

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0049932</u></p> <p>Facility Name: <u>Continental Nursing & Rehabilitation Center, LLC</u></p> <p>Address: <u>5336 N. Western Ave</u> <u>Chicago</u> <u>60625</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 449-1900</u> Fax # <u>(708) 449-1500</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/01/08</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>(317) 237-5500</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/18</u> to <u>12/31/18</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Paresh Vipani</u> (Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>CFO</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td> </tr> <tr> <td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Paresh Vipani</u> (Date) _____	Paid Preparer	(Title) <u>CFO</u>	(Signed) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225</u>		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932 Report Period Beginning: 1/1/18 Ending: 12/31/18

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	38,853	927	3,636	43,416	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,853	927	3,636	43,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.19%

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Continental Nursing & Rehabilitation Center # 0049932 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	349,229	31,012	11,915	392,156		392,156	(27)	392,129		1
2	Food Purchase		272,633		272,633		272,633	1,186	273,819		2
3	Housekeeping	249,165	34,897		284,062		284,062	12	284,074		3
4	Laundry	77,672	24,924		102,596		102,596		102,596		4
5	Heat and Other Utilities			297,097	297,097		297,097	1,960	299,057		5
6	Maintenance	106,168	37,834	121,225	265,227		265,227	1,074	266,301		6
7	Other (specify):*										7
8	TOTAL General Services	782,234	401,300	430,237	1,613,771		1,613,771	4,205	1,617,976		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,095,320	234,858	55,668	3,385,846		3,385,846	(20,802)	3,365,044		10
10a	Therapy			634,028	634,028		634,028		634,028		10a
11	Activities	137,635	11,098		148,732		148,732		148,732		11
12	Social Services	120,908		7,714	128,622		128,622		128,622		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			12,870	12,870		12,870	(300)	12,570		15
16	TOTAL Health Care and Programs	3,353,863	245,955	740,279	4,340,098		4,340,098	(21,102)	4,318,996		16
	C. General Administration										
17	Administrative	126,388			126,388		126,388	(29,731)	96,657		17
18	Directors Fees										18
19	Professional Services			460,295	460,295		460,295	(344,275)	116,020		19
20	Dues, Fees, Subscriptions & Promotions			7,370	7,370		7,370	(87)	7,283		20
21	Clerical & General Office Expenses	145,971	68,952	453,419	668,342		668,342	(83,674)	584,668		21
22	Employee Benefits & Payroll Taxes			811,462	811,462		811,462	28,916	840,378		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,338	17,338		17,338	(1,534)	15,804		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			341,760	341,760		341,760	64,131	405,891		26
27	Other (specify):*										27
28	TOTAL General Administration	272,358	68,952	2,091,644	2,432,955		2,432,955	(366,254)	2,066,701		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,408,455	716,208	3,262,161	8,386,824		8,386,824	(383,151)	8,003,673		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			61,704	61,704		61,704	250,068	311,772		30
31	Amortization of Pre-Op. & Org.			9,490	9,490		9,490	424,177	433,667		31
32	Interest			1,074,278	1,074,278		1,074,278	299,525	1,373,803		32
33	Real Estate Taxes							312,212	312,212		33
34	Rent-Facility & Grounds			1,575,348	1,575,348		1,575,348	(1,571,469)	3,879		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			2,720,820	2,720,820		2,720,820	(285,487)	2,435,333		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			39,139	39,139		39,139		39,139		38
39	Ancillary Service Centers		208,634		208,634		208,634	(4,433)	204,201		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			358,870	358,870		358,870		358,870		42
43	Other (specify):*			113,806	113,806		113,806	(113,806)	0		43
44	TOTAL Special Cost Centers		208,634	511,815	720,450		720,450	(118,239)	602,211		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,408,455	924,843	6,494,796	11,828,094		11,828,094	(786,877)	11,041,217		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	147,504	30		9
10	Interest and Other Investment Income	(12,869)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(27)	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	(119,750)	21		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	(113,806)	43		24
25	Fund Raising, Advertising and Promotional	(16,549)	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	(6,499)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,996)		\$	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)	(664,881)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (664,881)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (786,877)		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				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Continental Nursing & Rehabilitation Center, LLC

ID# 0049932

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	RP Profit	\$ (109)	10	1
2	RP Profit	(300)	15	2
3	RP Profit	(4,433)	39	3
4	Misc Income	(1,115)	10	4
5	Misc Income	(417)	21	5
6	PAC Expense	(125)	20	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
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,499)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	(27)	0	0	0	0	0	0	0	0	0	0	(27)	1
2	Food Purchase	0	1,186	0	0	0	0	0	0	0	0	0	1,186	2
3	Housekeeping	0	12	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,960	0	0	0	0	0	0	0	0	0	1,960	5
6	Maintenance	0	1,074	0	0	0	0	0	0	0	0	0	1,074	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(27)	4,232	0	0	0	0	0	0	0	0	0	4,205	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,224)	(19,578)	0	0	0	0	0	0	0	0	0	(20,802)	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):*	(300)	0	0	0	0	0	0	0	0	0	0	(300)	15
16	TOTAL Health Care and Programs	(1,524)	(19,578)	0	0	0	0	0	0	0	0	0	(21,102)	16
	C. General Administration													
17	Administrative	0	(29,731)	0	0	0	0	0	0	0	0	0	(29,731)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(349,186)	4,911	0	0	0	0	0	0	0	0	(344,275)	19
20	Fees, Subscriptions & Promotions	(125)	38	0	0	0	0	0	0	0	0	0	(87)	20
21	Clerical & General Office Expenses	(136,716)	52,914	128	0	0	0	0	0	0	0	0	(83,674)	21
22	Employee Benefits & Payroll Taxes	0	28,916	0	0	0	0	0	0	0	0	0	28,916	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(1,534)	0	0	0	0	0	0	0	0	0	(1,534)	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	1,046	63,085	0	0	0	0	0	0	0	0	64,131	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(136,841)	(297,537)	68,124	0	(366,254)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(138,392)	(312,883)	68,124	0	(383,151)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC# 0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	147,504	0	102,564	0	0	0	0	0	0	0	0	250,068	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	(12,869)	0	312,394	0	0	0	0	0	0	0	0	299,525	32
33	Real Estate Taxes	0	0	312,212	0	0	0	0	0	0	0	0	312,212	33
34	Rent-Facility & Grounds	0	0	(1,571,469)	0	0	0	0	0	0	0	0	(1,571,469)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	134,635	0	(420,122)	0	(285,487)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(4,433)	0	0	0	0	0	0	0	0	0	0	(4,433)	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):*	(113,806)	0	0	0	0	0	0	0	0	0	0	(113,806)	43
44	TOTAL Special Cost Centers	(118,239)	0	0	0	0	0	0	0	0	0	0	(118,239)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(121,996)	(312,883)	(351,998)	0	(786,877)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	37.50%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Infinity Healthcare Management of Illinois		\$	\$	1
2	V	2 Food Purchases		Infinity Healthcare Management of Illinois		1,186	1,186	2
3	V	3 Housekeeping		Infinity Healthcare Management of Illinois		12	12	3
4	V	5 Utilities		Infinity Healthcare Management of Illinois		1,960	1,960	4
5	V	6 Maintenance		Infinity Healthcare Management of Illinois		1,074	1,074	5
6	V	10 Nursing	55,981	Infinity Healthcare Management of Illinois		36,403	(19,578)	6
7	V	19 Professional Fees	350,847	Infinity Healthcare Management of Illinois		1,661	(349,186)	7
8	V	20 Dues & Fees	77	Infinity Healthcare Management of Illinois		115	38	8
9	V	21 Office Expense	150,188	Infinity Healthcare Management of Illinois		203,102	52,914	9
10	V	22 Employee Benefits	2,001	Infinity Healthcare Management of Illinois		30,917	28,916	10
11	V	24 Travel & Seminar	5,211	Infinity Healthcare Management of Illinois		3,677	(1,534)	11
12	V	26 Insurance		Infinity Healthcare Management of Illinois		1,046	1,046	12
13	V	17 Administrative	29,731	Infinity Healthcare Management of Illinois			(29,731)	13
14	Total		\$ 594,036			\$ 281,153	\$ * (312,883)	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 Management of Illinois		\$ 3,389	\$ 3,389
16	V	34 Rent		Infinity Healthcare Management of Illinois		3,879	3,879
17	V						
18	V	19 Professional Fees		Continental Nursing Realty, LLC		4,911	4,911
19	V	21 Office Expense		Continental Nursing Realty, LLC		128	128
20	V	26 Insurance		Continental Nursing Realty, LLC		63,085	63,085
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		309,005	309,005
24	V	33 Real Estate Taxes		Continental Nursing Realty, LLC		312,212	312,212
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			\$ 1,223,350	\$ * (351,998)

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

Facility Name & ID Number

Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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			Landmark of Des Plaines Rehab Center	Des Plaines				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 Nursing & Rehabilitation Cente # 0049932 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Nursing & Rehabilitation Center, LLC # 0049932 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD Loan		X	Mortgage	\$37,313.00	9/24/14	\$ 8,720,000	\$ 8,176,311	10/1/49	3.7500	\$ 309,005	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	10,624,587	8/31/18	3.9800	203,387	6								
7	Infinity Funding	X		Working Capital	Various	Various	Various		Various	Various	874,280	7								
8												8								
9	TOTAL Facility Related				\$37,313.00		\$ 34,720,000	\$ 18,800,898			\$ 1,386,672	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 34,720,000	\$ 18,800,898			\$ 1,386,672	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 54,589 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 2017 report.		\$	7,241	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.)		\$	339,815	2
3. Under or (over) accrual (line 2 minus line 1).		\$	332,574	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(20,362)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	312,212	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	258,371	8	
	2014	263,575	9	
	2015	303,118	10	
	2016	331,310	11	
	2017	339,815	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	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:

- 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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Nursing & Rehabilitation Center, LLC 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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>13-12-226-006-0000</u>	<u>Nursing Facility</u>	\$ <u>287,798.00</u>	\$ <u>287,798.00</u>
2. <u>13-12-226-007-0000</u>	<u>Nursing Facility</u>	\$ <u>45,567.00</u>	\$ <u>45,567.00</u>
3. <u>13-12-226-018-0000</u>	<u>Nursing Facility</u>	\$ <u>6,450.00</u>	\$ <u>6,450.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>339,815.00</u></u>	\$ <u><u>339,815.00</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Home, 108,000, 2008, \$ 300,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 108,000, (blank), \$ 300,000, 3.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	208		2008	1976	\$ 4,000,000	\$ 102,564	39	\$ 102,564	\$	\$ 1,156,137	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing		2008		1,106	28	39	28		303	9
10	TV System		2008		4,000	103	39	103		1,105	10
11	Alarm		2008		695	18	39	18		192	11
12	Alarm		2008		682	17	39	17		186	12
13	Alarm		2008		741	19	39	19		204	13
14	Alarm Service		2008		537	14	39	14		149	14
15	Waste Disposal Machine		2009		833	21	39	21		212	15
16	Cooling Tower		2009		3,274	84	39	84		840	16
17	Roofwork		2009		4,500	116	39	115	(1)	1,158	17
18	New Water Heater		2010		15,928	408	39	408		3,675	18
19	Sprinkler Heads		2010		7,900	203	39	203		1,826	19
20	Railing for Patio and Stairwells		2010		10,434	269	39	268	(1)	2,415	20
21	Repair Roof		2010		550	14	39	14		126	21
22	Paint concrete, floor, ceiling, & balcony		2010		1,500	38	39	38		344	22
23	Roof Repair		2010		2,000	51	39	51		460	23
24	Roof Repair		2010		2,000	51	39	51		460	24
25	Hot Water Storage Tank Replacement		2011		11,900	305	39	305		2,441	25
26	Repairment of Pipe Leaks		2011		2,287	59	39	59		471	26
27	Cooling Tower Evaporator Pads		2011		1,510	39	39	39		311	27
28	Cooling Tower Evaporator Pads		2011		470	12	39	12		96	28
29	Window/Sign/Lighting/Sidewalk Work		2011		1,050	27	39	27		216	29
30	Lighting Retrofit for Facility		2011		15,762	404	39	404		3,233	30
31	System Installation		2011		1,524	39	39	39		312	31
32	New Mechanical Room Partition Wall		2011		15,920	408	39	408		3,265	32
33	Construction Permit/Drawings		2011		1,588	41	39	41		327	33
34	Communication system and booster		2011		7,960	204	39	204		1,632	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 & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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		\$ 294	37
38	New drains and water supply in Dialysis room	2012	10,000	256	39	256		1,793	38
39	Replace windows	2012	1,500	38	39	38		267	39
40	Contrete sidewalks and stairs	2012	4,800	123	39	123		861	40
41	Carpet Installation for front office and administration area	2012	3,200	82	39	82		574	41
42	Plumbing chase and wall cabinets in Dialysis room	2012	8,704	223	39	223		1,561	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)	52,883	51
52									52
53	Mounted fixtures 4th floor dayroom	2013	1,716	44	39	44		242	53
54	Chiller condenser	2013	3,700	95	39	95		522	54
55	Chiller condenser couplings	2013	2,871	74	39	74		407	55
56	Sprinkler system	2013	2,101	54	39	54		297	56
57	Piping valves	2013	5,300	136	39	136		748	57
58	boiler	2013	1,682	43	39	43		237	58
59	Caulking windows/buidling base	2013	2,900	74	39	74		407	59
60	4 sided smoking shelter	2013	5,422	139	39	139		765	60
61	4 sided smoking shelter	2013	1,000	26	39	26		143	61
62	Wiring on first floor	2013	16,697	428	39	428		2,354	62
63	Wallpaper, door trims, paint for resident rooms on 4th floor	2013	17,745	455	39	455		2,502	63
64	Sliding door system	2013	27,100	694	39	695	1	3,817	64
65	Electrical Wiring 4th floor dialysis unit,	2013	6,815	175	39	175		962	65
66	Cove base/vinyl 4th floor dialysis room,	2013	8,121	208	39	208		1,145	66
67	Door Alarm system	2013	2,595	67	39	67		368	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,546,864	\$ 116,587		\$ 116,585	\$ (2)	\$ 1,255,245	70

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

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,546,864	\$ 116,587		\$ 116,585	\$ (2)	\$ 1,255,245	1
2	Ceiling ligh fixtures in corridors	2014	2,053	53	39	53		265	2
3	Security Door release	2014	2,225	57	39	57		285	3
4	Electric, plumbing, drywall and painting in Dialysis Room	2014	4,060	104	39	104		520	4
5	Shield straight passage lever and vertical ejector pump	2014	4,759	122	39	122		610	5
6	Parking garage structure, lights and concrete	2014	53,182	1,364	39	1,364		6,820	6
7	Chiller barrels, cooler, thermostat, descaler for kitchen	2014	13,327	342	39	342		1,710	7
8	Sprinkler in admin office	2014	2,683	69	39	69		345	8
9	Structual engineering	2014	2,814	72	39	72		360	9
10	Waterproofing upper deck and concrete	2014	16,604	426	39	426		2,130	10
11	Valve repair	2014	2,235	57	39	57		285	11
12	install grab bars	2014	9,374	240	39	240		1,200	12
13									13
14									14
15	New canopy in smoking area	2015	7,900	202	39	203	1	808	15
16	Clean and service chiller	2015	4,118	106	39	106		424	16
17	Remove wallpaper, sand, paint 25 rooms on 3rd floor	2015	12,500	321	39	321		1,284	17
18	Remove damaged railing, fix, and reinstall	2015	3,220	83	39	83		332	18
19	Purchase, deliver, & install new fire rated door	2015	2,500	64	39	64		256	19
20									20
21	Resurface I 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		7,524	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	21,536	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,973,768	\$ 127,534		\$ 127,534	\$	\$ 1,301,939	34

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

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,973,768	\$ 127,534		\$ 127,534	\$	\$ 1,301,939	1
2	New Door	2016	3,611	93	39	93		276	2
3	4th Floor Quad Outlets in Generator Panel	2016	7,500	192	39	192		569	3
4	New Flooring Resident Room #208, 301, 305, 316, 324, 402,	2016	5,495	141	39	141		417	4
5	413, 415, 43, 420 & 422								5
6	Prime, patch, paint and wallpaper in 12 Residential Rooms	2016	11,600	297	39	297		879	6
7	on 2nd Floor								7
8	Prime, patch, paint and wallpaper 2nd floor dining room,	2016	1,928	49	39	49		145	8
9	library, bathroom & railing 2nd Floor								9
10	Painting & Repair 12 Residential Rooms on 2nd Floor	2016	11,600	297	39	297		879	10
11	Install Outlets in Resident Room #205, 206, 207, 208,209, 210,	2016	3,005	77	39	77		228	11
12	211 and 221. Repair light fixture in 2nd floor dining room								12
13	Paint & patch 2 hallway bathrooms, install drywall , paint,	2016	700	18	39	18		53	13
14	patch electrical wall								14
15	Emergency Panels	2016	36,000	925	39	923	(2)	2,731	15
16	Paint 1st Floor Windows & Doors, Install 3 Toilets	2016	2,589	66	39	66		196	16
17									17
18	Painting & drywall repair from broken pipe along with new	2017	2,983	76	39	76		116	18
19	tile in rooms 311, 314, 214								19
20	Painting and repairs - Room 416, 305, 316, 326,	2017	5,000	128	39	128		192	20
21	410, 317, 315, 324, & 417								21
22									22
23	New Building Sign	2017	8,552	219	39	219		329	23
24	Ceiling & Bathroom repairs to Rooms 326,310,305,309,	2017	4,656	119	39	119		179	24
25	318, 315, 410, 414, 405, 325								25
26	Replace Exhaust Fans 6 & 11	2017	3,690	95	39	95		142	26
27	New Phone System for Social Services Office	2017	2,478	64	39	64		96	27
28	Chiller Headers	2017	4,843	124	39	124		186	28
29	AC Switch Over	2017	4,000	103	39	103		154	29
30	Relocate 2 Fire Alarm Bells from Front Office to 3rd Floor	2017	2,475	63	39	63		95	30
31	Nursing Station								31
32	B&G Bearing Assembly fo Circulating Pump	2017	2,463	63	39	63		95	32
33	GAF TPO Roofing System at Elevator Penthouse	2017	8,290	213	39	213		319	33
34	TOTAL (lines 1 thru 33)		\$ 5,107,227	\$ 130,956		\$ 130,954	\$ (2)	\$ 1,310,215	34

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

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	\$ 130,956		\$ 130,954	\$ (2)	\$ 1,310,215	1
2	8 Resident Room Bathroom Floors	2017	2,486	64	39	64		96	2
3	Replace 6" Test Header Valve for Sprinkler System	2017	3,010	77	39	77		116	3
4									4
5	Closed Loop Water Filtration Filter	2018	2,850	37	39	73	36	37	5
6	New Walk-In Cooler and cooling tower circulation pump	2018	8,304	106	39	213	107	106	6
7	Electrical & Lighting Work Throughout Building	2018	3,240	42	39	83	41	42	7
8	Upgrade Fire Alarm System	2018	7,655	98	39	196	98	98	8
9	Require Computer Wires & Cabling	2018	6,110	78	39	157	79	78	9
10	Repair Wall Above Window in 2nd Floor Dining Room	2018	3,292	42	39	84	42	42	10
11	New Generator Room Louvers	2018	3,432	44	39	88	44	44	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)		\$ 5,147,606	\$ 131,544		\$ 131,989	\$ 445	\$ 1,310,874	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	\$ 174,586	\$ 32,463	\$ 34,917	\$ 2,454	5	\$ 89,923	71
72	Current Year Purchases	3,653	261	731	470	5	261	72
73	Fully Depreciated Assets	720,678		144,136	144,136	5	720,678	73
74								74
75	TOTALS	\$ 898,917	\$ 32,724	\$ 179,783	\$ 147,059		\$ 810,862	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)	\$ 6,346,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 164,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,772	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 147,504	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,121,736	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	TOTAL				\$			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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	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

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$	3,587	\$ 234,174	\$	3,587	\$ 234,174	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,543	152,267		2,543	152,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,125	247,587		5,125	247,587	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				198,670		198,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-ray & Lab</u>	39-2					9,964		9,964	12
13	Other (specify): _____									13
14	TOTAL			\$	11,255	\$ 634,028	\$ 208,634	11,255	\$ 842,662	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 Nursing & Rehabilitation Center, LLC**

0049932

Report Period Beginning: **1/1/18**

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (85,172)	\$ (1,946)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,950,328	2,950,328	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	222,490	222,490	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow accounts</u>		124,280	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,087,645	\$ 3,295,152	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	1,147,606	1,147,606	15
16	Equipment, at Historical Cost	398,917	898,917	16
17	Accumulated Depreciation (book methods)	(465,599)	(2,121,736)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	140,212	6,502,871	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,884)	(4,570,787)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Replacement Reserves</u>)		476,962	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,210,252	\$ 6,633,834	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,297,897	\$ 9,928,986	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 749,917	\$ 872,541	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,492	30,492	28
29	Short-Term Notes Payable		142,792	29
30	Accrued Salaries Payable	205,400	205,400	30
31	Accrued Taxes Payable (excluding real estate taxes)	86,955	86,955	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		25,551	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Working Capital</u>	10,624,587	10,624,587	36
37	<u>Due to Infinity Funding</u>	(1,864)	(1,864)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,695,487	\$ 11,986,455	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,033,519	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,033,519	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,695,487	\$ 20,019,974	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,397,590)	\$ (10,090,988)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,297,897	\$ 9,928,986	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,034,745)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,034,745)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,362,845)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,362,845)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (7,397,590)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Continental Nursing & Rehabilitation Center, LLC # 0049932 Report Period Beginning: 1/1/18

Ending: 12/31/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,908,387	1
2	Discounts and Allowances for all Levels	790,103	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,698,490	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	626,294	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 626,294	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	116,162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,358	19
20	Radiology and X-Ray	3,745	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,265	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,279	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,279	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	1,920	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,920	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,465,248	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,613,771	31
32	Health Care	4,340,098	32
33	General Administration	2,432,955	33
B. Capital Expense			
34	Ownership	2,720,820	34
C. Ancillary Expense			
35	Special Cost Centers	208,634	35
36	Provider Participation Fee	358,870	36
D. Other Expenses (specify):			
37	Medically necessary transportation	39,139	37
38	Bad debt expense	113,806	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,828,093	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,362,845)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,362,845)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,947,029	44
45	Private Pay - Net Inpatient Revenue	177,000	45
46	Medicare - Net Inpatient Revenue	1,331,713	46
47	Other-(specify)	242,749	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,698,491	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 Nursing & Rehabilitation Center, LLC

0049932

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	2,196	2,213	\$ 125,223	\$ 56.58	1
2	Assistant Director of Nursing	5,408	5,603	210,763	37.61	2
3	Registered Nurses	24,181	25,993	873,444	33.60	3
4	Licensed Practical Nurses	20,989	22,592	657,825	29.12	4
5	CNAs & Orderlies	69,871	76,213	1,141,564	14.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	9,600	10,291	137,635	13.37	9
10	Activity Assistants					10
11	Social Service Workers	4,210	4,419	120,908	27.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,007	22,499	349,229	15.52	15
16	Dishwashers					16
17	Maintenance Workers	3,968	4,331	106,168	24.52	17
18	Housekeepers	16,654	18,267	249,165	13.64	18
19	Laundry	3,693	4,394	77,672	17.68	19
20	Administrator	1,228	1,703	126,388	74.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,296	8,920	145,971	16.36	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	1,879	2,126	40,240	18.93	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	1,979	2,160	46,262	21.41	33
34	TOTAL (lines 1 - 33)	195,159	211,726	\$ 4,408,455 *	\$ 20.82	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	254	\$ 11,915	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	257	12,870	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	320	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	42	2,583	12-3	45
46	Other(specify)				46
47					47
48	<u>Marketing Consultant</u>	10	500	21-3	48
49	TOTAL (lines 35 - 48)	2,160	\$ 83,856		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

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? Yes
If YES, give association name and amount. Illinois Council - \$125
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 52,593 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 358,870
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0%
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? N/A**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees