

**Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall So, P O Box 94986
Lincoln, NE 68509-4986**

2/16/16dy

DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC HEALTH CERTIFIES THAT	
The Ambassador Omaha MEETS STATUTORY REQUIREMENTS AS SKILLED NSG/NSG FAC DISTINCT PART	
Services	Lic # 264003
PHYSICAL THERAPY	
OCCUPATIONAL THERAPY	
SPEECH THERAPY	
RESPIRATORY THERAPY	
PEDIATRIC	
EXPIRES 03/31/2017	  <small>Chief Executive Officer Department of Health and Human Services</small>

Cut on heavy line and place on license.

FACILITY NAME: The Ambassador Omaha

ADDRESS: 1540 NORTH 72ND STREET, OMAHA, NE 68114

This is to verify that your SKILLED NSG/NSG FAC DISTINCT PART is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

9-15-15

LICENSURE UNIT

FEB 10 2016



NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Make Payment to DHHS LU
Renewal Fees:
1 - 50 beds: \$1550
51 - 100 beds: \$1750
101 or more: \$1950

Expiration Date
03/31/2016

Nursing Home Licensure Renewal Application

Nursing Home Type: Please Check Skilled Nursing Facility Nursing Facility Intermediate Care Facility

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

The Ambassador Omaha
1540 NORTH 72ND STREET
OMAHA, NE 68114

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

LICENSE NO: 264003

TELEPHONE NUMBER: (402) 393-6500

FAX NUMBER: (402) 393-8693

ADMINISTRATOR: MITCH JEVNE

DIRECTOR OF NURSING: POLLY STERN, R.N.

E-Mail Address, if available: AmbassadorOmaha@ambhealthsys.com

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: _____

4. NUMBER OF BEDS TO BE RELICENSED: 156

5. ACCREDITATION/CERTIFICATION: JCAHO Medicare Medicaid Other
Are you requesting deemed status? yes no

6. SPECIAL CARE AND TREATMENT SPECIFICALLY FOR THE FOLLOWING GROUPS:
if different from Current Services listed, please check changes.

- Physical Therapy
- Alzheimers/Special Care Unit
- Speech Therapy
- Pediatric
- Respiratory
- Occupational Therapy
- Behavioral Needs

Current Services

- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH THERAPY
- RESPIRATORY THERAPY
- PEDIATRIC

2016 FEB 11 AM 11:02
REC'D HHS ACCOUNTING

OWNERSHIP INFORMATION

7. OWNERSHIP OF FACILITY: THE AMBASSADOR OMAHA, INC.
(Legal Name of individual or business organization)

MAILING ADDRESS: 1240 N. 19TH STREET, PO BOX 640
NEBRASKA CITY, NE 68410

8. BUSINESS ORGANIZATION: (Check one):

- Sole Proprietorship
- Partnership
- Limited Partnership
- Corporation
- Limited Liability Company
- Governmental (____ State, ____ District, ____ County, ____ City or Municipal)
- Other (Please Specify) _____

(check one)
 Profit Non Profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by

- (1) the owner, if the applicant is an individual or partnership,
- (2) two of its members, if the applicant is a limited liability company,
- (3) two of its officers, if the applicant is a corporation, or
- (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Timothy J Juiles
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

2-1-2016
DATE

Sally M Juiles
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT

2-1-2016
DATE



Disclosure of Ownership and Controlling Interest Statement

Name and Address of Facility : The Ambassador Omaha, Inc. 1540 N 72 nd Street Omaha, NE 68114	Type of License: SNF
--	----------------------

Type of Entity	Sole Proprietorship	Unincorporated Association	X Corporation
	Partnership	Other (Specify) _____	

List names, addresses for each individual owners, partners, member of board of directors owning or managing facility.

Name & Title	Address (street, city, state & zip code)
Timothy J. Juilfs, Board of Director/Owner	PO BOX 640, Nebraska City, 68410
Sally M. Juilfs, Board of Director/Owner	PO BOX 640, Nebraska City, 68410
The Ambassador Group Inc. /Management Co	PO BOX 640, Nebraska City, 68410
The Ambassador Holding Company Inc. / Parent	PO Box 640, Nebraska City, 68410

List any other person with financial interest or investments in facility

Name & Title	Address (street, city, state, & zip code)

Affidavit

State of Nebraska _____

County of Otoe

I, Timothy J. Juilfs _____ certify that the information contained herein is complete and true to the best of my knowledge.

Timothy J. Juilfs _____

Authorized Representative

[Redacted Signature]

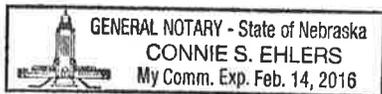
Owner/CEO _____

2-5-2016 _____

Title

Date

Sworn to and I subscribed before me on the 5th of Feb, 2016 _____



[Redacted Notary Signature]

Notary Public

NEBRASKA STATE FIRE MARSHAL OCCUPANCY PERMIT

Certificate Number: 403167

Name of Facility: **The Ambassador - Omaha**
Type of Facility: **Nursing Home**
Location: **1540 N 72nd St Omaha**
Maximum Occupancy: **156 Beds**
Date Issued: **9/15/2015**

Approved By:



Inspected By: **8713 Alan Viox**
Deputy State Fire Marshal

State Fire Marshal



POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

May 8, 2014

Mitch Jevne, Administrator
The Ambassador Omaha
1540 North 72nd St.
Omaha, NE 68114

Dear Mr. Jevne:

This letter replaces the May 8, 2014 letter regarding the Medicaid bed provider number changes that have occurred in your facility effective May 1, 2014.

We have amended our copy of the record of Medicaid certified beds to read that effective May 1, 2014 the record of beds designated as serving vent residents under provider number 470707622-01 are as follows:

Medicaid certified beds designated as vent beds under provider number 470707622-01 are located in room numbers 3100, 3101, 3102, 3103, 3104, 3105, 3106, 3107, 3119, 3120, 3121, 3122, 3123, 3124, 3125, 3126 one bed each, and 314, 315, 316, 317, 318, 319 and 320 two beds each for a total of 30 Medicaid Pulmonary Unit beds.

If you have any questions regarding this, please contact me.

Sincerely,

Joette Novak
Interim Unit Manager
MDS/OASIS Automation Coordinator
DHHS Medicaid & Long-Term Care
P.O. Box 95026
Lincoln, NE 68509-5026
(402)471-9279 phone
(402)471-9092 fax
Joette.Novak@nebraska.gov



December 9, 2013

Mitch Jevne, Administrator
The Ambassador Omaha
1540 North 72nd St.
Omaha, NE 68114

Dear Mr. Jevne:

This letter is regarding the Medicaid room changes that will occur in your facility effective January 1, 2014.

We have amended our copy of the record of Medicaid certified beds to read that effective January 1, 2014, the Medicaid certified beds for The Ambassador Omaha in Omaha, NE are as follows:

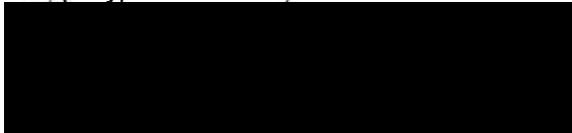
Dually certified beds are located in room numbers **214, 216, 218, 220 (2 beds each)**, 300 (1 bed), 302, 304, 306, 307, 308, 309, 310, 311, 312, 314 (2 beds each), 315, 316, 317, 318, 319, 320 (3 beds each), 326, 327, 328, 329, 330, 331, 332, 334 (2 beds each) and 333 (4 beds each) for a total of 67 Medicare/Medicaid certified beds.

Medicaid only certified beds are located in rooms 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 3100, 3101, 3102, 3103, 3104, 3105, 3106, 3107, 3119, 3120, 3121, 3122, 3123, 3124, 3125, 3126 (1 bed each) for a total of 48 Medicaid only certified beds.

Effective January 1, 2014, The Ambassador Omaha has 48 Medicaid only certified beds and 67 Medicare/Medicaid certified beds.

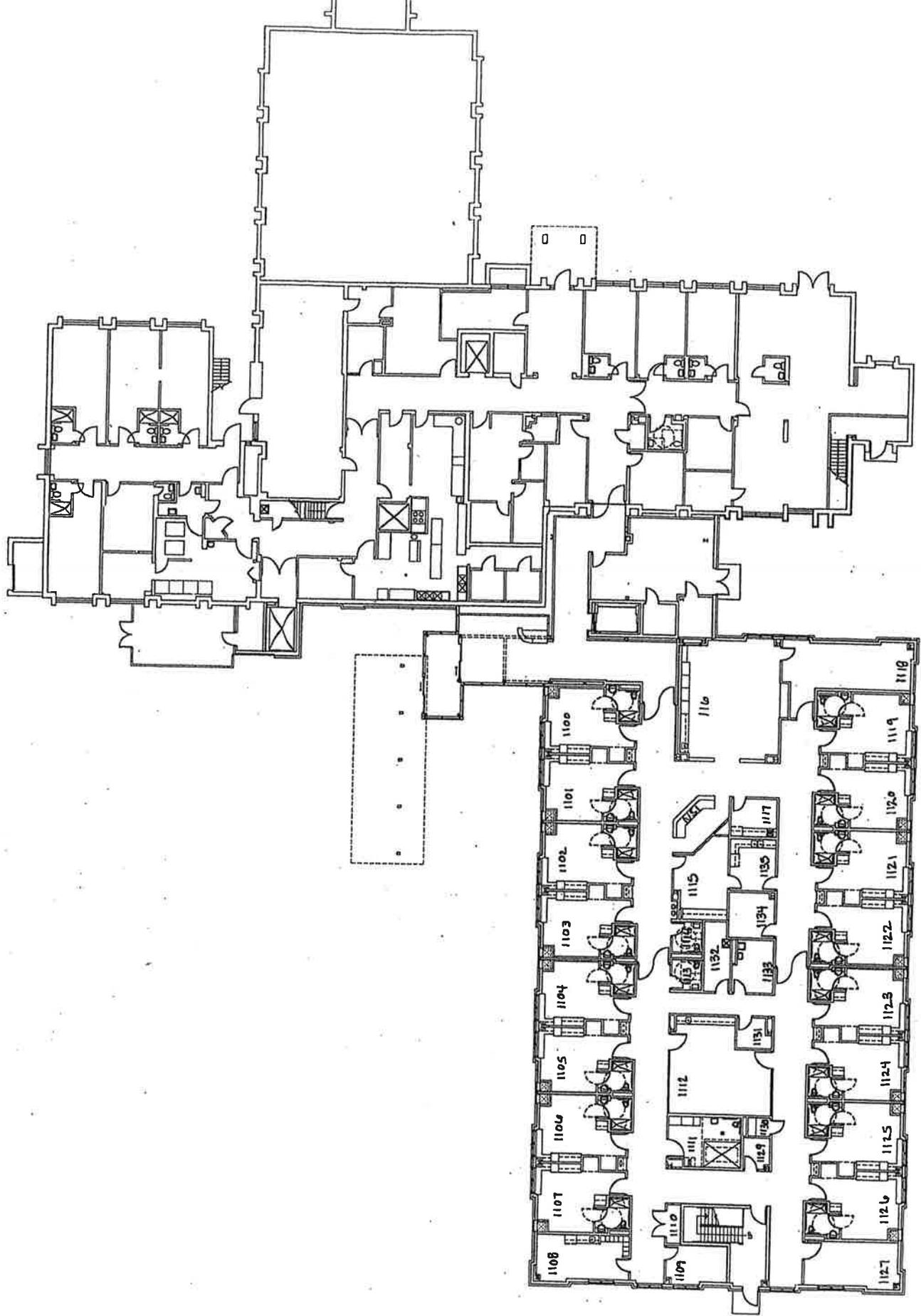
If you have any questions regarding this, please contact me.

Sincerely,

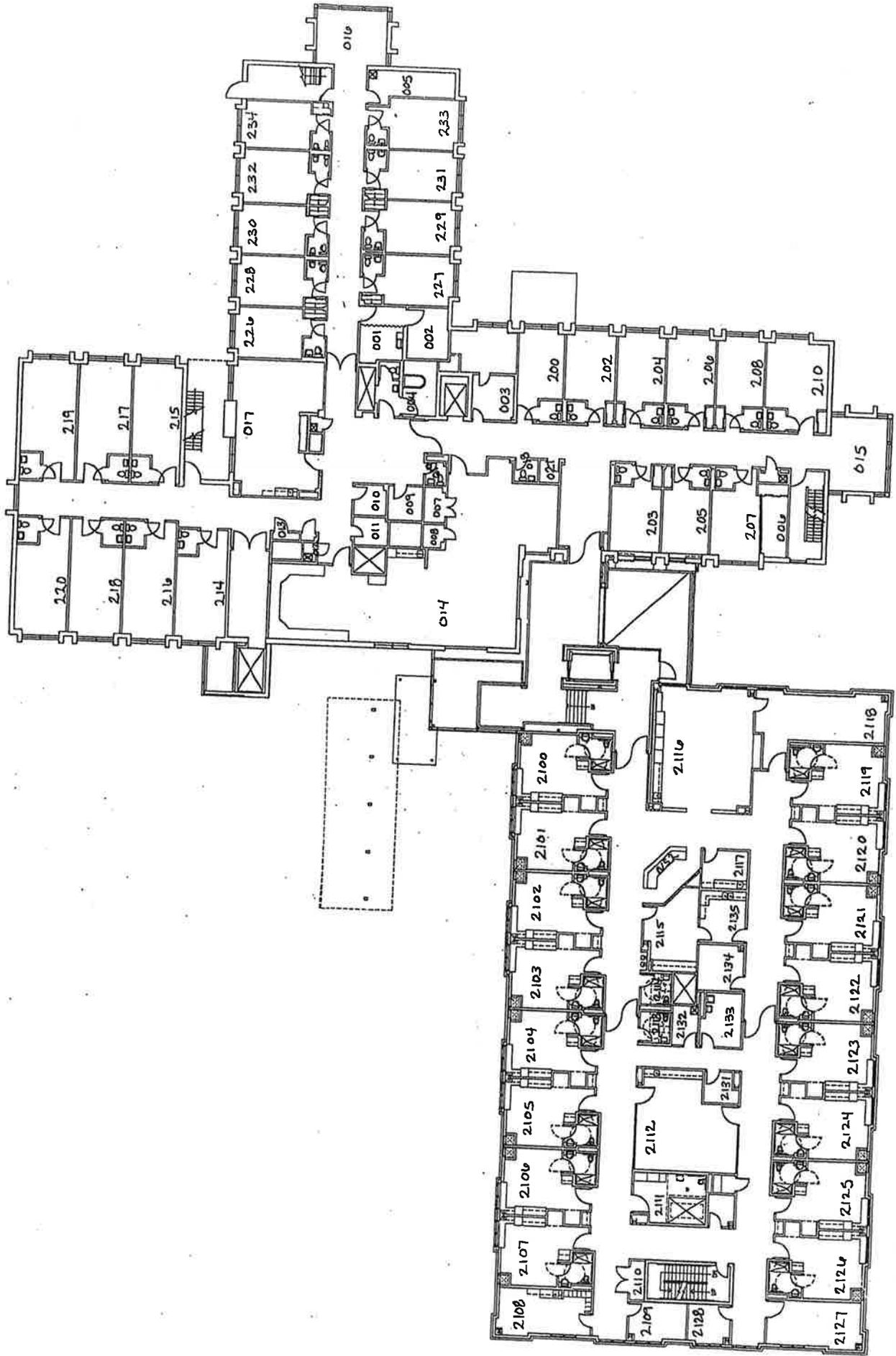


Interim MDS/OASIS Program Specialist
DHHS Medicaid & Long-Term Care
P.O. Box 95026
Lincoln, NE 68509-5026
(402)471-9678 phone
(402)471-9092 fax
danny.vanourney@nebraska.gov

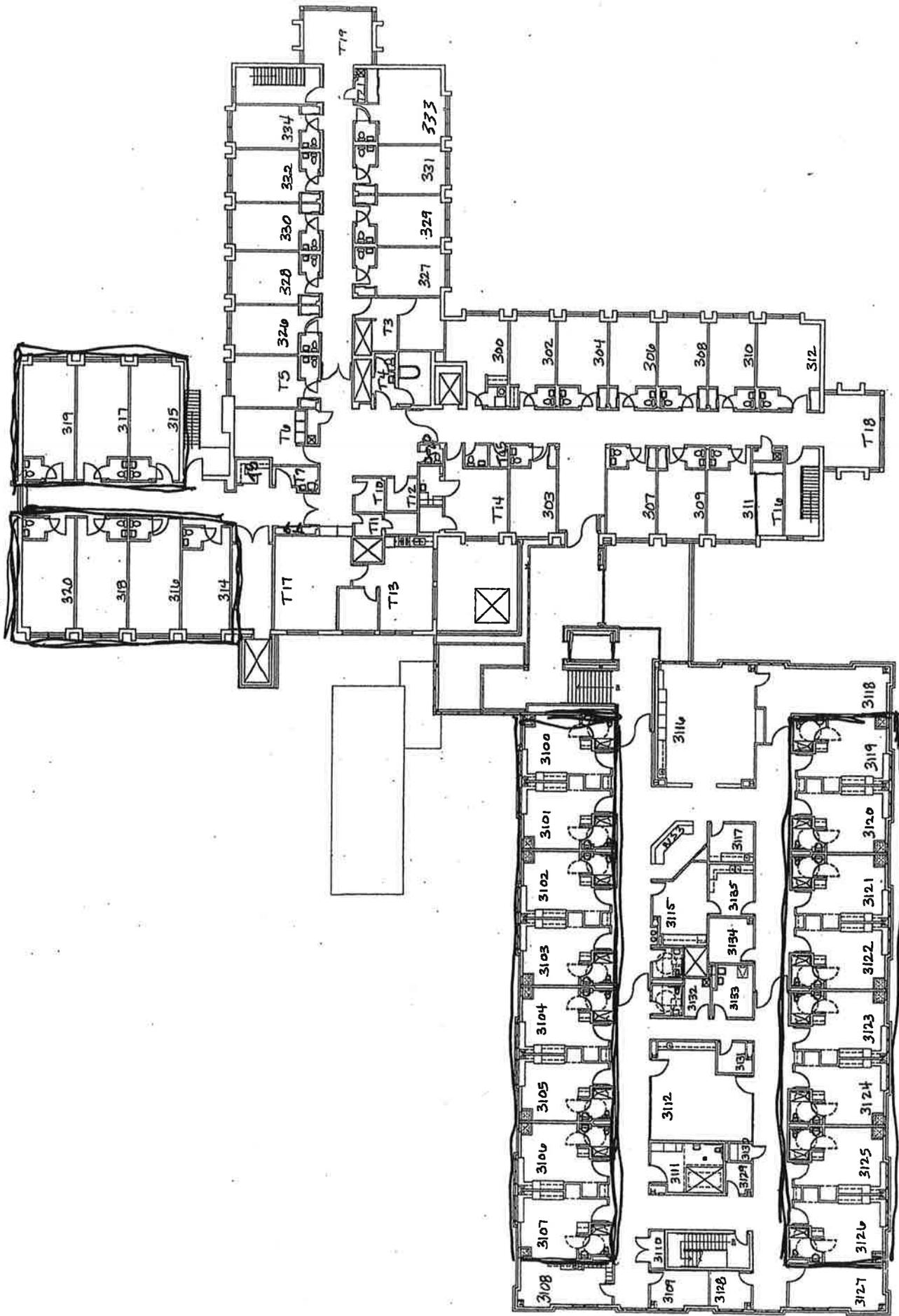
cc: Eve Lewis, Program Manager – Public Health
Donna Jobman - Public Health



FIRST LEVEL FLOOR PLAN
SCALE: NTS



SECOND LEVEL FLOOR PLAN
SCALE: NTS



THIRD LEVEL FLOOR PLAN

SCALE: 1/8" = 1'-0"