

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0049924</u> Facility Name: <u>Ambassador Nsg Rehab Center</u> Address: <u>4900 N Bernard</u> <u>Chicago</u> <u>60625</u> Number City Zip Code County: <u>Cook</u> Telephone Number: <u>708-449-1900</u> Fax # <u>708-449-1500</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>4/1/2008</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td></td></tr></table> IRS Exemption Code _____ In the event there are further questions about this report, please contact: Name: <u>Aaron Mauer</u> Telephone Number: <u>773-747-4506</u> Email Address: _____	☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐		☐	Corporation	☐	Other _____	☐		☒	"Sub-S" Corp.	☐		☐		☐	Limited Liability Co.	☐		☐		☐	Trust	☐		☐		☐	Other _____	☐		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Paresh Vipani</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) <u>3/5/2021</u></td></tr><tr><td>(Print Name and Title) <u>Aaron Mauer</u> <u>President</u></td></tr><tr><td>(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimitz Parkway South Bend IN 46628</u></td></tr><tr><td>(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u></td></tr></table> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Paresh Vipani</u>	(Title) <u>CFO</u>	Paid Preparer	(Signed) _____	(Date) <u>3/5/2021</u>	(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>	(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimitz Parkway South Bend IN 46628</u>	(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>
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#	0049924	Report Period Beginning:	1/1/20	Ending:	12/31/20
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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)

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/8/08

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/8/08 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 190 and days of care provided

Medicare Intermediary Wisconsin Physician Service**MODIFIED**

ACCRUAL	X
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CASH*	
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CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/20 **Fiscal Year:** 12/31/20

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	46,207	433	6,808	53,448	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,207	433	6,808	53,448	14

77.07%

Facility Name & ID Number Ambassador Nsg Rehab Center # 0049924 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	460,827	31,644	12,300	504,771		504,771	(12)	504,759			1
2	Food Purchase		306,370		306,370		306,370		306,370			2
3	Housekeeping	379,515	47,992		427,507		427,507		427,507			3
4	Laundry	99,478	25,786		125,264		125,264		125,264			4
5	Heat and Other Utilities			246,516	246,516		246,516	1,317	247,833			5
6	Maintenance	85,752	36,985	114,047	236,784		236,784	1,038	237,822			6
7	Other (specify):*											7
8	TOTAL General Services	1,025,572	448,777	372,863	1,847,212		1,847,212	2,343	1,849,555			8
	B. Health Care and Programs											
9	Medical Director			30,100	30,100		30,100		30,100			9
10	Nursing and Medical Records	4,939,569	390,974	56,553	5,387,096		5,387,096	7,125	5,394,221			10
10a	Therapy			801,302	801,302		801,302		801,302			10a
11	Activities	181,774	29,013		210,787		210,787		210,787			11
12	Social Services	59,101		4,994	64,095		64,095		64,095			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			15,804	15,804		15,804	(348)	15,456			15
16	TOTAL Health Care and Programs	5,180,444	419,987	908,753	6,509,184		6,509,184	6,777	6,515,961			16
	C. General Administration											
17	Administrative	54,078		1,991	56,069		56,069	61,536	117,605			17
18	Directors Fees											18
19	Professional Services			731,828	731,828		731,828	27,719	759,547			19
20	Dues, Fees, Subscriptions & Promotions			2,148	2,148		2,148	160	2,308			20
21	Clerical & General Office Expenses	245,752	70,498	591,178	907,428		907,428	14,861	922,289			21
22	Employee Benefits & Payroll Taxes			1,100,384	1,100,384		1,100,384	44,949	1,145,333			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,258	19,258		19,258	11,168	30,426			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			971,629	971,629		971,629	41,430	1,013,059			26
27	Other (specify):*											27
28	TOTAL General Administration	299,830	70,498	3,418,416	3,788,744		3,788,744	201,823	3,990,567			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,505,846	939,262	4,700,032	12,145,140		12,145,140	210,943	12,356,083			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			85,019	85,019		85,019	308,307	393,326			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638	384,943	398,581			31
32	Interest			(24,190)	(24,190)		(24,190)	186,897	162,707			32
33	Real Estate Taxes			391,309	391,309		391,309		391,309			33
34	Rent-Facility & Grounds			887,008	887,008		887,008	(881,568)	5,440			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement tax			4,108	4,108		4,108	(4,108)				36
37	TOTAL Ownership			1,356,892	1,356,892		1,356,892	(5,529)	1,351,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			74,159	74,159		74,159		74,159			38
39	Ancillary Service Centers		253,453		253,453		253,453	(4,728)	248,725			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,168	396,168		396,168		396,168			42
43	Other (specify):* Bad Debt			233,309	233,309		233,309	(233,309)				43
44	TOTAL Special Cost Centers		253,453	703,636	957,089		957,089	(238,037)	719,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,505,846	1,192,715	6,760,560	14,459,121		14,459,121	(32,622)	14,426,499			45

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

VI. ADJUSTMENT DETAIL

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

	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	121,585	30		9
10	Interest and Other Investment Income	(9,477)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions	(1,900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(233,309)	43		24
25	Fund Raising, Advertising and Promotional	(22,604)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,108)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,425)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,680)		\$	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	126,058	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 126,058		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (32,622)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	RP Profit	\$ (212)	10	1
2	RP Profit	(348)	15	2
3	RP Profit	(4,728)	39	3
4	Misc Income - Med Records	(864)	5	4
5	Misc Income - Rebates	(1,273)	10	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
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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	(7,425)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nsg Rehab Center # 0049924 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(12)	0	0	0	0	0	0	0	0	0	0	(12)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(864)	2,181	0	0	0	0	0	0	0	0	0	1,317	5
6	Maintenance	0	1,038	0	0	0	0	0	0	0	0	0	1,038	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(876)	3,219	0	0	0	0	0	0	0	0	0	2,343	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,485)	8,610	0	0	0	0	0	0	0	0	0	7,125	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(348)	0	0	0	0	0	0	0	0	0	0	(348)	15
16	TOTAL Health Care and Programs	(1,833)	8,610	0	0	0	0	0	0	0	0	0	6,777	16
	C. General Administration													
17	Administrative	0	61,536	0	0	0	0	0	0	0	0	0	61,536	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,358	6,361	0	0	0	0	0	0	0	0	27,719	19
20	Fees, Subscriptions & Promotions	0	160	0	0	0	0	0	0	0	0	0	160	20
21	Clerical & General Office Expenses	(25,934)	40,795	0	0	0	0	0	0	0	0	0	14,861	21
22	Employee Benefits & Payroll Taxes	0	44,949	0	0	0	0	0	0	0	0	0	44,949	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,168	0	0	0	0	0	0	0	0	0	11,168	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	2,386	39,044	0	0	0	0	0	0	0	0	41,430	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25,934)	182,352	45,405	0	0	0	0	0	0	0	0	201,823	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(28,643)	194,181	45,405	0	0	0	0	0	0	0	0	210,943	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ambassador Nsg Rehab Center # 0049924 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	121,585	71	186,651	0	0	0	0	0	0	0	0	308,307	30
31	Amortization of Pre-Op. & Org.	0	0	384,943	0	0	0	0	0	0	0	0	384,943	31
32	Interest	(9,477)	5,991	190,383	0	0	0	0	0	0	0	0	186,897	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,440	(887,008)	0	0	0	0	0	0	0	0	(881,568)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(4,108)	0	0	0	0	0	0	0	0	0	0	(4,108)	36
37	TOTAL Ownership	108,000	11,502	(125,031)	0	0	0	0	0	0	0	0	(5,529)	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	(4,728)	0	0	0	0	0	0	0	0	0	0	(4,728)	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):*	(233,309)	0	0	0	0	0	0	0	0	0	0	(233,309)	43
44	TOTAL Special Cost Centers	(238,037)	0	0	0	0	0	0	0	0	0	0	(238,037)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(158,680)	205,684	(79,626)	0	0	0	0	0	0	0	0	(32,622)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	37.50	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	37.50	Belhaven Nursing & Rehab Center	Chicago	Ambassador Realty, LLC		Realty Co.
A & F Realty LLC	5.00	City View Nursing & Rehab Center	Cicero	United Rx		Pharmacy Co.
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.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$ 69	Infinity Healthcare Management of IL LLC		\$ 2,250	\$ 2,181	1
2	V	6	Maintenance	243	Infinity Healthcare Management of IL LLC		1,281	1,038	2
3	V	10	Nursing and Medical Records	57,102	Infinity Healthcare Management of IL LLC		65,712	8,610	3
4	V	17	Administrative	754	Infinity Healthcare Management of IL LLC		62,290	61,536	4
5	V	19	Professional Services	647,952	Infinity Healthcare Management of IL LLC		669,310	21,358	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		160	160	6
7	V	21	Clerical & General Office Expenses	189,000	Infinity Healthcare Management of IL LLC		229,795	40,795	7
8	V	22	Employee Benefits & Payroll Taxes		Infinity Healthcare Management of IL LLC		44,949	44,949	8
9	V	24	Travel and Seminar	4,260	Infinity Healthcare Management of IL LLC		15,428	11,168	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		2,386	2,386	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		71	71	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		5,991	5,991	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		5,440	5,440	13
14	Total			\$ 899,380			\$ 1,105,064	\$ * 205,684	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	\$ 887,008	Ambassador Realty, LLC		\$	(887,008)	15
16	V	31	Amortization		Ambassador Realty, LLC		384,943	384,943	16
17	V	30	Depreciation		Ambassador Realty, LLC		186,651	186,651	17
18	V	19	Professional Services		Ambassador Realty, LLC		6,361	6,361	18
19	V	26	Insurance		Ambassador Realty, LLC		39,044	39,044	19
20	V	32	Interest		Ambassador Realty, LLC		190,383	190,383	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 887,008			\$ 807,382	\$ * (79,626)	39

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

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 Nrusing & 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	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 12/31/20

Name of Related Organization

Fax Number

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

	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage	\$44,674.00	9/28/12	\$ 9,913,500	\$ 7,336,557	9/28/42	2.5400	\$ 191,113	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Infinity H Funding	X		Working Capital	None	Various	Various	Various	None	Various	1,505	6
7												7
8												8
9	TOTAL Facility Related				\$44,674.00		\$ 9,913,500	\$ 7,336,557			\$ 192,618	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	\$ 7,336,557			\$ 192,618	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,044 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 Ambassador Nsg Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049924

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,497

B. General Construction Type: Exterior BrickFrame Concrete/SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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?

☒ 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:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	190		2008		\$ 1,847,237	\$ 139,286	39	\$ 139,286	\$	\$ 1,282,939
5										
6										
7										
8										
	Improvement Type**									
9	BEARINGS		2008		1,148	29	39	29		380
10	PATIO		2008		950	24	39	24		315
11	PATIO		2008		63	2	39	2		23
12	PUMP		2008		796	20	39	20		263
13	PATIO		2008		650	17	39	17		218
14	DIGITAL TV SYSTEM		2008		15,000	385	39	385		4,883
15										
16	CURTAINS AND LIGHTS		2009		1,165	30	39	30		329
17	DOORS		2009		1,210	31	39	31		372
18	WARDROBES		2009		8,125	208	39	208		2,498
19	BEDSPREADS, CURTAINS, WARDROBES		2009		16,147	414	39	414		5,003
20	PHONE WIRING		2009		3,000	77	39	77		924
21	PHONE CONTROL CABINET		2009		2,200	56	39	56		675
22	COMPUTER WIRING		2009		680	17	39	17		207
23	PAINT		2009		504	13	39	13		156
24	PAINT		2009		594	15	39	15		182
25	REFRIGERATOR		2009		2,331	60	39	60		718
26										
27	CUBICLE CURTAINS		2010		4,526	116	39	116		1,276
28	WHEELCHAIR RAMP		2010		20,975	538	39	538		5,916
29	MASONRY		2010		11,175	287	39	287		3,155
30	DOORS		2010		1,498	38	39	38		420
31	DOORS		2010		1,162	30	39	30		328
32	BOILER		2010		7,879	202	39	202		2,222
33	FREEZER REPAIR		2010		1,400	36	39	36		396
34	CIRCUIT BREAKER REPAIR		2010		850	22	39	22		240
35	PATIO RAILINGS		2010		2,980	76	39	76		838
36					2,100	54	39	54		594

*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

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Replacement Pavement	2010	\$ 27,735	\$ 711	39	\$ 711	\$	\$ 7,822	37
38									38
39	Sprinkler Heads	2011	2,325	60	39	60		598	39
40	Domestic Storage Tank Replacement	2011	18,745	481	39	481		4,808	40
41	Clean Chiller Barralls, Filter, Heat Exchanger	2011	5,871	151	39	151		1,508	41
42	Lighting	2011	15,156	389	39	389		3,888	42
43	Waterproofing North Patio	2011	3,402	87	39	87		871	43
44	Waterproofing North Patio	2011	3,402	87	39	87		871	44
45	Custom Cabinets	2011	1,628	42	39	42		418	45
46	Cement	2011	4,100	105	39	105		1,060	46
47									47
48	Cooling Tower	2012	5,068	130	39	130		1,170	48
49	New Boiler Burners	2012	5,170	133	39	133		1,196	49
50	Patch Basement Hallway Floors/Tiles	2012	2,450	63	39	63		566	50
51									51
52	Fire Dampers	2013	7,725	198	39	198		1,485	52
53	Ceiling tiles, 2nd Floor	2013	94,133	2,414	39	2,414		18,104	53
54	Build Closets, 2nd & 3rd Floors	2013	7,450	191	39	191		1,433	54
55	80 ton water cooler	2013	110,843	2,842	39	2,842		21,315	55
56	Plumbing for instillation of sinks in beauty shop	2013	1,800	46	39	46		345	56
57	Santelli Custom Cabinet - Nursing Station	2013	13,500	346	39	346		2,595	57
58	Closets, Shelving 3rd Floor	2013	18,714	480	39	480		3,600	58
59									59
60	Generator Repairs	2014	2,877	74	39	74		585	60
61	Install Cove Base in 2nd floor corridor	2014	8,211	211	39	211		1,376	61
62	Sprinkler Head Replacement	2014	4,407	113	39	113		757	62
63	Run Pipe to Shut off Valve	2014	1,563	40	39	40		267	63
64	Install Remote Annunciator	2014	2,758	71	39	71		475	64
65	Leaking Cooling Tower	2014	28,800	738	39	738		5,455	65
66	Hot Water Boiler Leak	2014	3,249	83	39	83		572	66
67	Winterize and Clean Tower	2014	2,409	62	39	62		402	67
68	Install Boiler	2014	8,850	227	39	227		1,441	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,368,686	\$ 152,656		\$ 152,656	\$	\$ 1,400,453	70

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

Facility Name & ID Number Ambassador Nsg Rehab Center

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,368,686	\$ 152,656		\$ 152,656		\$ 1,400,453	1
2	2nd Floor Artwork	2014	4,257	109	39	109		654	2
3	Storage Tank Repair	2015	2,941	75	39	75		451	3
4	Chiller Maintenance	2015	3,370	86	39	86		517	4
5	Wallcovering in lobby, 2nd Floor Dinning Room, Handrails and	2015	45,880	1,176	39	1,176		72,057	5
6	Guards, Lights, Cover Base, Tile								6
7	Painting Therapy Room	2015	9,934	255	39	255		1,529	7
8	Hot Water Boiler Repair	2015	3,995	102	39	102		613	8
9	CC TV System	2015	4,978	128	39	128		767	9
10	Remodeling / Tiling	2015	2,787	71	39	71		427	10
11	3rd Floor - New Flooring, Cove Base, Nurse Station Countertops	2015	147,124	3,772	39	3,772		22,633	11
12	Wall Coverings, Drop Ceiling								12
13	Fire Sprinkler Survey	2015	2,880	74	39	74		444	13
14	Masonry Wall and Concrete Work	2015	13,100	336	39	336		2,016	14
15									15
16	Replace faulty booster pump on chiler	2016	3,943	101	39	101		1,213	16
17	Exterior awnings	2016	10,615	272	39	272		3,266	17
18	Install 20 amp 120v outlet from generator to computer outlet	2016	2,075	53	39	53		638	18
19	3rd Floor dining room labor complete	2016	1,510	39	39	39		465	19
20	Replacement of 80 ton chiller	2016	5,000	128	39	128		1,538	20
21	Conference room shade, 3rd floor cove base	2016	25,203	646	39	646		7,755	21
22	Concrete work for stairwell, plat survey and masonry work	2016	8,625	221	39	221		2,654	22
23	Repack AC 500 gpm pump and packing glands	2016	6,698	172	39	172		2,061	23
24	Basement back door repair	2016	1,723	44	39	44		530	24
25									25
26	Repair and paint - Rms 201-211, kitchen ceiling	2017	13,916	357	39	357		1,249	26
27	1st Floor Admissions Office, Shower Rooms,								27
28	Bathrooms & Janitor Closets on 1st, 2nd, 3rd Floors								28
29									29
30	Labor & Materials to fix Pipes in Basement & Laundry Room	2017	1,800	46	39	46		161	30
31	Eight New Exhaust Fans	2017	6,045	155	39	155		542	31
32	Hot Water Boilers	2017	26,800	687	39	687		2,405	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,723,885	\$ 161,764		\$ 161,764		\$ 1,527,038	34

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

Facility Name & ID Number Ambassador Nsg Rehab Center

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,723,885	\$ 161,764		\$ 161,764	\$	\$ 1,527,038	1
2	90 New Closet Doors	2017	9,322	239	39	239		836	2
3	Wall Repairs to 1st & 2nd Floor Shower Rooms	2017	2,573	66	39	66		231	3
4	New Carpet in Adminstrator Office room, Conference Room & Re	2017	3,946	101	39	101		355	4
5	New Doors for Kitchen	2017	5,953	153	39	153		534	5
6	Hot Water Energy Management Controller	2017	2,450	63	39	63		219	6
7									7
8	Walk-in Cooler	2018	7,985	205	39	205		512	8
9	Closet Doors	2018	4,088	105	39	105		262	9
10	Paint Kitchen Ceiling	2018	2,400	62	39	62		154	10
11	Patch & Paint 2nd Floor Rms, Patch & Paint 1st Floor Office	2018	3,842	99	39	99		246	11
12	New Generator	2018	3,198	82	39	82		205	12
13	Patch & Paint 1st-3rd Flr Shower Rms, Laura's Office & Kitchen	2018	3,865	99	39	99		248	13
14	New Wiring & Cabling for Computers	2018	6,013	154	39	154		385	14
15	Cold Water Back Flow for Janitor Closet & Hot Water	2018	4,740	122	39	122		183	15
16	Back Flow for Dish Washer								16
17	Hallway Video Camera	2018	5,518	141	39	141		354	17
18									18
19	Rebuild Parking Lot Catch Basin	2019	5,900	151	39	151		227	19
20	New Traps for Plumbing Basin	2019	2,200	56	39	56		85	20
21	Solar Shades for 2nd Floor	2019	8,371	215	39	215		322	21
22	New Kitchen Exhaust Fan	2019	1,470	38	39	38		57	22
23	Replace Left Hand Boiler Ignition Module	2019	864	22	39	22		33	23
24	Repairs to Kitchen Air Handler Coil	2019	920	24	39	24		35	24
25	Repairs to Laundry Room Air Handler Coil	2019	1,095	28	39	28		42	25
26	Replace Laundry Room Air Handler Coil	2019	1,773	45	39	45		68	26
27	Replace Laundry Room & Kitchen Air Handler Coils	2019	1,363	35	39	35		52	27
28	Replace Components on Water Boiler Pipe	2019	4,995	128	39	128		192	28
29	Replace RPZ Valve, Replace Leaking Pipe in Basement Water Fee	2019	3,338	86	39	86		128	29
30	Replace Coil on Kitchen Air Handler & Repair Leaks	2019	6,699	172	39	172		258	30
31	Replace Coil on Storage Room Air Handler & Repair Leaks	2019	3,357	86	39	86		129	31
32	Replace Actuator in Kitchen Air Handler	2019	2,235	57	39	57		86	32
33	Replace Front Doors with Sliding Glass Doors	2019	2,760	71	39	71		106	33
34	TOTAL (lines 1 thru 33)		\$ 2,837,118	\$ 164,667		\$ 164,667	\$	\$ 1,533,581	34

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

Facility Name & ID Number Ambassador Nsg Rehab Center

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,837,118	\$ 164,667		\$ 164,667	\$	\$ 1,533,581	1
2	Replace Front Doors with Sliding Glass Doors	2019	10,818	277	39	277		416	2
3	New Flooring for Front Office Area	2019	10,646	273	39	273		409	3
4	Replace Actuators in Laundry Room Air Handler	2019	3,255	83	39	83		125	4
5	New Master Locks & Door Guards throughout Building	2019	5,022	129	39	129		193	5
6	New Lighting Fixtures Kitchen and 1st and 2nd Hallway	2019	2,607	67	39	67		100	6
7	Remodernization of the 2 Main Elevators	2019	9,643	247	39	247		371	7
8	Remodernization of the 2 Main Elevators	2019	9,310	239	39	239		358	8
9	Cooling Tower Cleaning	2019	2,873	74	39	74		220	9
10	Installation of Door Alarm System on 1st Floor South Stairway	2019	2,592	66	39	66		100	10
11	New Concrete Apron, New Walkway Slab, Masonry Work on Pati	2019	9,320	239	39	239		358	11
12	New TV RF Mini Modulators	2019	5,546	142	39	142		213	12
13	Concrete Stair Repair with Metal Iron Railing	2019	2,930	75	39	75		113	13
14	Roof Repair	2019	2,516	65	39	65		97	14
15	Repair 1st Floor Door Frames	2019	2,780	71	39	71		107	15
16	Replace Mixing Valve & Piping on Domestic Hot Water Heater	2019	11,950	306	39	306		460	16
17									17
18	New Hot Water Pipes from Boiler to Storage Tank	2020	21,945	563	39	563		563	18
19	Sand, Patch & Paint all Doors and Frames on 3rd & 2nd Floor	2020	3,290	84	39	84		84	19
20	Remodel 3rd Floor Men's Common Shower Room & Bathroom, R	2020	5,590	143	39	143		143	20
21	New Electirc heater for Kitchen	2020	2,616	67	39	67		67	21
22	Repair & Paint 2nd Floor East Hallway	2020	2,400	62	39	56	(5)	62	22
23	Demo 2nd Floor Men's & Women's Shower & Bathrooms, Install	2020	6,627	170	39	156	(14)	170	23
24	Run New 3 Pole 60 Amp Electrical Feeds for Heaters in Electrical	2020	2,450	63	39	58	(5)	63	24
25	Wall & Floor Tile for Throughout Building	2020	4,828	124	39	113	(10)	124	25
26	Clean Chiller Barres., Filters and Heat Exchanger	2020	2,798	72	39	60	(12)	72	26
27	Install Back Flow on Hot Water Pipe to Dish Washer in Kitchen. I	2020	2,215	57	39	43	(14)	57	27
28	2nd & 3rd floor Elevator Wanderer Systems	2020	3,500	90	39	67	(22)	90	28
29	Replace Faulty Transfer Switch on Generator	2020	2,335	60	39	40	(20)	60	29
30	Video Intercom for Administrator's Office	2020	1,093	28	39	16	(12)	28	30
31	Video Intercom for Receptionist	2020	1,340	34	39	20	(14)	34	31
32	Delay Egress and Magnetic Lock for Front Door	2020	3,527	90	39	53	(38)	90	32
33	Delay Egress and Magnetic Lock for Basement Exit Door	2020	2,392	61	39	31	(31)	61	33
34	TOTAL (lines 1 thru 33)		\$ 2,997,871	\$ 168,789		\$ 168,592	\$ (198)	\$ 1,538,989	34

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

Facility Name & ID Number Ambassador Nsg Rehab Center

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

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 12D, Carried Forward		\$ 2,997,871	\$ 168,789		\$ 168,592	\$ (198)	\$ 1,538,989	1
2	Replace Cold Water Isolation Valves for Cold Water Feed to Buil	2020	4,602	118	39	59	(59)	118	2
3	Replace Building Hot Water Return Pump	2020	2,933	75	39	38	(38)	75	3
4	Delay Egress and Magnetic Lock for 1st Floor Exit Door to Patio	2020	2,658	68	39	28	(40)	68	4
5	Canopy Package with Sneeze Guards	2020	3,000	77	39	19	(58)	77	5
6	Winterize Cooling Tower	2020	3,153	81	39	20	(61)	81	6
7	16 Gallon Water Heater	2020	3,985	102	39	26	(77)	102	7
8	Replace Bearing Assembly & Motor on Hot Water Heater	2020	2,534	65	39	11	(54)	65	8
9	New TV RF Mini Modulators (original invoice amount \$5,546.00)	2020	(1,546)	(40)	39	(40)		(40)	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,019,189	\$ 169,336		\$ 168,753	\$ (583)	\$ 1,539,536	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,108,967	\$ 74,039	\$ 221,673	\$ 147,634		\$ 991,135	71
72	Current Year Purchases	28,295	28,295	2,830	(25,466)		28,295	72
73	Fully Depreciated Assets	311,727					311,727	73
74								74
75	TOTALS	\$ 1,448,989	\$ 102,334	\$ 224,503	\$ 122,169		\$ 1,331,157	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	6,013,178
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	271,670
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	393,255
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	121,585
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,870,693

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.

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

☒ 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)	\$			

- (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.

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	

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

12345678										
	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	\$	4,511	\$ 291,480	\$	4,511	\$ 291,480	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,843	150,408		1,843	150,408	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,875	359,415		6,875	359,415	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				194,632		194,632	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					10,375		10,375	12
13	Other (specify): Lab	39-2					48,466		48,466	13
14	TOTAL			\$	13,228	\$ 801,303	\$ 253,473	13,228	\$ 1,054,776	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (151,777)	\$ 215,606	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,300,863	5,300,863	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	243,882	243,882	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		139,953	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,392,968	\$ 5,900,304	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	1,171,951	1,171,951	15
16	Equipment, at Historical Cost	473,389	1,448,389	16
17	Accumulated Depreciation (book methods)	(664,531)	(2,805,706)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	58,215	5,832,367	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(4,788,027)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	485,623	554,979	22
23	Other(specify):		7	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,499,644	\$ 4,806,196	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,892,612	\$ 10,706,500	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,498,284	\$ 1,999,602	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,680	55,680	28
29	Short-Term Notes Payable		353,835	29
30	Accrued Salaries Payable	334,922	334,922	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,479	50,479	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,529	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,939,365	\$ 2,810,047	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,982,722	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)	\$	\$ 6,982,722	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,939,365	\$ 9,792,769	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,953,247	\$ 913,731	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,892,612	\$ 10,706,500	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,328,918	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,328,918	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	624,329	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	()	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)	\$ 624,329	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)	\$ 4,953,247	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Ambassador Nsg Rehab Center

0049924

Report Period Beginning: 1/1/20

Ending: 12/31/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,708,369	1
2	Discounts and Allowances for all Levels	(29,588)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,678,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	335,929	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 335,929	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,007,840	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	10,769	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	33,271	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,051,880	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,477	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,477	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	7,383	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,383	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,083,450	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,847,212	31
32	Health Care	6,509,184	32
33	General Administration	3,788,744	33
	B. Capital Expense		
34	Ownership	1,356,892	34
	C. Ancillary Expense		
35	Special Cost Centers	957,089	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,459,121	40
41	Income before Income Taxes (line 30 minus line 40)**	624,329	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 624,329	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,070,068	44
45	Private Pay - Net Inpatient Revenue	93,095	45
46	Medicare - Net Inpatient Revenue	3,019,850	46
47	Other-(specify) <u>Net Patient Revenue</u>	495,768	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,678,781	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,949	2,112	\$ 118,907	\$ 56.30	1
2	Assistant Director of Nursing	4,318	4,576	207,031	45.24	2
3	Registered Nurses	21,698	25,744	1,043,281	40.53	3
4	Licensed Practical Nurses	35,087	40,266	1,407,241	34.95	4
5	CNAs & Orderlies	80,478	99,413	2,064,696	20.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,909	9,980	181,774	18.21	10
11	Social Service Workers	1,920	2,107	59,101	28.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,451	25,215	460,827	18.28	15
16	Dishwashers					16
17	Maintenance Workers	3,768	4,075	85,752	21.04	17
18	Housekeepers	17,680	19,529	324,865	16.64	18
19	Laundry	5,552	6,402	99,478	15.54	19
20	Administrator	1,216	1,434	54,078	37.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,935	11,357	245,752	21.64	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	4,589	5,079	153,063	30.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,550	257,289	\$ 6,505,846 *	\$ 25.29	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	256	\$ 12,300	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	812	43,345	10-3	38
39	Pharmacist Consultant	316	15,804	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	64	4,134	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,448	\$ 75,583		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	790	13,208	10-2	52
53	TOTAL (lines 50 - 52)	790	\$ 13,208		53

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

** See instructions.

STATE OF ILLINOIS

0049924

Report Period Beginning:

1/1/20

Ending:

12/31/20

Facility Name & ID Number

Ambassador Nsg Rehab Center

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Nudell, Raphael

Administrator

0

\$ 37,324

Perl, Michael

Administrator

0

16,754

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 54,078

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

Dutton Cassey and Mesoloras

Legal

\$ 3,000

Sedgewick

Legal

34,640

Infinity healthcare management

Legal

506

Kaluke Law Group

Legal

26

Neal Gerber and Eisenberg

Legal

1,447

Erich Pavell

Legal

2,118

McGuire Woods

Legal

2,099

Abbey Road Tax Consultants

Professional

734

Empire Risk Management

Professional

12,175

Joseph Laroche and Nonnerre

Legal

(2,333)

See Total in attached schedule

677,416

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 731,828

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 106,310

Unemployment Compensation Insurance

37,774

FICA Taxes

545,183

Employee Health Insurance

380,816

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Pension

53,100

Uniforms

6,447

Background Checks

2,193

Other Employee Benefits

13,510

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,145,333

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

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

Travel Reimbursement

1,093

In-State Travel

Travel Reimbursement

7,268

Travel Reimbursement

11,168

Seminar Expense

Education and Seminars

10,898

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 30,427

* Attach copy of IMRF notifications

**See instructions.

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IL478-2471

XX. GENERAL INFORMATION:

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

YES

(2) Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

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.

\$ 83,181

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.

\$ 396,168

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 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.

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