FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049932

Facility Name: CONTINENTAL NURSING AND REHABILITATION

Address: 5336 NORTH WESTERN AVENUE (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 271-5600 **Fax #** (773) 271-2144

HFS ID Number:

Date of Initial License for Current Owners: 3/1/08

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

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

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 3/31/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 208 and days of care provided 6,573

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,910	38,910		38,910	160,387	199,297			30
31	Amortization of Pre-Op. & Org.			143	143		143	424,177	424,320			31
32	Interest			53,289	53,289		53,289	476,315	529,604			32
33	Real Estate Taxes							209,015	209,015			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,306,678)	13,322			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			1,786	1,786		1,786		1,786			36
37	TOTAL Ownership			1,414,128	1,414,128		1,414,128	(36,784)	1,377,344			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		392,420		392,420		392,420	(1,144)	391,276			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,880	113,880		113,880		113,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		392,420	113,880	506,300		506,300	(1,144)	505,156			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,911,539	1,321,112	3,821,921	9,054,572		9,054,572	(99,848)	8,954,724			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,606)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,271)	21		25
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	(22,930)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,829)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(50,019)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (50,019)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (99,848)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

CONTINENTAL NURSING AND REHABILITATION

ID# 0049932

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (877)	6	1
2	MISC. INCOME - VENDING	(918)	6	2
3	MISC. INCOME - MEDICAL RECORDS	(1,612)	10	3
4	MISC. INCOME - THERAPY	(548)	10A	4
5	MISC. INCOME - OFFICE	(507)	21	5
6	MISC. INCOME - LAB	(1,144)	39	6
7	COMMUTING	(7,324)	24	7
8	G/L CORRECTION - RECLASSED EXP.	(10,000)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,930)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(22)	(4,859)	0	0	0	0	0	0	0	0	0	(4,881)	1
2	Food Purchase	0	(43)	0	0	0	0	0	0	0	0	0	(43)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	535	0	0	0	0	0	0	0	0	0	535	5
6	Maintenance	(1,795)	831	0	0	0	0	0	0	0	0	0	(964)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,817)	(3,536)	0	0	0	0	0	0	0	0	0	(5,353)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,612)	19,066	0	0	0	0	0	0	0	0	0	17,454	10
10a	Therapy	(548)	0	0	0	0	0	0	0	0	0	0	(548)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,160)	19,066	0	0	0	0	0	0	0	0	0	16,906	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(243,979)	0	0	0	0	0	0	0	0	0	(243,979)	19
20	Fees, Subscriptions & Promotions	0	275	0	0	0	0	0	0	0	0	0	275	20
21	Clerical & General Office Expenses	(23,778)	180,892	71	0	0	0	0	0	0	0	0	157,185	21
22	Employee Benefits & Payroll Taxes	0	6,979	0	0	0	0	0	0	0	0	0	6,979	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,324)	524	0	0	0	0	0	0	0	0	0	(6,800)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	456	12,411	0	0	0	0	0	0	0	0	12,867	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,102)	(54,853)	12,482	0	0	0	0	0	0	0	0	(73,473)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,079)	(39,323)	12,482	0	0	0	0	0	0	0	0	(61,920)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,606)	0	173,993	0	0	0	0	0	0	0	0	160,387	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	0	0	476,315	0	0	0	0	0	0	0	0	476,315	32
33	Real Estate Taxes	0	0	209,015	0	0	0	0	0	0	0	0	209,015	33
34	Rent-Facility & Grounds	0	13,322	(1,320,000)	0	0	0	0	0	0	0	0	(1,306,678)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,606)	13,322	(36,500)	0	0	0	0	0	0	0	0	(36,784)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,144)	0	0	0	0	0	0	0	0	0	0	(1,144)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,144)	0	0	0	0	0	0	0	0	0	0	(1,144)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(49,829)	(26,001)	(24,018)	0	0	0	0	0	0	0	0	(99,848)	45

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

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	$ 10,141	$ (4,859)	1
2	V	2	FOOD	43	INFINITY HEALTHCARE MANAGEMENT			(43)	2
3	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		535	535	3
4	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		831	831	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		44,266	19,066	5
6	V	19	PROFESSIONAL SVCS.	276,000	INFINITY HEALTHCARE MANAGEMENT		269	(275,731)	6
7	V	21	OFFICE EXPENSES	33,372	INFINITY HEALTHCARE MANAGEMENT		214,264	180,892	7
8	V	22	EMPLOYEE BENEFITS	3,164	INFINITY HEALTHCARE MANAGEMENT		10,143	6,979	8
9	V	24	TRAVEL/SEMINAR		INFINITY HEALTHCARE MANAGEMENT		524	524	9
10	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		456	456	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		13,322	13,322	11
12	V	19	PROFESSIONAL FEES		CONTINENTAL NURSING REALTY		31,752	31,752	12
13	V	20	FILING FEES		CONTINENTAL NURSING REALTY		275	275	13
14	Total			$ 352,779			$ 326,778	$ * (26,001)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OFFICE EXPENSES	$	CONTINENTAL NURSING REALTY		$ 71	$ 71	15
16	V	26	INSURANCE		CONTINENTAL NURSING REALTY		12,411	12,411	16
17	V	30	DEPRECIATION		CONTINENTAL NURSING REALTY		173,993	173,993	17
18	V	31	AMORTIZATION		CONTINENTAL NURSING REALTY		424,177	424,177	18
19	V	32	INTEREST	161	CONTINENTAL NURSING REALTY		476,476	476,315	19
20	V	33	PROPERTY TAXES		CONTINENTAL NURSING REALTY		209,015	209,015	20
21	V	34	RENT	1,320,000	CONTINENTAL NURSING REALTY			(1,320,000)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,320,161			$ 1,296,143	$ * (24,018)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS

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

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
INFINITY HEALTHCARE MANAGEMENT	HILLSIDE, IL	MANAGEMENT CO.

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 189,428	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 221,007	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,579	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 177,436	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 209,015	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007	250,331	9
2008	252,842	10
2009	167,629	11
2010	221,007	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL NURSING AND REHABILITATION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049932

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. **Summary of Real Estate Tax Cost**

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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

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 [X] (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? [X] (a) Own the Equipment [X] (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? [X] YES [ ] NO
If so, please complete the following:

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 507,083	$ 72,559	$ 72,845	$ 286	various	$ 271,812	71
72	Current Year Purchases	33,679	34,788	5,371	(29,417)	5 years	34,788	72
73	Fully Depreciated Assets	81,991		16,398	16,398	various	81,991	73
74								74
75	TOTALS	$ 622,753	$ 107,347	$ 94,614	$ (12,733)		$ 388,591	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,031,443	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,903	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 199,297	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,606)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 778,222	85	

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 233,664	$		$ 233,664	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			112,246			112,246	2
3	Licensed Recreational Therapist	10A-3	hrs			219,458			219,458	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				382,570		382,570	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY/LAB	39-2					9,850		9,850	12
13	Other (specify):									13
14	TOTAL			$		$ 565,368	$ 392,420		$ 957,788	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ (312,499)	$ 189,135	1
2	Cash-Patient Deposits	(2,126)	(2,126)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,807,544	3,808,852	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	217,743	217,743	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,710,662	$ 4,213,604	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	108,689	108,689	15
16	Equipment, at Historical Cost	122,754	622,754	16
17	Accumulated Depreciation (book methods)	(125,749)	(778,222)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,144	6,364,803	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(536)	(1,591,200)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 107,302	$ 9,026,824	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,817,964	$ 13,240,428	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,982,296	$ 2,171,725	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	468,792	468,792	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKING CAPITAL NOTE	1,150,000	1,150,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,601,088	$ 3,790,517	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,847,282	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,847,282	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,601,088	$ 14,637,799	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 216,876	$ (1,397,371)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,817,964	$ 13,240,428	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (23,485)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (23,485)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	670,361	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(430,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 240,361	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 216,876	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,959,724	1
2	Discounts and Allowances for all Levels	(614,501)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,345,223	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	983,132	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 983,132	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	376,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,115	19
20	Radiology and X-Ray	4,093	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 396,984	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	877	28
28a	MISCELLANEOUS INCOME	(1,283)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (406)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,724,933	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,411,286	31
32	Health Care	4,104,991	32
33	General Administration	1,617,867	33
	B. Capital Expense		
34	Ownership	1,414,128	34
	C. Ancillary Expense		
35	Special Cost Centers	392,420	35
36	Provider Participation Fee	113,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,054,572	40
41	**Income before Income Taxes (line 30 minus line 40)****	670,361	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 670,361	43

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

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director		34,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	659	32,925	10-3	38
39	Pharmacist Consultant	231	11,527	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	403	14,109	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,722	$ 107,561		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marcelino Villafania	Admin	0%	$ 87,546
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,546

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clausen Miller	Legal	$ 17,764
Bradley Associates	Accounting	10,238
Johnson, Goldberg & Brown	Accounting	3,000
Infinity Healthcare Mgmt.	Professional Svcs.	276,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 307,002

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,083
Unemployment Compensation Insurance	86,719
FICA Taxes	303,463
Employee Health Insurance	193,116
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	4,627
Employee Expense	55,750
Pension Expense	25,023
TOTAL (agree to Schedule V, line 22, col.8)	$ 759,781

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Chug and Clia Laboratory	325
State of Illinois	25
Secretary of State	150
City of Chicago	5,480
Realty Co. - Filing Fees	275
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,255

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	2,225
Infinity - Auto Expense/Mileage	524
Seminar Expense	
Education	233
Seminar	669
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,651

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,539** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **113,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.