



Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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	75,920	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	75,920	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	37,197	79	5,832	43,108	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,197	79	5,832	43,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.78%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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 03/31/08

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/31/08 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 3,430

Medicare Intermediary Wisconsin Physician Service

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	315,633	28,210	12,359	356,202		356,202	(995)	355,207		1
2	Food Purchase		255,024		255,024		255,024	1,496	256,520		2
3	Housekeeping	239,021	45,481		284,502		284,502	452	284,954		3
4	Laundry	63,120	26,922		90,042		90,042		90,042		4
5	Heat and Other Utilities			275,191	275,191		275,191	611	275,802		5
6	Maintenance	100,403	44,600	79,275	224,278		224,278	514	224,792		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	718,177	400,237	366,825	1,485,239		1,485,239	2,078	1,487,317		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			29,375	29,375		29,375		29,375		9
10	Nursing and Medical Records	3,138,434	233,480	55,668	3,427,582		3,427,582	(4,284)	3,423,298		10
10a	Therapy			722,627	722,627		722,627		722,627		10a
11	Activities	79,122	17,791		96,913		96,913		96,913		11
12	Social Services	105,009		12,453	117,462		117,462		117,462		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>RX Consultant</b>			12,573	12,573		12,573	(231)	12,342		15
16	<b>TOTAL Health Care and Programs</b>	3,322,565	251,271	832,696	4,406,532		4,406,532	(4,515)	4,402,017		16
	<b>C. General Administration</b>										
17	Administrative	136,893			136,893		136,893		136,893		17
18	Directors Fees										18
19	Professional Services			504,069	504,069		504,069	(199,185)	304,884		19
20	Dues, Fees, Subscriptions & Promotions			13,704	13,704		13,704	105	13,809		20
21	Clerical & General Office Expenses	274,739	70,397	120,049	465,185		465,185	131,235	596,420		21
22	Employee Benefits & Payroll Taxes			758,204	758,204		758,204	35,865	794,069		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,099	18,099		18,099	4,383	22,482		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			290,734	290,734		290,734	64,044	354,778		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	411,632	70,397	1,704,859	2,186,888		2,186,888	36,447	2,223,335		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,452,374	721,905	2,904,380	8,078,659		8,078,659	34,010	8,112,669		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			62,136	62,136		62,136	248,172	310,308		30
31	Amortization of Pre-Op. & Org.			143	143		143	424,177	424,320		31
32	Interest			175,094	175,094		175,094	290,193	465,287		32
33	Real Estate Taxes							359,696	359,696		33
34	Rent-Facility & Grounds			1,575,348	1,575,348		1,575,348	(1,569,531)	5,817		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,812,721	1,812,721		1,812,721	(247,293)	1,565,428		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			19,223	19,223		19,223		19,223		38
39	Ancillary Service Centers		243,234		243,234		243,234	(4,294)	238,940		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			352,334	352,334		352,334		352,334		42
43	Other (specify):* <b>Bad Debt Expense</b>			190,524	190,524		190,524	(190,524)			43
44	<b>TOTAL Special Cost Centers</b>		243,234	562,081	805,315		805,315	(194,818)	610,497		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,452,374	965,139	5,279,182	10,696,695		10,696,695	(408,101)	10,288,594		45

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

**VI. ADJUSTMENT DETAIL**

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

		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	145,446	30		9
10	Interest and Other Investment Income	(23,928)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2)	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	(2,350)	21		18
19	Entertainment				19
20	Contributions	(9,342)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,524)	43		24
25	Fund Raising, Advertising and Promotional	(10,874)	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	(8,824)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (100,398)		\$	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)	(307,703)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (307,703)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (408,101)		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	

Continental Nsg & Rehab Ctr

ID# 0049932

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (3,435)	21	1
2	Lobbying	(686)	20	2
3	Collection costs	(18)	21	3
4	RP Profit	(160)	10	4
5	RP Profit	(231)	15	5
6	RP Profit	(4,294)	39	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>	(8,824)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/17

Ending:

12/31/17

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	(2)	(993)	0	0	0	0	0	0	0	0	0	(995)	1
2	Food Purchase	0	1,496	0	0	0	0	0	0	0	0	0	1,496	2
3	Housekeeping	0	452	0	0	0	0	0	0	0	0	0	452	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	611	0	0	0	0	0	0	0	0	0	611	5
6	Maintenance	0	514	0	0	0	0	0	0	0	0	0	514	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2)</b>	<b>2,080</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>2,078</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	(160)	(4,124)	0	0	0	0	0	0	0	0	0	(4,284)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(231)	0	0	0	0	0	0	0	0	0	0	(231)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(391)</b>	<b>(4,124)</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>(4,515)</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	(202,885)	3,700	0	0	0	0	0	0	0	0	(199,185)	19
20	Fees, Subscriptions & Promotions	(686)	791	0	0	0	0	0	0	0	0	0	105	20
21	Clerical & General Office Expenses	(26,019)	156,947	307	0	0	0	0	0	0	0	0	131,235	21
22	Employee Benefits & Payroll Taxes	0	35,865	0	0	0	0	0	0	0	0	0	35,865	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,383	0	0	0	0	0	0	0	0	0	4,383	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	736	63,308	0	0	0	0	0	0	0	0	64,044	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(26,705)</b>	<b>(4,163)</b>	<b>67,315</b>	<b>0</b>	<b>36,447</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(27,098)</b>	<b>(6,207)</b>	<b>67,315</b>	<b>0</b>	<b>34,010</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	145,446	162	102,564	0	0	0	0	0	0	0	0	248,172	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	(23,928)	0	314,121	0	0	0	0	0	0	0	0	290,193	32
33	Real Estate Taxes	0	0	359,696	0	0	0	0	0	0	0	0	359,696	33
34	Rent-Facility & Grounds	0	0	(1,569,531)	0	0	0	0	0	0	0	0	(1,569,531)	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>121,518</b>	<b>162</b>	<b>(368,973)</b>	<b>0</b>	<b>(247,293)</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	(4,294)	0	0	0	0	0	0	0	0	0	0	(4,294)	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):*	(190,524)	0	0	0	0	0	0	0	0	0	0	(190,524)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(194,818)</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>(194,818)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(100,398)</b>	<b>(6,045)</b>	<b>(301,658)</b>	<b>0</b>	<b>(408,101)</b>	<b>45</b>							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	37.50%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt Co
Moishe Gubin	37.50%	Belhaven Nursing & Rehab Center	Chicago	Continental		Realty Co
A&F Realty	5.00%	City View Multicare Center	Cicero			
C&W Investment	20.00%	Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$ 3,899	Infinity Healthcare Management of Illinois		\$ 2,906	\$ (993)	1
2	V	2 Food Purchases		Infinity Healthcare Management of Illinois		1,496	1,496	2
3	V	3 Housekeeping		Infinity Healthcare Management of Illinois		452	452	3
4	V	5 Utilities		Infinity Healthcare Management of Illinois		611	611	4
5	V	6 Maintenance		Infinity Healthcare Management of Illinois		514	514	5
6	V	10 Nursing	55,668	Infinity Healthcare Management of Illinois		51,544	(4,124)	6
7	V	19 Professional Fees	335,480	Infinity Healthcare Management of Illinois		132,595	(202,885)	7
8	V	20 Dues, Fees, Subs, & Promotions		Infinity Healthcare Management of Illinois		791	791	8
9	V	21 Office Expense	106,547	Infinity Healthcare Management of Illinois		263,494	156,947	9
10	V	22 Employee Benefits		Infinity Healthcare Management of Illinois		35,865	35,865	10
11	V	24 Travel & Seminar		Infinity Healthcare Management of Illinois		4,383	4,383	11
12	V	26 Insurance		Infinity Healthcare Management of Illinois		736	736	12
13	V	30 Depreciation		Infinity Healthcare Management of Illinois		162	162	13
14	Total		\$ 501,594			\$ 495,549	\$ * (6,045)	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	32 Interest	\$	Infinity Healthcare Mangement		\$ 17	\$ 17
16	V	34 Rent		Infinity Healthcare Mangement		5,817	5,817
17	V						
18	V	19 Professional Services		Continental Nursing Realty, LLC		3,700	3,700
19	V	21 Office Expense		Continental Nursing Realty, LLC		307	307
20	V	26 Insurance		Continental Nursing Realty, LLC		63,308	63,308
21	V	30 Depreciation		Continental Nursing Realty, LLC		102,564	102,564
22	V	31 Amortization		Continental Nursing Realty, LLC		424,177	424,177
23	V	32 Interest		Continental Nursing Realty, LLC		314,104	314,104
24	V	33 Real Estate Taxes		Continental Nursing Realty, LLC		359,696	359,696
25	V	34 Rent	1,575,348	Continental Nursing Realty, LLC			(1,575,348)
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		\$ 1,575,348			\$ 1,273,690	\$ * (301,658)

\* 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:

1/1/17

Ending:

12/31/17

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 1/1/17 Ending: 12/31/17

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:

1/1/17

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD Loan		X	Mortgage	\$37,313.00	9/24/14	\$ 8,720,000	\$ 8,314,634	10/1/49	3.7500	\$ 314,104	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	8,338,534	8/31/18	3.9800	175,111	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$37,313.00		\$ 34,720,000	\$ 16,653,168			\$ 489,215	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 34,720,000	\$ 16,653,168			\$ 489,215	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 54,659 Line # 26

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

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

**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 2016 report.		\$	<b>(21,145)</b>	<b>1</b>
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>331,310</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>352,455</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>7,241</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>359,696</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	<b>254,921</b>	<b>8</b>	
	2013	<b>258,371</b>	<b>9</b>	
	2014	<b>263,575</b>	<b>10</b>	
	2015	<b>303,118</b>	<b>11</b>	
	2016	<b>331,310</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

**2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-12-226-006-0000</u>	<u>Nursing Facility</u>	\$ <u>281,813.00</u>	\$ <u>281,813.00</u>
2. <u>13-12-226-007-0000</u>	<u>Nursing Facility</u>	\$ <u>43,494.00</u>	\$ <u>43,494.00</u>
3. <u>13-12-226-018-0000</u>	<u>Nursing Facility</u>	\$ <u>6,003.00</u>	\$ <u>6,003.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>331,310.00</u></u>	\$ <u><u>331,310.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning:

1/1/17

Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 54,228 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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:

(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	<u>Nursing Home</u>	<u>108,000</u>	<u>2008</u>	<u>\$ 300,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>108,000</b>		<b>\$ 300,000</b>	<b>3</b>

**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	\$	\$ 1,053,573	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Plumbing	2008		1,106	28	39	28		275	9
10	TV System	2008		4,000	103	39	103		1,002	10
11	Alarm	2008		695	18	39	18		174	11
12	Alarm	2008		682	17	39	17		169	12
13	Alarm	2008		741	19	39	19		185	13
14	Alarm Service	2008		537	14	39	14		135	14
15	Waste Disposal Machine	2009		833	21	39	21		191	15
16	Cooling Tower	2009		3,274	84	39	84		756	16
17	Roofwork	2009		4,500	116	39	115	(1)	1,042	17
18	New Water Heater	2010		15,928	408	39	408		3,267	18
19	Sprinkler Heads	2010		7,900	203	39	203		1,623	19
20	Railing for Patio and Stairwells	2010		10,434	269	39	268	(1)	2,146	20
21	Repair Roof	2010		550	14	39	14		112	21
22	Paint concrete, floor, ceiling, & balcony	2010		1,500	38	39	38		306	22
23	Roof Repair	2010		2,000	51	39	51		409	23
24	Roof Repair	2010		2,000	51	39	51		409	24
25	Hot Water Storage Tank Replacement	2011		11,900	305	39	305		2,136	25
26	Repairment of Pipe Leaks	2011		2,287	59	39	59		412	26
27	Cooling Tower Evaporator Pads	2011		1,510	39	39	39		272	27
28	Cooling Tower Evaporator Pads	2011		470	12	39	12		84	28
29	Window/Sign/Lighting/Sidewalk Work	2011		1,050	27	39	27		189	29
30	Lighting Retrofit for Facility	2011		15,762	404	39	404		2,829	30
31	System Installation	2011		1,524	39	39	39		273	31
32	New Mechanical Room Partition Wall	2011		15,920	408	39	408		2,857	32
33	Construction Permit/Drawings	2011		1,588	41	39	41		286	33
34	Communication system and booster	2011		7,960	204	39	204		1,428	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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

# 0049932

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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	2012	\$ 1,643	\$ 42	39	\$ 42		\$ 252	37
38	New drains and water supply in Dialysis room	2012	10,000	256	39	256		1,537	38
39	Replace windows	2012	1,500	38	39	38		229	39
40	Contrete sidewalks and stairs	2012	4,800	123	39	123		738	40
41	Carpet Installation for front office and administration area	2012	3,200	82	39	82		492	41
42	Plumbing chase and wall cabinets in Dialysis room	2012	8,704	223	39	223		1,338	42
43									43
44	2nd floor: corridor - ceiling tile, lighting, cove base, floor, paint, wall coverings, room signs, artwork, nurses station cabinet tops, dayroom								44
45	ceilings, lighting								45
46									46
47	3rd floor: corridor - ceiling tile, lighting, cove base, flooring, paint, wall coverings, room signs, nurses station cabinet tops								47
48									48
49	4th floor: corridor - ceiling tile, lighting, cove base, flooring, paint, wall coverings, room signs, nurses station wall coverings, paint doors								49
50									50
51	Dining room chairs, tables, blinds	2012	294,602	7,555	39	7,554	(1)	45,328	51
52									52
53	Mounted fixtures 4th floor dayroom	2013	1,716	44	39	44		198	53
54	Chiller condenser	2013	3,700	95	39	95		427	54
55	Chiller condenser couplings	2013	2,871	74	39	74		333	55
56	Sprinkler system	2013	2,101	54	39	54		243	56
57	Piping valves	2013	5,300	136	39	136		612	57
58	boiler	2013	1,682	43	39	43		194	58
59	Caulking windows/buidling base	2013	2,900	74	39	74		333	59
60	4 sided smoking shelter	2013	5,422	139	39	139		626	60
61	4 sided smoking shelter	2013	1,000	26	39	26		117	61
62	Wiring on first floor	2013	16,697	428	39	428		1,926	62
63	Wallpaper, door trims, paint for resident rooms on 4th floor	2013	17,745	455	39	455		2,047	63
64	Sliding door system	2013	27,100	694	39	695	1	3,123	64
65	Electrical Wiring 4th floor dialysis unit,	2013	6,815	175	39	175		787	65
66	Cove base/vinyl 4th floor dialysis room,	2013	8,121	208	39	208		937	66
67	Door Alarm system	2013	2,595	67	39	67		301	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,546,864	\$ 116,587		\$ 116,585	\$ (2)	\$ 1,138,658	70

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

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

# 0049932

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,546,864	\$ 116,587		\$ 116,585	\$ (2)	\$ 1,138,658	1
2	Ceiling ligh fixtures in corridors	2014	2,053	53	39	53		212	2
3	Security Door release	2014	2,225	57	39	57		228	3
4	Electric, plumbing, drywall and painting in Dialysis Room	2014	4,060	104	39	104		416	4
5	Shield straight passage lever and vertical ejector pump	2014	4,759	122	39	122		488	5
6	Parking garage structure, lights and concrete	2014	53,182	1,364	39	1,364		5,456	6
7	Chiller barrels, cooler, thermostat, descaler for kitchen	2014	13,327	342	39	342		1,368	7
8	Sprinkler in admin office	2014	2,683	69	39	69		276	8
9	Structual engineering	2014	2,814	72	39	72		288	9
10	Waterproofing upper deck and concrete	2014	16,604	426	39	426		1,704	10
11	Valve repair	2014	2,235	57	39	57		228	11
12	install grab bars	2014	9,374	240	39	240		960	12
13									13
14									14
15	New canopy in smoking area	2015	7,900	202	39	203	1	606	15
16	Clean and service chiller	2015	4,118	106	39	106		318	16
17	Remove wallpaper, sand, paint 25 rooms on 3rd floor	2015	12,500	321	39	321		963	17
18	Remove damaged railing, fix, and reinstall	2015	3,220	83	39	83		249	18
19	Purchase, deliver, & install new fire rated door	2015	2,500	64	39	64		192	19
20									20
21	Resurface 1 side of exterior bldg in stucco & stone, apply								21
22	liquid "gold coat", install base coat w/ fiberglass mesh,								22
23	apply acrylic coat, install approx 800 sq ft of stone, install								23
24	aluminum flashing, replace framing where needed	2015	73,350	1,881	39	1,881		5,643	24
25									25
26	Resurface rest of the exterior bldg in stucco & stone, apply								26
27	liquid "gold coat", install base coat w/ fiberglass mesh,								27
28	apply acrylic coat, install approx 800 sq ft of stone, install								28
29	aluminum flashing, replace framing where needed	2015	210,000	5,384	39	5,385	1	16,152	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,973,768	\$ 127,534		\$ 127,534	\$	\$ 1,174,405	34

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

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

# 0049932

Report Period Beginning:

1/1/17

Ending:

12/31/17

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,973,768	\$ 127,534		\$ 127,534		\$ 1,174,405	1
2	New Door	2016	3,611	93	39	93		182	2
3	4th Floor Quad Outlets in Generator Panel	2016	7,500	192	39	192		376	3
4	New Flooring Resident Room #208, 301, 305, 316, 324, 402, 413, 415, 43, 420 & 422	2016	5,495	141	39	141		276	4
5									5
6	Prime, patch, paint and wallpaper in 12 Residential Rooms on 2nd Floor	2016	11,600	297	39	297		582	6
7									7
8	Prime, patch, paint and wallpaper 2nd floor dining room, library, bathroom & railing 2nd Floor	2016	1,928	49	39	49		96	8
9									9
10	Painting & Repair 12 Residential Rooms on 2nd Floor	2016	11,600	297	39	297		582	10
11	Install Outlets in Resident Room #205, 206, 207, 208,209, 210, 211 and 221. Repair light fixture in 2nd floor dining room	2016	3,005	77	39	77		151	11
12									12
13	Paint & patch 2 hallway bathrooms, install drywall , paint, patch electrical wall	2016	700	18	39	18		35	13
14									14
15	Emergency Panels	2016	36,000	925	39	923	(2)	1,810	15
16	Paint 1st Floor Windows & Doors, Install 3 Toilets	2016	2,589	66	39	66		130	16
17									17
18	Painting & drywall repair from broken pipe along with new tile in rooms 311, 314, 214	2017	2,983	40	39	76	36	40	18
19									19
20	Painting and repairs - Room 416, 305, 316, 326, 410, 317, 315, 324, & 417	2017	5,000	64	39	128	64	64	20
21									21
22									22
23	New Building Sign	2017	8,552	110	39	219	109	110	23
24	Ceiling & Bathroom repairs to Rooms 326,310,305,309, 318, 315, 410, 414, 405, 325	2017	4,656	60	39	119	59	60	24
25									25
26	Replace Exhaust Fans 6 & 11	2017	3,690	47	39	95	48	47	26
27	New Phone System for Social Services Office	2017	2,478	32	39	64	32	32	27
28	Chiller Headers	2017	4,843	62	39	124	62	62	28
29	AC Switch Over	2017	4,000	51	39	103	52	51	29
30	Relocate 2 Fire Alarm Bells from Front Office to 3rd Floor Nursing Station	2017	2,475	32	39	63	31	32	30
31									31
32	B&G Bearing Assembly fo Circulating Pump	2017	2,463	32	39	63	31	32	32
33	GAF TPO Roofing System at Elevator Penthouse	2017	8,290	106	39	213	107	106	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,107,227	\$ 130,325		\$ 130,954	\$ 629	\$ 1,179,261	34

\*\*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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,107,227	\$ 130,325		\$ 130,954	\$ 629	\$ 1,179,261	1
2	8 Resident Room Bathroom Floors	2017	2,486	32	39	64	32	32	2
3	Replace 6" Test Header Valve for Sprinkler System	2017	3,010	36	39	77	41	36	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	TOTAL (lines 1 thru 33)		\$ 5,112,723	\$ 130,393		\$ 131,095	\$ 702	\$ 1,179,329	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 853,411	\$ 29,561	\$ 170,843	\$ 141,282	5	\$ 773,231	71
72	Current Year Purchases	41,852	4,908	8,370	3,462	5	4,908	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 895,263	\$ 34,469	\$ 179,213	\$ 144,744		\$ 778,139	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)	\$ 6,307,986	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 164,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 310,308	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 145,446	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,957,468	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number

Continental Nsg & Rehab Ctr

# 0049932

Report Period Beginning: 1/1/17

Ending: 12/31/17

**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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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.

**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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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	\$	4,400	\$ 274,790	\$	4,400	\$ 274,790	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,182	115,109		2,182	115,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,936	332,728		5,936	332,728	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				233,848		233,848	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs				9,386		9,386	11
12	Other (specify): <u>X-ray &amp; Lab</u>	39-2								12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	12,518	\$ 722,627	\$ 243,234	12,518	\$ 965,861	14

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

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (124,842)	\$ 251,077	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,328,520	3,328,520	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	238,179	238,179	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow accounts</u>		152,059	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,441,857	\$ 3,969,835	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	1,112,723	1,112,723	15
16	Equipment, at Historical Cost	395,264	895,264	16
17	Accumulated Depreciation (book methods)	(403,895)	(1,957,468)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	140,212	6,502,871	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,394)	(4,137,120)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Replacement Reserves</u>		388,027	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,242,910	\$ 7,104,297	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,684,767	\$ 11,074,132	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,092,833	\$ 1,243,061	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,789	33,789	28
29	Short-Term Notes Payable		137,532	29
30	Accrued Salaries Payable	170,400	170,400	30
31	Accrued Taxes Payable (excluding real estate taxes)	83,956	83,956	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		25,983	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Working Capital</u>	8,338,534	8,338,534	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 9,719,512	\$ 10,033,255	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		8,177,101	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>	\$	\$ 8,177,101	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 9,719,512	\$ 18,210,356	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (5,034,745)	\$ (7,136,224)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,684,767	\$ 11,074,132	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,807,327)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,807,327)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,227,418)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,227,418)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(5,034,745)</b>	<b>24</b> *

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

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

# 0049932

Report Period Beginning: 1/1/17

Ending: 12/31/17

**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	\$ 7,795,559	1
2	Discounts and Allowances for all Levels	796,940	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,592,499	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	713,184	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 713,184	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	120,239	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,845	19
20	Radiology and X-Ray	2,598	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 136,682	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	23,477	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,477	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Miscellaneous Income</b>	3,435	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,435	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,469,277	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,485,240	31
32	Health Care	4,406,531	32
33	General Administration	2,186,888	33
<b>B. Capital Expense</b>			
34	Ownership	1,812,721	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	243,234	35
36	Provider Participation Fee	352,334	36
<b>D. Other Expenses (specify):</b>			
37	<u>Medically necessary transportation</u>	19,223	37
38	<u>Bad debt expense</u>	190,524	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,696,695	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,227,418)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,227,418)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,529,586	44
45	Private Pay - Net Inpatient Revenue	15,340	45
46	Medicare - Net Inpatient Revenue	1,453,600	46
47	Other-(specify)	593,973	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,592,499	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:

1/1/17

Ending:

12/31/17

**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	2,140	2,182	\$ 120,980	\$ 55.44	1
2	Assistant Director of Nursing	5,537	5,963	216,944	36.38	2
3	Registered Nurses	21,856	23,666	788,772	33.33	3
4	Licensed Practical Nurses	20,439	22,919	626,621	27.34	4
5	CNAs & Orderlies	82,578	90,389	1,254,598	13.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,615	6,054	79,122	13.07	9
10	Activity Assistants					10
11	Social Service Workers	3,874	4,035	105,009	26.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,816	22,718	315,633	13.89	15
16	Dishwashers					16
17	Maintenance Workers	3,885	4,079	100,403	24.61	17
18	Housekeepers	16,478	17,836	239,021	13.40	18
19	Laundry	3,470	3,873	63,120	16.30	19
20	Administrator	2,051	2,322	136,893	58.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,352	17,994	274,739	15.27	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	1,963	2,254	41,791	18.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	1,663	1,746	88,727	50.82	33
34	TOTAL (lines 1 - 33)	208,717	228,030	\$ 4,452,373 *	\$ 19.53	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	263	\$ 12,359	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,591	55,668	10-3	38
39	Pharmacist Consultant	251	12,573	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	127	7,853	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,232	\$ 88,453		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. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jonathon Dixon	Administrator		\$ 18,769	Workers' Compensation Insurance	\$ 144,680	IDPH License Fee	\$	
Dino Varnavas	Administrator		118,124	Unemployment Compensation Insurance	13,949	Advertising: Employee Recruitment		
				FICA Taxes	341,018	Health Care Worker Background Check		
				Employee Health Insurance	218,253	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	9,572	
				Pension	63,046	ILL Dept of Health	1,990	
				Uniforms	3,014	City of Chicago	1,079	
				Employee Expense	10,109	Lincoln Square Ravenswood Chamber	200	
						Other	968	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 136,893			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,809	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 794,069	
			\$					
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Description	Amount
(Attach a copy of any management service agreement)							Out-of-State Travel	\$
C. Professional Services								
Vendor/Payee	Type		Amount				In-State Travel	
Bradley Associates	Accounting		\$ 11,634				Auto Allowance	4,383
Johnson, Goldburg	Accounting		3,900				Mileage	14,944
Hennessy & Roach	Legal		6,289				Seminar Expense	
Hepler Brrom	Legal		4,406				Education and Seminars	3,155
Infinity Funding/Sedgwick	Legal		123,718					
Johnson & Bell	Legal		(4,313)				Entertainment Expense	( )
Peter D. Corti Law Group P.C.	Legal		1,650				(agree to Sch. V, line 24, col. 8)	
Misc	Various		2,819				TOTAL	\$ 22,482
MTS consulting	Professional		6,486					
Empire Risk	Professional		12,000					
Infinity Healthcare	Professional/Mgmt		335,480					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 504,069	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*See instructions.

