



Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

**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	208	Skilled (SNF)	208	76,128	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	208	TOTALS	208	76,128	7

B. Census-For the entire report period.

	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	47,450	936	5,833	54,219	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,450	936	5,833	54,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.22%

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

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

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

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

none

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

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

YES  NO

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 3/31/08 NO

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 5,512

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

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
	<b>A. General Services</b>										
1	Dietary	308,905	28,447	15,000	352,352		352,352	(4,326)	348,026		1
2	Food Purchase		259,383		259,383		259,383		259,383		2
3	Housekeeping	222,881	36,184		259,065		259,065		259,065		3
4	Laundry	69,149	19,697		88,846		88,846		88,846		4
5	Heat and Other Utilities			313,323	313,323		313,323	683	314,006		5
6	Maintenance	99,001	41,321	116,143	256,465		256,465	4,316	260,781		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	699,936	385,032	444,466	1,529,434		1,529,434	673	1,530,107		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,919,660	535,972	33,825	3,489,457		3,489,457	16,988	3,506,445		10
10a	Therapy			511,163	511,163		511,163	80,364	591,527		10a
11	Activities	98,140	17,883		116,023		116,023		116,023		11
12	Social Services	156,669		19,744	176,413		176,413		176,413		12
13	CNA Training										13
14	Program Transportation			1,702	1,702		1,702		1,702		14
15	Other (specify):* <b>Pharmacy Consultant</b>			15,858	15,858		15,858		15,858		15
16	<b>TOTAL Health Care and Programs</b>	3,174,469	553,855	618,292	4,346,616		4,346,616	97,352	4,443,968		16
	<b>C. General Administration</b>										
17	Administrative	102,398			102,398		102,398		102,398		17
18	Directors Fees										18
19	Professional Services			297,316	297,316		297,316	(294,863)	2,453		19
20	Dues, Fees, Subscriptions & Promotions			13,935	13,935		13,935		13,935		20
21	Clerical & General Office Expenses	132,753	104,530	32,294	269,577		269,577	64,880	334,457		21
22	Employee Benefits & Payroll Taxes			840,525	840,525		840,525	76,034	916,559		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,280	12,280		12,280	280	12,560		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			217,777	217,777		217,777	13,333	231,110		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	235,151	104,530	1,414,127	1,753,808		1,753,808	(140,336)	1,613,472		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,109,556	1,043,417	2,476,885	7,629,858		7,629,858	(42,311)	7,587,547		29

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

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

Facility Name &amp; ID Number

Continental Nsg &amp; Rehab Ctr

#0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			17,539	17,539		17,539	193,186	210,725			30
31	Amortization of Pre-Op. & Org.							424,177	424,177			31
32	Interest			181,933	181,933		181,933	469,129	651,062			32
33	Real Estate Taxes							215,694	215,694			33
34	Rent-Facility & Grounds			1,830,691	1,830,691		1,830,691	(1,823,026)	7,665			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>Replacement Tax</b>			7,547	7,547		7,547		7,547			36
37	<b>TOTAL Ownership</b>			2,037,710	2,037,710		2,037,710	(520,840)	1,516,870			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			314,530	314,530		314,530		314,530			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			634,160	634,160		634,160		634,160			42
43	Other (specify):* <b>Bad Debt</b>			255,024	255,024		255,024		255,024			43
44	<b>TOTAL Special Cost Centers</b>			1,203,714	1,203,714		1,203,714		1,203,714			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,109,556	1,043,417	5,718,309	10,871,282		10,871,282	(563,151)	10,308,131			45

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

Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

**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	19,018	30		9
10	Interest and Other Investment Income	(2,374)	32		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	(20,648)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	90,645	various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 86,619		\$	30

**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)	(649,770)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (649,770)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (563,151)		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.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Continental Nsg & Rehab Ctr

ID# 0049932

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	prior year inc	\$ 80,364	10a	1
2	misc inc	10,281	21	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				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	<b>Total</b>		90,645	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Nsg & Rehab Ctr# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

## 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	(22)	(4,304)	0	0	0	0	0	0	0	0	0	(4,326)	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	0	683	0	0	0	0	0	0	0	0	0	683	5
6	Maintenance	0	4,316	0	0	0	0	0	0	0	0	0	4,316	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(22)</b>	<b>695</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>673</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	16,988	0	0	0	0	0	0	0	0	0	16,988	10
10a	Therapy	80,364	0	0	0	0	0	0	0	0	0	0	80,364	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	<b>TOTAL Health Care and Programs</b>	<b>80,364</b>	<b>16,988</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>97,352</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(294,863)	0	0	0	0	0	0	0	0	0	(294,863)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(10,367)	75,070	177	0	0	0	0	0	0	0	0	64,880	21
22	Employee Benefits & Payroll Taxes	0	76,034	0	0	0	0	0	0	0	0	0	76,034	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	280	0	0	0	0	0	0	0	0	0	280	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	464	12,869	0	0	0	0	0	0	0	0	13,333	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(10,367)</b>	<b>(143,015)</b>	<b>13,046</b>	<b>0</b>	<b>(140,336)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>69,975</b>	<b>(125,332)</b>	<b>13,046</b>	<b>0</b>	<b>(42,311)</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number Continental Nsg & Rehab Ctr# 0049932

Report Period Beginning:

1/1/2012 Ending:

Summary B

12/31/2012

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	19,018	175	173,993	0	0	0	0	0	0	0	0	193,186	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	(2,374)	0	471,503	0	0	0	0	0	0	0	0	469,129	32
33	Real Estate Taxes	0	0	215,694	0	0	0	0	0	0	0	0	215,694	33
34	Rent-Facility & Grounds	0	7,165	(1,830,191)	0	0	0	0	0	0	0	0	(1,823,026)	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	<b>TOTAL Ownership</b>	<b>16,644</b>	<b>7,340</b>	<b>(544,824)</b>	<b>0</b>	<b>(520,840)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	86,619	(117,992)	(531,778)	0	0	0	0	0	0	0	0	(563,151)	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%			Infinity Healthcare	Hillside, IL	Management CO.
Moishe Gubin	37.50%					
C & W Realty Investments	20.00%					
A & F General Partnership	5.00%					

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	1 DIETARY	\$ 15,000	Infinity Healthcare Management		\$ 10,696	\$ (4,304)	1
2	V	2 FOOD						2
3	V	5 UTILITIES		Infinity Healthcare Management		683	683	3
4	V	6 MAINTENANCE		Infinity Healthcare Management		4,316	4,316	4
5	V	10 NURSING	25,200	Infinity Healthcare Management		42,188	16,988	5
6	V	19 PROFESSIONAL SERVICES	20,000	Infinity Healthcare Management		1,137	(18,863)	6
7	V	21 OFFICE EXPENSES	20,985	Infinity Healthcare Management		96,055	75,070	7
8	V	22 EMPLOYEE BENEFITS	4,180	Infinity Healthcare Management		80,214	76,034	8
9	V	24 TRAVEL/SEMINAR		Infinity Healthcare Management		280	280	9
10	V	26 INSURANCE		Infinity Healthcare Management		464	464	10
11	V	34 RENT		Infinity Healthcare Management		7,165	7,165	11
12	V	19 PROFESSIONAL FEES	276,000	Infinity Healthcare Management			(276,000)	12
13	V	30 DEPRECIATION		Infinity Healthcare Management		175	175	13
14	Total		\$ 361,365			\$ 243,373	\$ * (117,992)	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.  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		\$ 177	\$ 177
16	V	26 INSURANCE		Continental Nursing Realty		12,869	12,869
17	V	30 DEPRECIATION		Continental Nursing Realty		173,993	173,993
18	V	31 AMORTIZATION		Continental Nursing Realty		424,177	424,177
19	V	32 INTEREST		Continental Nursing Realty		471,503	471,503
20	V	33 PROPERTY TAXES		Continental Nursing Realty		215,694	215,694
21	V	34 RENT	1,830,691	Continental Nursing Realty		500	(1,830,191)
22	V	19 PROFESSIONAL FEES		Continental Nursing Realty			
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,830,691			\$ 1,298,913	\$ * (531,778)

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

Facility Name & ID Number

Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending: 2/31/2012

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

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

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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First Bank		x	Mortgage	\$110,000.00	1/16/08	\$ 8,800,000	\$ 8,780,000	1/16/33	3+libor	\$ 286,578	1						
2	Meisels Ltd. Partnership		x	Mortgage	\$16,909.00	4/1/12	2,254,553	2,042,282	4/1/14	9.0000	184,924	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	First Merit		x	working capital	None	11/1/09	1,150,000	1,150,000	6/30/13	5.5000	64,376	6						
7	Infinity Funding	x		working capital	various	various	2,100,000	2,100,000	various	various	117,557	7						
8												8						
9	<b>TOTAL Facility Related</b>				<b>\$126,909.00</b>		<b>\$ 14,304,553</b>	<b>\$ 14,072,282</b>			<b>\$ 653,435</b>	<b>9</b>						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	<b>14</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 14,304,553</b>	<b>\$ 14,072,282</b>			<b>\$ 653,435</b>	<b>15</b>						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_

\* 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.)

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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>																	
1. Real Estate Tax accrual used on 2011 report.		\$	<b>177,436</b> 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.)		\$	<b>220,088</b> 2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>42,652</b> 3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>173,042</b> 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>215,694</b> 7														
Real Estate Tax History:																	
Real Estate Tax Bill for Calendar Year:	2007	<b>250,331</b>	8														
	2008	<b>252,842</b>	9														
	2009	<b>167,629</b>	10														
	2010	<b>221,007</b>	11														
	2011	<b>220,088</b>	12														
	<table border="1"> <tr> <td colspan="2"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																	
13	FROM R. E. TAX STATEMENT FOR 2011 \$	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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Nsg & Rehab Ctr 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 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-12-226-006-0000</u>	<u>Nursing Home</u>	\$ <u>174,357.84</u>	\$ <u>174,357.84</u>
2. <u>13-12-226-007-0000</u>	<u>Nursing Home</u>	\$ <u>29,593.31</u>	\$ <u>29,593.31</u>
3. <u>13-12-226-008-0000</u>	<u>Nursing Home</u>	\$ <u>16,137.20</u>	\$ <u>16,137.20</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>220,088.35</u></u>	\$ <u><u>220,088.35</u></u>

**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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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: 54,228 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).

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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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>nursing home</u>	<u>108,000</u>	<u>3/31/2008</u>	<u>\$ 300,000</u>	1
2					2
3	<b>TOTALS</b>	<b>108,000</b>		<b>\$ 300,000</b>	<b>3</b>

Facility Name &amp; ID Number Continental Nsg &amp; Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**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	\$ 0	\$ 487,179	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Plumbing		12/21/2008		1,106	28	39	28		122	9
10	TV System		8/14/2008		4,000	103	39	103		440	10
11	Alarm		8/5/2008		695	18	39	18		76	11
12	Alarm		8/5/2008		682	17	39	17		75	12
13	Alarm		8/5/2008		741	19	39	19		81	13
14	Alarm Service		8/18/2008		537	14	39	14		59	14
15	Waste Disposal Machine		6/19/2009		833	21	39	21		92	15
16	Cooling Tower		7/22/2009		3,274	84	39	84		372	16
17	Roofwork		4/1/2009		4,500	115	39	115		512	17
18	New Water Heater		5/19/2010		15,928	408	39	408		1,226	18
19	Sprinkler Heads		8/24/2010		7,900	203	39	203		608	19
20	Railing for Patio and Stairwells		7/31/2010		10,434	268	39	268		803	20
21	Repair Roof		5/18/2010		550	14	39	14		42	21
22	Paint concrete, floor, ceiling, & balcony		8/16/2010		1,500	38	39	38		115	22
23	Roof Repair		9/3/2010		2,000	51	39	51		154	23
24	Roof Repair		11/12/2010		2,000	51	39	51		154	24
25	Hot Water Storage Tank Replacement		9/6/2011		11,900	305	39	305	0	611	25
26	Repairment of Pipe Leaks		3/1/2011		2,287	59	39	59	(0)	117	26
27	Cooling Tower Evaporator Pads		5/24/2011		1,510	39	39	39	(0)	77	27
28	Cooling Tower Evaporator Pads		5/24/2011		470	12	39	12	0	24	28
29	Window/Sign/Lighting/Sidewalk Work		12/1/2011		1,050	27	39	27	(0)	54	29
30	Lighting Retrofit for Facility		4/28/2011		15,762	404	39	404	0	808	30
31	System Installation		5/31/2011		1,524	39	39	39	0	78	31
32	New Mechanical Room Partition Wall		9/26/2011		15,920	408	39	408	0	816	32
33	Construction Permit/Drawings		9/22/2011		1,588	41	39	41	(0)	81	33
34	Communication system and booster		12/31/2011		7,960	204	39	204		408	34
35	Renovations to 2nd, 3rd and 4th floors		4/18/2012		64,000	1,641	39	1,231	(410)	1,641	35
36	Renovations to 2nd, 3rd and 4th floors		10/17/2012		230,602	5,913	39	1,478	(4,435)	5,913	36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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	Sprinkler heads installation	8/10/2012	\$ 1,643	\$ 42	39	\$ 17	\$ (25)	\$ 42	37
38	New drains and water supply	9/13/2012	10,000	256	39	85	(171)	256	38
39	Replace windows	2/7/2012	1,500	38	39	35	(3)	38	39
40	Contrete sidewalks and stairs	10/23/2012	4,800	123	39	31	(92)	123	40
41	Carpet Installation	11/21/2012	3,200	82	39	14	(68)	82	41
42	Plumbing chase and wall cabinets	11/24/2012	8,704	223	39	37	(186)	223	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)		\$ 4,441,098	\$ 113,875		\$ 108,483	\$ (5,391)	\$ 503,503	70

\*\*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	\$ 72,702	\$ 72,845	\$ 143	various	\$ 344,372	71
72	Current Year Purchases	52,556	4,955	6,453	1,498	various	4,955	72
73	Fully Depreciated Assets	116,779		22,944	22,944	various	115,670	73
74								74
75	TOTALS	\$ 676,418	\$ 77,657	\$ 102,242	\$ 24,585		\$ 464,997	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)	\$ 5,417,516	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,532	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,725	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,193	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 968,500	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.

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_/2013 \$ \_\_\_\_\_

13. \_\_\_\_\_/2014 \$ \_\_\_\_\_

14. \_\_\_\_\_/2015 \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 1/1/2012 Ending: 12/31/2012  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

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

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

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

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

	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	\$		\$ 216,046	\$		\$ 216,046	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			104,997			104,997	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			190,120			190,120	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 prescripts				307,035		307,035	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>lab/radiology</u>	39-2					7,495		7,495	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 511,163	\$ 314,530		\$ 825,693	14

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

Facility Name & ID Number Continental Nsg & Rehab Ctr# 0049932Report Period Beginning: 1/1/2012Ending: 12/31/2012

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 72,894	\$ 835,701	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,793,379	3,793,462	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	247,177	247,177	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,113,450	\$ 4,876,340	10
	<b>B. Long-Term Assets</b>			
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	441,098	441,098	15
16	Equipment, at Historical Cost	176,418	676,418	16
17	Accumulated Depreciation (book methods)	(143,145)	(969,611)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,144	6,364,804	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(679)	(2,015,520)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 475,836	\$ 8,797,189	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,589,286	\$ 13,673,529	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,368,946	\$ 1,558,374	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	531,739	531,739	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>working capital notes</u>	3,250,000	3,250,000	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,150,685	\$ 5,340,113	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		10,822,282	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 10,822,282	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,150,685	\$ 16,162,395	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (561,399)	\$ (2,488,866)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,589,286	\$ 13,673,529	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 216,876	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 216,876	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(578,275)	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	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (778,275)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (561,399)	24 *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,338,929	1
2	Discounts and Allowances for all Levels	(546,662)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,792,267</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,049	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 146,049</b>	8
<b>C. Other Operating Revenue</b>			
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	243,215	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,825	19
20	Radiology and X-Ray	1,632	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 261,672</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,374	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,374</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Therapy Credit prior yr</u>	80,364	28
28a	<u>Miscellaneous Income</u>	10,281	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 90,645</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 10,293,007</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,529,434	31
32	Health Care	4,346,616	32
33	General Administration	1,753,808	33
<b>B. Capital Expense</b>			
34	Ownership	2,037,710	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	569,554	35
36	Provider Participation Fee	634,160	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 10,871,282</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(578,275)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (578,275)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 7,242,843	44
45	Private Pay - Net Inpatient Revenue	101,413	45
46	Medicare - Net Inpatient Revenue	2,448,011	46
47	Other-(specify) <u>Insurance</u>		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 9,792,267</b>	49

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

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**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	1,967	2,221	\$ 121,465	\$ 54.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	38,860	42,550	1,326,152	31.17	3
4	Licensed Practical Nurses	19,895	21,833	548,313	25.11	4
5	CNAs & Orderlies	77,974	84,539	887,733	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,384	8,840	98,140	11.10	9
10	Activity Assistants					10
11	Social Service Workers	7,182	7,498	156,669	20.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,992	26,189	308,905	11.80	15
16	Dishwashers					16
17	Maintenance Workers	3,955	4,243	99,001	23.33	17
18	Housekeepers	16,521	18,627	222,881	11.97	18
19	Laundry	5,017	5,695	69,149	12.14	19
20	Administrator	1,599	1,704	102,398	60.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,308	8,230	131,753	16.01	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	1,936	2,169	36,997	17.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,590	234,338	\$ 4,109,556 *	\$ 17.54	34

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

\*\* See instructions.

**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		36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	677	33,825	10-3	38
39	Pharmacist Consultant	317	15,858	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	564	19,744	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,987	\$ 120,427		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



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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Continental Nsg &amp; Rehab Ctr

# 0049932

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

## 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. \$ 29,400 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. \$ 634,160  
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 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.