2012	5,170	133	39	133	(0)	927	49
50	Patch Basement Hallway Floors/Tiles	2012	2,450	63	39	63	(0)	440	50
51									51
52	Fire Dampers	2013	7,725	198	39	198	0	1,089	52
53	Ceiling tiles, 2nd floor	2013	94,133	2,414	39	2,414	(0)	13,277	53
54	Build closets, 2nd & 3rd floors	2013	7,450	191	39	191	0	1,051	54
55	80 ton water cooler	2013	110,843	2,842	39	2,842	0	15,631	55
56	Plumbing for installation of sinks in beauty shop	2013	1,800	46	39	46	0	253	56
57	Santelli Custom Cabinet - Nurse station	2013	13,500	346	39	346	0	1,903	57
58	Closets, Shelving 3rd floor	2013	18,714	480	39	480	(0)	2,640	58
59									59
60	Generator Repairs	2014	2,877	74	39	74	(0)	438	60
61	Install Cove Base in Second Floor Corridor	2014	8,211	211	39	211	(0)	955	61
62	Sprinkler Head Replacement	2014	4,407	113	39	113		531	62
63	Run Pipe to Shut-Off Valve	2014	1,563	40	39	40	0	187	63
64	Install Remote Annunciator	2014	2,758	71	39	71	(0)	334	64
65	Leaking Cooling Tower	2014	28,800	738	39	738	0	3,978	65
66	Hot Water Boiler Leak	2014	3,249	83	39	83	0	405	66
67	Winterize and Clean Tower	2014	2,409	62	39	62	(0)	279	67
68	Install Boiler	2014	8,850	227	39	227	(0)	987	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,368,687	$ 152,658		$ 60,736	$ (91,922)	$ 1,095,126	70

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$ 60,736	$ (91,922)	$ 1,095,126	1
2	2nd Floor Artwork	2014	4,257	109	39	109	0	436	2
3	Storage Tank Repair	2015	2,941	75	39	75	0	300	3
4	Chiller Maintenance	2015	3,370	86	39	86	0	344	4
5	Wallcoverings in lobby, 2nd Floor Dining Room, Handrails and	2015	45,880	1,176	39	1,176	0	4,704	5
6	Guards, Lights, Cove Base, Tile								6
7	Painted Therapy Room	2015	9,934	255	39	255	(0)	1,020	7
8	Hot Water Boiler Repair	2015	3,995	102	39	102	0	408	8
9	CC TV System	2015	4,978	128	39	128	(0)	512	9
10	Remodeling / Tiling	2015	2,787	71	39	71	0	284	10
11	3rd Floor - New Flooring, Cove Base, Nurse Station Countertops	2015	147,124	3,772	39	3,772	0	15,096	11
12	Wall Coverings, Drop Ceiling								12
13	Fire Sprinkler Survey	2015	2,880	74	39	74	(0)	296	13
14	Masonry Wall and Concrete Work	2015	13,100	336	39	336	(0)	1,344	14
15									15
16	Replace faulty booster pump on chiler	2016	3,943		39	101	101	578	16
17	Exterior awnings	2016	10,615		39	272	272	1,555	17
18	Install 20 amp 120v outlet from generator to computer outlet	2016	2,075		39	53	53	304	18
19	3rd floor dining room labor to complete	2016	1,510		39	39	39	221	19
20	Replacement of 80 ton chiller	2016	5,000		39	128	128	733	20
21	conference room shade, 3rd floor cove base	2016	25,203		39	646	646	3,692	21
22	Concrete work for stairwell, plat survey and masonary work	2016	8,625		39	221	221	1,264	22
23	Repack AC 500 gpm pump and packing glands	2016	6,698		39	172	172	981	23
24	Basement back door repair	2016	1,723		39	44	44	252	24
25									25
26	Repair and paint - Rms 201-211, kitchen ceiling,	2017	13,916	357	39	357	(0)	535	26
27	1st Floor Admissions Office, Shower Rooms,								27
28	Bathrooms & Janitor Closets on 1st, 2nd, 3rd Floors								28
29									29
30									30
31	Labor & Materials to fix Pipes in Basement & Laundry Room	2017	1,800	46	39	46	0	69	31
32	Eight New Exhaust Fans	2017	6,045	155	39	155		232	32
33	Hot Water Boilers	2017	26,800	687	39	687	0	1,030	33
34	TOTAL (lines 1 thru 33)		$ 2,723,885	$ 160,087		$ 69,843	$ (90,244)	$ 1,131,316	34

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,723,885	$ 160,087		$ 69,843	$ (90,244)	$ 1,131,316	1
2	90 New Closet Doors	2017	9,322	239	39	239	0	358	2
3	Wall Repairs to 1st & 2nd Floor Shower Rooms	2017	2,573	66	39	66	(0)	99	3
4	New Carpet in Administrator Office room, Conference Room & R	2017	3,946	101	39	101	0	152	4
5	New Doors for Kitchen	2017	5,953	153	39	153	(0)	229	5
6	Hot Water Energy Management Controller	2017	2,450	63	39	63	(0)	94	6
7									7
8	Walk-In Cooler	2018	7,985	102	39	205	103	102	8
9	Closet Doors	2018	4,088	52	39	105	53	52	9
10	Paint Kitchen Ceiling	2018	2,400	31	39	62	31	31	10
11	Patch & Paint 2nd Floor Rms; Patch & Paint 1st Floor Office	2018	3,842	49	39	99	50	49	11
12	New Generator	2018	3,198	41	39	82	41	41	12
13	Patch & Paint 1st-3rd Flr Shower Rms, Laura's Office & Kitchen	2018	3,865	50	39	99	49	50	13
14	New Wiring & Cabling for Computers	2018	6,013	77	39	154	77	77	14
15	Cold Water Back Flow for Janitor Closet & Hot Water	2018	4,740	61	39	122	61	61	15
16	Back Flow for Dish Washer								16
17	Hallway Video Camera	2018	5,518	71	39	141	70	71	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,789,778	$ 161,243		$ 71,533	$ (89,710)	$ 1,132,782	34

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,014,176	$ 74,038	$ 202,835	$ 128,797	5	$ 833,515	71
72	Current Year Purchases	13,548	13,548	2,710	(10,838)	5	13,548	72
73	Fully Depreciated Assets	342,722				5	342,722	73
74								74
75	TOTALS	$ 1,370,446	$ 87,586	$ 205,545	$ 117,959		$ 1,189,785	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)	$ 5,705,224	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 248,829	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 277,078	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 28,248	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,322,567	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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.

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	$	4,618	$ 296,703	$	4,618	$ 296,703	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,100	105,118		2,100	105,118	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,338	300,532		4,338	300,532	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				133,516		133,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					2,444		2,444	12
13	Other (specify): Lab	39-2					3,067		3,067	13
14	TOTAL			$	11,056	$ 702,353	$ 139,027	11,056	$ 841,380	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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ (94,083)	$ 255,002	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,567,275	2,567,275	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	226,010	226,010	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	678,724	794,401	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,377,926	$ 3,842,688	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	942,540	942,540	15
16	Equipment, at Historical Cost	395,446	1,370,446	16
17	Accumulated Depreciation (book methods)	(554,663)	(2,322,535)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	17,301	5,791,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,993,138)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	308,000	643,536	22
23	Other(specify):		146,413	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,108,624	$ 5,970,951	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,486,550	$ 9,813,639	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,004,482	$ 2,511,057	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,787	37,787	28
29	Short-Term Notes Payable		336,327	29
30	Accrued Salaries Payable	213,549	213,549	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,702	21,702	31
32	Accrued Real Estate Taxes(Sch.IX-B)	681,957	681,958	32
33	Accrued Interest Payable		16,971	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	(2,224,791)	(2,224,791)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 734,686	$ 1,594,560	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,681,527	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)**	$	$ 7,681,527	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 734,686	$ 9,276,087	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,751,864	$ 537,552	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,486,550	$ 9,813,639	48

***(See instructions.)**

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,817,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,817,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	942,752	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	(8,083)	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)**	$ 934,669	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)**	$ 3,751,864	24 *

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

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 10,250,277	1
2	Discounts and Allowances for all Levels	775,378	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,025,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	482,685	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 482,685	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	45,247	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,043	19
20	Radiology and X-Ray	1,495	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 48,785	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,857	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,857	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Misc Revenue	74,443	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 74,443	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,652,425	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,463,006	31
32	Health Care	5,029,607	32
33	General Administration	2,482,765	33
	B. Capital Expense		
34	Ownership	1,013,160	34
	C. Ancillary Expense		
35	Special Cost Centers	139,027	35
36	Provider Participation Fee	411,386	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	138,128	37
38	Medically Necessary Transportation	32,594	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,709,673	40
41	**Income before Income Taxes (line 30 minus line 40)****	942,752	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 942,752	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,973,269	44
45	Private Pay - Net Inpatient Revenue	234,685	45
46	Medicare - Net Inpatient Revenue	1,266,641	46
47	Other-(specify) Net Patient Revenue	551,060	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,025,655	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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,531	1,735	$ 93,199	$ 53.72	1
2	Assistant Director of Nursing	4,555	4,887	181,696	37.18	2
3	Registered Nurses	22,490	24,194	859,552	35.53	3
4	Licensed Practical Nurses	30,907	34,165	1,043,136	30.53	4
5	CNAs & Orderlies	72,175	78,861	1,479,639	18.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,905	9,741	143,553	14.74	9
10	Activity Assistants					10
11	Social Service Workers	4,997	5,267	111,603	21.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,737	23,199	367,375	15.84	15
16	Dishwashers					16
17	Maintenance Workers	2,954	3,134	63,284	20.19	17
18	Housekeepers	12,957	14,332	208,275	14.53	18
19	Laundry	5,573	6,215	77,391	12.45	19
20	Administrator	1,896	2,107	127,978	60.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,743	11,645	214,447	18.42	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	2,159	2,269	35,234	15.53	31
32	Other Health Care(specify)					32
33	Other(specify)	253	296	8,698	29.39	33
34	TOTAL (lines 1 - 33)	202,832	222,047	$ 5,015,060 *	$ 22.59	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	240	$ 11,280	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,591	55,668	10-3	38
39	Pharmacist Consultant	296	14,805	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	93	5,780	12-3	45
46	Other(specify) Marketing Consul	19	946	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,239	$ 88,479		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 Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Elkes	Administrator		$ 91,483
Raphael Nudell	Administrator		36,495
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,978

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
Cook County	Legal	$ 348
Valee Salone	Legal	1,375
Infinity Funding/Sedgwick	Legal	99,243
Bradley Associates	Accounting	12,000
Infinity Healthcare	Professional	14,664
Professional Search Network	Professional	17,250
MTS Consulting	Consulting	(3,460)
Empire Risk	Mgmt	46,480
Infinity Healthcare	Mgmt	390,281
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 578,181

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 124,157
Unemployment Compensation Insurance	27,612
FICA Taxes	376,969
Employee Health Insurance	286,002
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	132,684
Uniforms	2,364
Background Checks	248
Employee Expense	13,655
Other Employee Benefits	33,444
TOTAL (agree to Schedule V, line 22, col.8)	$ 997,135

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

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	
IDPH License	1,161
IHCA	1,573
Illinois Dept of Public Health	650
Healthcare Urgency Group	950
Other Licenses and Dues	319
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,653

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	6,974
Seminar Expense	
Education and Seminars	230
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,204

**See instructions.

Facility Name & ID Number Ambassador Nsg & Rehab Center, LLC # 0049924 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Health Care Association $1,573**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(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. $ **71,700** 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. $ **411,386**
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