

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR

0049932 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	42,555	742	5,562	48,859	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,555	742	5,562	48,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.36%

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

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

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

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

NONE

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 3/31/08

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

YES Date _____ 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 4,570

Medicare Intermediary WISCONSIN PHYSICIANS SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

CONTINENTAL NURSING & REHABILITATION

0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	285,851	21,978	15,000	322,829		322,829	(522)	322,307		1
2	Food Purchase		203,780		203,780		203,780		203,780		2
3	Housekeeping	212,265	36,521		248,786		248,786		248,786		3
4	Laundry	52,860	13,627		66,487		66,487		66,487		4
5	Heat and Other Utilities			259,091	259,091		259,091		259,091		5
6	Maintenance	77,029	27,274	67,668	171,971		171,971	(2,934)	169,037		6
7	Other (specify):*										7
8	TOTAL General Services	628,005	303,180	341,759	1,272,944		1,272,944	(3,456)	1,269,488		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,340,401	399,701	30,388	2,770,490		2,770,490	19,405	2,789,895		10
10a	Therapy			489,071	489,071		489,071		489,071		10a
11	Activities	74,801	8,061		82,862		82,862		82,862		11
12	Social Services	87,543		13,599	101,142		101,142		101,142		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy			19,619	19,619		19,619		19,619		15
16	TOTAL Health Care and Programs	2,502,745	407,762	570,677	3,481,184		3,481,184	19,405	3,500,589		16
	C. General Administration										
17	Administrative	79,378			79,378		79,378		79,378		17
18	Directors Fees										18
19	Professional Services			352,936	352,936		352,936	(250,054)	102,882		19
20	Dues, Fees, Subscriptions & Promotions			6,511	6,511		6,511	478	6,989		20
21	Clerical & General Office Expenses	210,956	82,951	16,061	309,968		309,968	69,099	379,067		21
22	Employee Benefits & Payroll Taxes			603,152	603,152		603,152	26,716	629,868		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,056	14,056		14,056	(9,203)	4,853		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			187,163	187,163		187,163	7,295	194,458		26
27	Other (specify):*										27
28	TOTAL General Administration	290,334	82,951	1,179,879	1,553,164		1,553,164	(155,669)	1,397,495		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,421,084	793,893	2,092,315	6,307,292		6,307,292	(139,720)	6,167,572		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

CONTINENTAL NURSING & REHABILITATION CTR #0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,484	58,484		58,484	126,683	185,167			30
31	Amortization of Pre-Op. & Org.			143	143		143	424,177	424,320			31
32	Interest			74,247	74,247		74,247	471,051	545,298			32
33	Real Estate Taxes							167,632	167,632			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,319,246)	754			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,452,874	1,452,874		1,452,874	(129,703)	1,323,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			318,767	318,767		318,767		318,767			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,880	113,880		113,880		113,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			432,647	432,647		432,647		432,647			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,421,084	793,893	3,977,836	8,192,813		8,192,813	(269,423)	7,923,390			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(47,310)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(1,390)	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				24
25	Fund Raising, Advertising and Promotional	(24,308)	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	(38,413)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (111,441)		\$	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)	(157,982)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (157,982)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (269,423)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	

ID# 0049932

Report Period Beginning: 1/1/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	COMMUTING	\$ (9,580)	24	1
2	VENDING INCOME	(1,557)	6	2
3	MEDICAL RECORDS INCOME	(1,249)	10	3
4	PURCHASE DISCOUNT	(24,583)	21	4
5	VENDING INCOME	(1,444)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(38,413)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR# 0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(20)	(502)	0	0	0	0	0	0	0	0	0	(522)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,001)	67	0	0	0	0	0	0	0	0	0	(2,934)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,021)	(435)	0	0	0	0	0	0	0	0	0	(3,456)	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	(1,249)	20,654	0	0	0	0	0	0	0	0	0	19,405	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,249)	20,654	0	0	0	0	0	0	0	0	0	19,405	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(274,408)	24,354	0	0	0	0	0	0	0	0	(250,054)	19
20	Fees, Subscriptions & Promotions	0	228	250	0	0	0	0	0	0	0	0	478	20
21	Clerical & General Office Expenses	(50,281)	119,380	0	0	0	0	0	0	0	0	0	69,099	21
22	Employee Benefits & Payroll Taxes	0	26,716	0	0	0	0	0	0	0	0	0	26,716	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,580)	377	0	0	0	0	0	0	0	0	0	(9,203)	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	461	6,834	0	0	0	0	0	0	0	0	7,295	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(59,861)	(127,246)	31,438	0	0	0	0	0	0	0	0	(155,669)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,131)	(107,027)	31,438	0	0	0	0	0	0	0	0	(139,720)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR

0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	(47,310)	0	173,993	0	0	0	0	0	0	0	0	126,683	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	0	0	471,051	0	0	0	0	0	0	0	0	471,051	32
33	Real Estate Taxes	0	0	167,632	0	0	0	0	0	0	0	0	167,632	33
34	Rent-Facility & Grounds	0	(1,319,246)	0	0	0	0	0	0	0	0	0	(1,319,246)	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	(47,310)	(1,319,246)	1,236,853	0	0	0	0	0	0	0	0	(129,703)	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	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(111,441)	(1,426,273)	1,268,291	0	0	0	0	0	0	0	0	(269,423)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHMENT #1						

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

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

1	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	10 NURSING	\$ 21,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	\$ 41,654	\$ 20,654	1
2	V	1 DIETARY	12,500	INFINITY HEALTHCARE MANAGEMENT		11,998	(502)	2
3	V	6 MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		67	67	3
4	V	21 OFFICE EXPENSE	6,798	INFINITY HEALTHCARE MANAGEMENT		125,986	119,188	4
5	V	19 PROFESSIONAL SERVICES	274,900	INFINITY HEALTHCARE MANAGEMENT		492	(274,408)	5
6	V	22 LIFE INSURANCE	3,315	INFINITY HEALTHCARE MANAGEMENT		30,031	26,716	6
7	V	24 AUTO/TRAVEL EXPENSE	372	INFINITY HEALTHCARE MANAGEMENT		749	377	7
8	V	34 FACILITY/GROUNDS		INFINITY HEALTHCARE MANAGEMENT		754	754	8
9	V	26 INSURANCE		INFINITY HEALTHCARE MANAGEMENT		461	461	9
10	V	15 PHARMACY		INFINITY HEALTHCARE MANAGEMENT				10
11	V	20 CLASSIFIED ADS		INFINITY HEALTHCARE MANAGEMENT		228	228	11
12	V	34 RENT	1,320,000	CONTINENTAL NURSING REALTY			(1,320,000)	12
13	V	21 OTHER ADMIN EXP		CONTINENTAL NURSING REALTY		192	192	13
14	Total		\$ 1,638,885			\$ 212,612	\$ * (1,426,273)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30	DEPRECIATION	\$	CONTINENTAL NURSING REALTY		\$ 173,993	\$	173,993	15
16	V	26	LIABILITY INSURANCE		CONTINENTAL NURSING REALTY		6,834		6,834	16
17	V	32	INTEREST		CONTINENTAL NURSING REALTY		471,051		471,051	17
18	V	19	PROFESSIONAL FEES		CONTINENTAL NURSING REALTY		24,354		24,354	18
19	V	33	REAL ESTATE TAXES		CONTINENTAL NURSING REALTY		167,632		167,632	19
20	V	20	LICENSE & DUES		CONTINENTAL NURSING REALTY		250		250	20
21	V	31	AMORTIZATION		CONTINENTAL NURSING REALTY		424,177		424,177	21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 1,268,291	\$ *	1,268,291	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

CONTINENTAL NURSING & REHABILITATION

#

0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

<u>OWNERS</u>		<u>OTHER RELATED BUSINESS ENTITIES</u>		
NAME	OWNERSHIP %	NAME	CITY	TYPE OF BUSINESS
MICHAEL BLISKO	37.500%	INFINITY HEALTHCARE MANAGEMENT	HILLSIDE, IL	MANAGEMENT CO.
MOISHE GUBIN	37.500%			
C&W REALTY INVESTMENTS	20.000%			
A&F GENERAL PARTNERSHIP	<u>5.000%</u>			
	<u>100.000%</u>			

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

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR # 0049932 Report Period Beginning: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	FIRST BANK		X	MORTGAGE	INTEREST ON	1/16/08	\$ 8,800,000	\$ 8,780,000	1/16/2033	3+LIBOR	\$ 271,407	1								
2	MEISELS LIMITED PARTNERSHIP	X		MORTGAGE	\$16,909.00	4/1/08	2,254,553	2,130,000	4/1/2012	9.0000	199,644	2								
3												3								
4												4								
5												5								
Working Capital																				
6	FIRST BANK		X	WORKING CAPITAL	NONE	11/1/09	1,280,000	1,463,446	11/1/2011	5.5000	74,247	6								
7												7								
8												8								
9	TOTAL Facility Related				\$16,909.00		\$ 12,334,553	\$ 12,373,446			\$ 545,298	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 12,334,553	\$ 12,373,446			\$ 545,298	15								

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	189,428	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	167,632	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(21,796)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	189,428	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.		\$	167,632	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005		8
	2006		9
	2007	250,331	10
	2008	252,842	11
	2009	167,729	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL NURSING & REHABILITATION CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049932

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(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 HOME</u>	\$ <u>127,820.13</u>	\$ <u>127,820.13</u>
2. <u>13-12-226-007-0000</u>	<u>NURSING HOME</u>	\$ <u>24,284.00</u>	\$ <u>24,284.00</u>
3. <u>13-12-226-018-0000</u>	<u>NURSING HOME</u>	\$ <u>15,525.16</u>	\$ <u>15,525.16</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>167,629.29</u></u>	\$ <u><u>167,629.29</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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,288 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 130,250 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 8,683 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$	\$ 282,051	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing		12/21/2008		1,106	28	39	28	(0)	59	9
10	TV System		8/14/2008		4,000	103	39	103	0	324	10
11	Alarm		8/5/2008		695	18	39	18	0	43	11
12	Alarm		8/5/2008		682	17	39	17	(0)	42	12
13	Alarm		8/5/2008		741	19	39	19		46	13
14	Alarm Service		8/18/2008		537	14	39	14	0	33	14
15	Waste Disposal Machine		6/19/2008		833	21	39	21	(0)	34	15
16	Cooling Tower		7/22/2009		3,274	84	39	84	0	126	16
17	Roofwork		4/1/2009		4,500	115	39	115	(0)	202	17
18	New Water Heater		5/19/2010		15,928	408	39	272	(136)	272	18
19	Sprinkler Heads		8/24/2010		7,900	203	39	84	(119)	84	19
20	Railing for Patio and Stairwells		7/31/2010		10,434	268	39	134	(134)	134	20
21	Repair Roof		5/18/2010		550	14	39	9	(5)	9	21
22	Paint concrete, floor, ceiling, & balcony		8/16/2010		1,500	38	39	16	(22)	16	22
23	Roof Repair		9/3/2010		2,000	51	39	17	(34)	17	23
24	Roof Repair		11/12/2010		2,000	51	39	9	(42)	9	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	4,056,680	\$	104,017	\$	103,524	\$	(493)	\$	283,501	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION # 0049932 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 533,174	\$ 78,063	\$ 78,063	\$	Various	\$ 230,693	71
72	Current Year Purchases	55,900	50,397	3,580	(46,817)	Various	3,580	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 589,074	\$ 128,460	\$ 81,643	\$ (46,817)		\$ 234,273	75

D. Vehicle Depreciation (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)	\$ 4,945,754	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 232,477	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,167	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,310)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 517,774	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2011	\$ _____
13.	_____/2012	\$ _____
14.	_____/2013	\$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 206,020	\$		\$ 206,020	1
2	Licensed Speech and Language Development Therapist		hrs			103,762			103,762	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			179,289			179,289	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				311,600		311,600	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology & Lab						7,167		7,167	13
14	TOTAL			\$		\$ 489,071	\$ 318,767		\$ 807,838	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR # 0049932 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	\$ 130,977	\$ 507,325	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,305,620	3,339,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108,759	108,759	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,545,356	\$ 3,955,855	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	56,680	56,680	15
16	Equipment, at Historical Cost	89,074	589,074	16
17	Accumulated Depreciation (book methods)	(86,839)	(565,319)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	2,144	6,364,803	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	(393)	(1,166,880)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,666	\$ 9,578,358	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,606,022	\$ 13,534,213	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,648,267	\$ 1,837,695	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	431,240	431,240	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,079,507	\$ 2,268,935	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	550,000	550,000	39
40	Mortgage Payable		10,910,000	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)	\$ 550,000	\$ 11,460,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,629,507	\$ 13,728,935	46
47	TOTAL EQUITY (page 18, line 24)	\$ (23,485)	\$ (194,722)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,606,022	\$ 13,534,213	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (33,566)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (33,566)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	160,081	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	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,081	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)	\$ (23,485)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,807,551	1
2	Discounts and Allowances for all Levels	(838,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,968,649	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,023,081	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,023,081	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	1,557	16
17	Sale of Drugs	307,493	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,674	19
20	Radiology and X-Ray	2,105	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323,829	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>VENDING</u>	1,557	28
28a	<u>MISCELLANEOUS</u>	35,777	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,334	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,352,894	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,272,944	31
32	Health Care	3,481,186	32
33	General Administration	1,553,163	33
B. Capital Expense			
34	Ownership	1,452,875	34
C. Ancillary Expense			
35	Special Cost Centers	318,767	35
36	Provider Participation Fee	113,878	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,192,813	40
41	Income before Income Taxes (line 30 minus line 40)**	160,081	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 160,081	43

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

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

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

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

Facility Name & ID Number CONTINENTAL NURSING & REHABILITATION CTR

0049932

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	2,085	2,289	\$ 108,472	\$ 47.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,051	33,366	1,004,266	30.10	3
4	Licensed Practical Nurses	19,337	21,088	517,644	24.55	4
5	CNAs & Orderlies	61,476	66,442	679,370	10.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,145	7,565	74,801	9.89	9
10	Activity Assistants					10
11	Social Service Workers	4,696	5,208	87,543	16.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,115	23,979	285,851	11.92	15
16	Dishwashers					16
17	Maintenance Workers	2,822	3,094	77,029	24.90	17
18	Housekeepers	16,299	18,437	212,265	11.51	18
19	Laundry	3,973	4,658	52,860	11.35	19
20	Administrator	1,995	2,135	79,378	37.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,490	11,727	210,956	17.99	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	1,732	2,104	30,649	14.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,216	202,092	\$ 3,421,084 *	\$ 16.93	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	429	\$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	608	30,388	10-3	38
39	Pharmacist Consultant	392	19,619	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	389	13,599	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,818	\$ 78,606		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	Amount	
Joseph Javier	ADMIN	0	\$ 25,368	Workers' Compensation Insurance	\$ 97,124	IDPH License Fee	\$		
Rudolf Sternschein	ADMIN	0	24,820	Unemployment Compensation Insurance	65,792	Advertising: Employee Recruitment			
Marcelino Villafania	ADMIN	0	29,190	FICA Taxes	262,252	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	137,201	Patient Background Checks			
				Employee Meals		City of Chicago	3,361		
				Illinois Municipal Retirement Fund (IMRF)*		Chicago Dept of Rev	210		
				UNIFORMS	9,147	Chicago Public Depart	1,990		
TOTAL (agree to Schedule V, line 17, col. 1)				EMPLOYEE PENSION	44,332	Secretary of State	580		
(List each licensed administrator separately.)			\$ 79,378		14,020	Filing Fees	848		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 629,868		\$ 6,989		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount			\$		\$	
MONTE LAW FIRM	LEGAL		50				Out-of-State Travel		
MEYER MAGENCE	LEGAL		63						
DANIELLE SINGER	LEGAL		1,522				In-State Travel		
BRADLEY & ASSOCIATES	ACCOUNTING		9,334				MILEAGE	1,691	
RUTTENBERG ROTH	ACCOUNTING		2,454						
INFINITY HEALTHCARE MGT.	MANAGEMENT CO.		339,513				Seminar Expense		
							EDUCATION	2,602	
							SEMINAR	560	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 352,936	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 4,853	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,248 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,880
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT