

		FOR BHF USE					

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

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>0049932</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>CONTINENTAL NURSING AND REHABILITATION</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</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.																							
Address: <u>5336 NORTH WESTERN AVENUE</u> <u>CHICAGO</u> <u>60625</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(773) 271-5600</u> Fax # <u>(773) 271-2144</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MOISHE GUBIN</u></td></tr><tr><td>(Title) <u>MANAGER</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>DANIEL S. GAAFAR</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BRADLEY & ASSOCIATES, INC.</u> <u>201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225</u></td></tr><tr><td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MOISHE GUBIN</u>	(Title) <u>MANAGER</u>	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>DANIEL S. GAAFAR</u> <u>PARTNER</u>	(Firm Name & Address) <u>BRADLEY & ASSOCIATES, INC.</u> <u>201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225</u>	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>												
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	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>																								
Date of Initial License for Current Owners: <u>3/1/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>DANIEL S. GAAFAR</u> Telephone Number: <u>(317) 237-5500</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL NURSING AND REHABILITATION# 0049932 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>208</u>	Skilled (SNF)	<u>208</u>	<u>75,920</u>	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	<u>208</u>	TOTALS	<u>208</u>	<u>75,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>46,898</u>	<u>961</u>	<u>6,751</u>	<u>54,610</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,898</u>	<u>961</u>	<u>6,751</u>	<u>54,610</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.93%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. 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 3/31/08

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

YES ☒Date 3/31/08NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 208 and days of care provided 6,573Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/11Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	298,929	26,871	15,000	340,800		340,800	(4,881)	335,919		1
2	Food Purchase		250,229		250,229		250,229	(43)	250,186		2
3	Housekeeping	216,448	31,548		247,996		247,996		247,996		3
4	Laundry	46,159	25,163		71,322		71,322		71,322		4
5	Heat and Other Utilities			253,305	253,305		253,305	535	253,840		5
6	Maintenance	95,658	47,105	104,871	247,634		247,634	(964)	246,670		6
7	Other (specify):*										7
8	TOTAL General Services	657,194	380,916	373,176	1,411,286		1,411,286	(5,353)	1,405,933		8
	B. Health Care and Programs										
9	Medical Director			34,000	34,000		34,000		34,000		9
10	Nursing and Medical Records	2,775,811	435,423	32,925	3,244,159		3,244,159	17,454	3,261,613		10
10a	Therapy			565,368	565,368		565,368	(548)	564,820		10a
11	Activities	82,924	15,229		98,153		98,153		98,153		11
12	Social Services	137,675		14,109	151,784		151,784		151,784		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consult.			11,527	11,527		11,527		11,527		15
16	TOTAL Health Care and Programs	2,996,410	450,652	657,929	4,104,991		4,104,991	16,906	4,121,897		16
	C. General Administration										
17	Administrative	87,546			87,546		87,546		87,546		17
18	Directors Fees										18
19	Professional Services			307,002	307,002		307,002	(243,979)	63,023		19
20	Dues, Fees, Subscriptions & Promotions			5,980	5,980		5,980	275	6,255		20
21	Clerical & General Office Expenses	170,389	97,124	33,981	301,494		301,494	157,185	458,679		21
22	Employee Benefits & Payroll Taxes			752,802	752,802		752,802	6,979	759,781		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,451	10,451		10,451	(6,800)	3,651		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			152,592	152,592		152,592	12,867	165,459		26
27	Other (specify):*										27
28	TOTAL General Administration	257,935	97,124	1,262,808	1,617,867		1,617,867	(73,473)	1,544,394		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,911,539	928,692	2,293,913	7,134,144		7,134,144	(61,920)	7,072,224		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			38,910	38,910		38,910	160,387	199,297			30
31	Amortization of Pre-Op. & Org.			143	143		143	424,177	424,320			31
32	Interest			53,289	53,289		53,289	476,315	529,604			32
33	Real Estate Taxes							209,015	209,015			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,306,678)	13,322			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			1,786	1,786		1,786		1,786			36
37	TOTAL Ownership			1,414,128	1,414,128		1,414,128	(36,784)	1,377,344			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		392,420		392,420		392,420	(1,144)	391,276			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,880	113,880		113,880		113,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		392,420	113,880	506,300		506,300	(1,144)	505,156			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,911,539	1,321,112	3,821,921	9,054,572		9,054,572	(99,848)	8,954,724			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL NURSING AND REHABILITATION # 0049932 Report Period Beginning: 1/1/2011 Ending: 12/31/2011
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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(13,606)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	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				24
25	Fund Raising, Advertising and Promotional	(13,271)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,930)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,829)		\$	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	2	
		Amount	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)	(50,019)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,019)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (99,848)		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	2	3	4	
		Yes	No	Amount	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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
CONTINENTAL NURSING AND REHABILITATION

Page 5A

Report Period Beginning: ID# 0049932
Ending: 1/1/2011
12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	VENDING INCOME	\$ (877)	6	1
2	MISC. INCOME - VENDING	(918)	6	2
3	MISC. INCOME - MEDICAL RECORDS	(1,612)	10	3
4	MISC. INCOME - THERAPY	(548)	10A	4
5	MISC. INCOME - OFFICE	(507)	21	5
6	MISC. INCOME - LAB	(1,144)	39	6
7	COMMUTING	(7,324)	24	7
8	G/L CORRECTION - RECLASSED EXP.	(10,000)	21	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	(22,930)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONTINENTAL NURSING AND REHABILITATION# 0049932

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	(22)	(4,859)	0	0	0	0	0	0	0	0	0	(4,881)	1
2	Food Purchase	0	(43)	0	0	0	0	0	0	0	0	0	(43)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	535	0	0	0	0	0	0	0	0	0	535	5
6	Maintenance	(1,795)	831	0	0	0	0	0	0	0	0	0	(964)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,817)	(3,536)	0	0	0	0	0	0	0	0	0	(5,353)	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	(1,612)	19,066	0	0	0	0	0	0	0	0	0	17,454	10
10a	Therapy	(548)	0	0	0	0	0	0	0	0	0	0	(548)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,160)	19,066	0	0	0	0	0	0	0	0	0	16,906	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(243,979)	0	0	0	0	0	0	0	0	0	(243,979)	19
20	Fees, Subscriptions & Promotions	0	275	0	0	0	0	0	0	0	0	0	275	20
21	Clerical & General Office Expenses	(23,778)	180,892	71	0	0	0	0	0	0	0	0	157,185	21
22	Employee Benefits & Payroll Taxes	0	6,979	0	0	0	0	0	0	0	0	0	6,979	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,324)	524	0	0	0	0	0	0	0	0	0	(6,800)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	456	12,411	0	0	0	0	0	0	0	0	12,867	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(31,102)	(54,853)	12,482	0	0	0	0	0	0	0	0	(73,473)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,079)	(39,323)	12,482	0	0	0	0	0	0	0	0	(61,920)	29

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	(13,606)	0	173,993	0	0	0	0	0	0	0	0	160,387	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	0	0	476,315	0	0	0	0	0	0	0	0	476,315	32
33	Real Estate Taxes	0	0	209,015	0	0	0	0	0	0	0	0	209,015	33
34	Rent-Facility & Grounds	0	13,322	(1,320,000)	0	0	0	0	0	0	0	0	(1,306,678)	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	(13,606)	13,322	(36,500)	0	0	0	0	0	0	0	0	(36,784)	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	(1,144)	0	0	0	0	0	0	0	0	0	0	(1,144)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,144)	0	0	0	0	0	0	0	0	0	0	(1,144)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(49,829)	(26,001)	(24,018)	0	0	0	0	0	0	0	0	(99,848)	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
SEE ATTACHMENT #1						

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)	
1	V	1	DIETARY	\$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	\$ 10,141	\$ (4,859)	1
2	V	2	FOOD	43	INFINITY HEALTHCARE MANAGEMENT			(43)	2
3	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		535	535	3
4	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		831	831	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		44,266	19,066	5
6	V	19	PROFESSIONAL SVCS.	276,000	INFINITY HEALTHCARE MANAGEMENT		269	(275,731)	6
7	V	21	OFFICE EXPENSES	33,372	INFINITY HEALTHCARE MANAGEMENT		214,264	180,892	7
8	V	22	EMPLOYEE BENEFITS	3,164	INFINITY HEALTHCARE MANAGEMENT		10,143	6,979	8
9	V	24	TRAVEL/SEMINAR		INFINITY HEALTHCARE MANAGEMENT		524	524	9
10	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		456	456	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		13,322	13,322	11
12	V	19	PROFESSIONAL FEES		CONTINENTAL NURSING REALTY		31,752	31,752	12
13	V	20	FILING FEES		CONTINENTAL NURSING REALTY		275	275	13
14	Total			\$ 352,779			\$ 326,778	\$ * (26,001)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		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	21	OFFICE EXPENSES	\$	CONTINENTAL NURSING REALTY		\$ 71	\$ 71	15
16	V	26	INSURANCE		CONTINENTAL NURSING REALTY		12,411	12,411	16
17	V	30	DEPRECIATION		CONTINENTAL NURSING REALTY		173,993	173,993	17
18	V	31	AMORTIZATION		CONTINENTAL NURSING REALTY		424,177	424,177	18
19	V	32	INTEREST	161	CONTINENTAL NURSING REALTY		476,476	476,315	19
20	V	33	PROPERTY TAXES		CONTINENTAL NURSING REALTY		209,015	209,015	20
21	V	34	RENT	1,320,000	CONTINENTAL NURSING REALTY			(1,320,000)	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			\$ 1,320,161			\$ 1,296,143	\$ * (24,018)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

<u>OWNERS</u>	
NAME	OWNERSHIP %
MICHAEL BLISKO	37.500%
MOISHE GUBIN	37.500%
C&W REALTY INVESTMENTS	20.000%
A&F GENERAL PARTNERSHIP	<u>5.000%</u>
	<u><u>100.000%</u></u>

<u>OTHER RELATED BUSINESS ENTITIES</u>		
NAME	CITY	TYPE OF BUSINESS
INFINITY HEALTHCARE MANAGEMENT HILLSIDE, IL		MANAGEMENT CO.

NOTE: INFINITY HEALTHCARE MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number CONTINENTAL NURSING AND REHAB # 0049932 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL NURSING AND REHABILITATION # 0049932 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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 ☒

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	FIRST BANK		X	MORTGAGE	Interest Only	1/16/08	\$ 8,800,000	\$ 8,780,000	1/16/2033	3 + Libor	\$ 288,363	1	
2	MEISELS LTD. PARTNERSHIP		X	MORTGAGE	\$16,909.00	4/1/08	2,254,553	2,067,282	4/1/2012	9.0000	188,114	2	
3												3	
4												4	
5												5	
	Working Capital												
6	FIRST BANK		X	WORKING CAPITAL	None	11/1/09	1,150,000	1,150,000	6/30/2012	5.5000	53,289	6	
7												7	
8												8	
9	TOTAL Facility Related				\$16,909.00		\$ 12,204,553	\$ 11,997,282			\$ 529,766	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 12,204,553	\$ 11,997,282			\$ 529,766	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	189,428	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.)		\$	221,007	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	31,579	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	177,436	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.		\$	209,015	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007	250,331	9	
		2008	252,842	10	
		2009	167,629	11	
		2010	221,007	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL NURSING AND REHABILITATION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049932

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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	13-12-226-006-0000	NURSING HOME	\$ 175,086.05	\$ 175,086.05
2.	13-12-226-007-0000	NURSING HOME	\$ 29,716.82	\$ 29,716.82
3.	13-12-226-018-0000	NURSING HOME	\$ 16,204.60	\$ 16,204.60
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 221,007.47	\$ 221,007.47

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

- A. Square Feet: 54,288
- B. General Construction Type: Exterior BRICK
- Frame
- Number of Stories 4
- C. Does the Operating Entity? (a) Own the Facility (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 (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? YES NO
- If so, please complete the following:
1. Total Amount Incurred: 130,250
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 8,683
4. Dates Incurred:
- Nature of Costs: ORGANIZATIONAL COSTS
- (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	108,000	3/31/2008	\$ 300,000	1
2					2
3	TOTALS	108,000		\$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	208		2008	1976	\$ 4,000,000	\$ 102,564	39	\$ 102,564	\$	\$ 384,615
5										
6										
7										
8										
	Improvement Type**									
9	Plumbing		12/21/2008		1,106	28	39	28		87
10	TV System		8/14/2008		4,000	103	39	103		427
11	Alarm		8/5/2008		695	18	39	18		61
12	Alarm		8/5/2008		682	17	39	17		59
13	Alarm		8/5/2008		741	19	39	19		65
14	Alarm Service		8/18/2008		537	14	39	14		47
15	Waste Disposal Machine		6/19/2008		833	21	39	21		64
16	Cooling Tower		7/22/2009		3,274	84	39	84		252
17	Roofwork		4/1/2009		4,500	115	39	115		347
18	New Water Heater		5/19/2010		15,928	409	39	409		817
19	Sprinkler Heads		8/24/2010		7,900	203	39	203		405
20	Railing for Patio and Stairwells		7/31/2010		10,434	268	39	268		535
21	Repair Roof		5/18/2010		550	14	39	14		28
22	Paint concrete, floor, ceiling, & balcony		8/16/2010		1,500	38	39	38		77
23	Roof Repair		9/3/2010		2,000	51	39	51		103
24	Roof Repair		11/12/2010		2,000	51	39	51		103
25	Hot Water Storage Tank Replacement		9/6/2011		11,900	352	39	102	(250)	352
26	Repairment of Pipe Leaks		3/1/2011		2,287	68	39	49	(19)	68
27	Cooling Tower Evaporator Pads		5/24/2011		1,510	45	39	26	(19)	45
28	Cooling Tower Evaporator Pads		5/24/2011		470	14	39	8	(6)	14
29	Window/Sign/Lighting/Sidewalk Work		12/1/2011		1,050	31	39	2	(29)	31
30	Lighting Retrofit for Facility		4/28/2011		15,762	466	39	303	(163)	466
31	System Installation		5/31/2011		1,524	45	39	26	(19)	45
32	New Mechanical Room Partition Wall		9/26/2011		15,920	472	39	136	(336)	472
33	Construction Permit/Drawings		9/22/2011		1,588	47	39	14	(33)	47
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$4,108,690	\$105,556		\$104,683	\$(873)	\$389,631	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$507,083	\$72,559	\$72,845	\$286	various	\$271,812	71
72	Current Year Purchases	33,679	34,788	5,371	(29,417)	5 years	34,788	72
73	Fully Depreciated Assets	81,991		16,398	16,398	various	81,991	73
74								74
75	TOTALS	\$622,753	\$107,347	\$94,614	\$(12,733)		\$388,591	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)	\$5,031,443	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$212,903	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$199,297	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(13,606)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$778,222	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:NOT APPLICABLE
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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

C. CONTRACTUAL INCOME

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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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IL478-2471

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	\$		\$ 233,664	\$		\$ 233,664	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			112,246			112,246	2
3	Licensed Recreational Therapist	10A-3	hrs			219,458			219,458	3
4	Licensed Physical Therapist		hrs							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				382,570		382,570	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY/LAB	39-2					9,850		9,850	12
13	Other (specify):									13
14	TOTAL			\$		\$ 565,368	\$ 392,420		\$ 957,788	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ (312,499)	\$ 189,135	1
2	Cash-Patient Deposits	(2,126)	(2,126)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,807,544	3,808,852	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	217,743	217,743	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,710,662	\$ 4,213,604	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	108,689	108,689	15
16	Equipment, at Historical Cost	122,754	622,754	16
17	Accumulated Depreciation (book methods)	(125,749)	(778,222)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,144	6,364,803	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(536)	(1,591,200)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 107,302	\$ 9,026,824	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,817,964	\$ 13,240,428	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,982,296	\$ 2,171,725	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	468,792	468,792	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKING CAPITAL NOTE	1,150,000	1,150,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,601,088	\$ 3,790,517	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,847,282	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)	\$	\$ 10,847,282	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,601,088	\$ 14,637,799	46
47	TOTAL EQUITY(page 18, line 24)	\$ 216,876	\$ (1,397,371)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,817,964	\$ 13,240,428	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (23,485)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (23,485)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	670,361	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	(430,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 240,361	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)	\$ 216,876	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL NURSING AND REHABILITATION # 0049932 Report Period Beginning: 1/1/2011Ending: 12/31/2011

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

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,959,724	1
2	Discounts and Allowances for all Levels	(614,501)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,345,223	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	983,132	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 983,132	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	376,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,115	19
20	Radiology and X-Ray	4,093	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 396,984	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	877	28
28a	MISCELLANEOUS INCOME	(1,283)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (406)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,724,933	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,411,286	31
32	Health Care	4,104,991	32
33	General Administration	1,617,867	33
	B. Capital Expense		
34	Ownership	1,414,128	34
	C. Ancillary Expense		
35	Special Cost Centers	392,420	35
36	Provider Participation Fee	113,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,054,572	40
41	Income before Income Taxes (line 30 minus line 40)**	670,361	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 670,361	43

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

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

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

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

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	1,806	2,125	\$ 111,428	\$ 52.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	37,605	40,929	1,251,367	30.57	3
4	Licensed Practical Nurses	20,553	22,091	550,901	24.94	4
5	CNAs & Orderlies	72,838	79,348	828,916	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,108	7,802	82,924	10.63	9
10	Activity Assistants					10
11	Social Service Workers	6,711	7,410	137,675	18.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,562	24,744	298,929	12.08	15
16	Dishwashers					16
17	Maintenance Workers	4,161	4,396	95,658	21.76	17
18	Housekeepers	16,643	18,811	216,448	11.51	18
19	Laundry	3,488	3,980	46,159	11.60	19
20	Administrator	2,137	2,250	87,546	38.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,895	9,332	170,389	18.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,891	2,191	33,199	15.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,398	225,409	\$ 3,911,539 *	\$ 17.35	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	429	\$ 15,000	1-3	35
36	Medical Director		34,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	659	32,925	10-3	38
39	Pharmacist Consultant	231	11,527	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	403	14,109	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,722	\$ 107,561		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				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

N/A
- (3)

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

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

5 YEARS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

20,539

Line

10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

113,880

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?

YES

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?

N/A
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT