FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0049932

Facility Name: Continental Nsg & Rehab Ctr

Address: 5336 N Western Ave (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: 03/01/2008

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: Alan Sorscher **Telephone Number:** 708-449-1900
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 01/01/2013 to 12/31/2013 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) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	49,332	506	5,561	55,399	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,332	506	5,561	55,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.97%

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 03/31/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/31/2008 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 5,482

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	311,190	29,272	21,505	361,967		361,967	(6,400)	355,567			1
2	Food Purchase		275,203		275,203		275,203	84	275,287			2
3	Housekeeping	223,131	39,201		262,332		262,332		262,332			3
4	Laundry	60,247	27,981		88,228		88,228		88,228			4
5	Heat and Other Utilities			253,846	253,846		253,846	1,610	255,456			5
6	Maintenance	130,373	40,280	116,004	286,657		286,657	4,717	291,374			6
7	Other (specify):*											7
8	**TOTAL General Services**	724,941	411,937	391,355	1,528,233		1,528,233	11	1,528,244			8
	B. Health Care and Programs											
9	Medical Director			36,500	36,500		36,500		36,500			9
10	Nursing and Medical Records	3,037,641	330,046	37,024	3,404,711		3,404,711	5,187	3,409,898			10
10a	Therapy			762,884	762,884		762,884		762,884			10a
11	Activities	105,347	14,628		119,975		119,975		119,975			11
12	Social Services	122,434		5,146	127,580		127,580		127,580			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* pharmacy consultant			16,164	16,164		16,164		16,164			15
16	**TOTAL Health Care and Programs**	3,265,422	344,674	857,718	4,467,814		4,467,814	5,187	4,473,001			16
	C. General Administration											
17	Administrative	114,217			114,217		114,217		114,217			17
18	Directors Fees											18
19	Professional Services			464,629	464,629		464,629	(234,670)	229,959			19
20	Dues, Fees, Subscriptions & Promotions			28,165	28,165		28,165		28,165			20
21	Clerical & General Office Expenses	168,557	101,268	81,845	351,670		351,670	63,847	415,517			21
22	Employee Benefits & Payroll Taxes			880,988	880,988		880,988	27,040	908,028			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,025	3,025		3,025	3,118	6,143			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			328,190	328,190		328,190	530	328,720			26
27	Other (specify):*											27
28	**TOTAL General Administration**	282,774	101,268	1,786,842	2,170,884		2,170,884	(140,135)	2,030,749			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,273,137	857,879	3,035,915	8,166,931		8,166,931	(134,937)	8,031,994			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Continental Nsg & Rehab Ctr #0049932 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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			222,536	222,536		222,536	38,463	260,999			30
31	Amortization of Pre-Op. & Org.			424,320	424,320		424,320		424,320			31
32	Interest			785,036	785,036		785,036	(7,962)	777,074			32
33	Real Estate Taxes			258,427	258,427		258,427		258,427			33
34	Rent-Facility & Grounds			1,580,254	1,580,254		1,580,254	(1,571,135)	9,119			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,270,573	3,270,573		3,270,573	(1,540,634)	1,729,939			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		309,299		309,299		309,299		309,299			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			418,940	418,940		418,940		418,940			42
43	Other (specify):* **Bad Debt Expense**			790,822	790,822		790,822	(790,822)				43
44	**TOTAL Special Cost Centers**		309,299	1,209,762	1,519,061		1,519,061	(790,822)	728,239			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,273,137	1,167,178	7,516,250	12,956,565		12,956,565	(2,466,393)	10,490,172			45

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Refer-ence	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	38,463	30		9
10	Interest and Other Investment Income	(8,167)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(790,822)	43		24
25	Fund Raising, Advertising and Promotional	(23,437)	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	(1,578,723)	34		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,362,708)		$	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)	(103,685)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (103,685)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,466,393)		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Continental Nsg & Rehab Ctr

ID# 0049932

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc income	$ 1,531	21	1
2	rent	(1,580,254)	34	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
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33				33
34				34
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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**	(1,578,723)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Nsg & Rehab Ctr **#** 0049932 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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)	(6,378)	0	0	0	0	0	0	0	0	0	(6,400)	1
2	Food Purchase	0	84	0	0	0	0	0	0	0	0	0	84	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	1,610	0	0	0	0	0	0	0	0	0	1,610	5
6	Maintenance	0	4,717	0	0	0	0	0	0	0	0	0	4,717	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22)	33	0	0	0	0	0	0	0	0	0	11	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	0	5,187	0	0	0	0	0	0	0	0	0	5,187	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**	0	5,187	0	0	0	0	0	0	0	0	0	5,187	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	(234,670)	0	0	0	0	0	0	0	0	0	(234,670)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(21,906)	85,753	0	0	0	0	0	0	0	0	0	63,847	21
22	Employee Benefits & Payroll Taxes	0	27,040	0	0	0	0	0	0	0	0	0	27,040	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,118	0	0	0	0	0	0	0	0	0	3,118	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	530	0	0	0	0	0	0	0	0	0	530	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,906)	(118,229)	0	0	0	0	0	0	0	0	0	(140,135)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,928)	(113,009)	0	0	0	0	0	0	0	0	0	(134,937)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	38,463	0	0	0	0	0	0	0	0	0	0	38,463	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,167)	205	0	0	0	0	0	0	0	0	0	(7,962)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,580,254)	9,119	0	0	0	0	0	0	0	0	0	(1,571,135)	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**	(1,549,958)	9,324	0	0	0	0	0	0	0	0	0	(1,540,634)	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):*	(790,822)	0	0	0	0	0	0	0	0	0	0	(790,822)	43
44	**TOTAL Special Cost Centers**	(790,822)	0	0	0	0	0	0	0	0	0	0	(790,822)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,362,708)	(103,685)	0	0	0	0	0	0	0	0	0	(2,466,393)	45

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	37.50%			Infinity Healthcare	Hillside, Il	Consulting CO
Moishe Gubin	37.50%					
C & W Realty Investments	20.00%					
A & F Realty	5.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 16,781	Infinity Healthcare Management		$ 10,403	$ (6,378)	1
2	V	2	FOOD	(84)	Infinity Healthcare Management			84	2
3	V	5	UTILITIES		Infinity Healthcare Management		1,610	1,610	3
4	V	6	MAINTENANCE		Infinity Healthcare Management		4,717	4,717	4
5	V	10	NURSING	30,418	Infinity Healthcare Management		35,605	5,187	5
6	V	19	PROFESSIONAL SERVICES	235,810	Infinity Healthcare Management		1,140	(234,670)	6
7	V	21	OFFICE EXPENSES	45,457	Infinity Healthcare Management		131,210	85,753	7
8	V	22	EMPLOYEE BENEFITS	862	Infinity Healthcare Management		27,902	27,040	8
9	V	24	TRAVEL/SEMINAR	274	Infinity Healthcare Management		3,392	3,118	9
10	V	26	INSURANCE		Infinity Healthcare Management		530	530	10
11	V	34	RENT		Infinity Healthcare Management		9,119	9,119	11
12	V	19	PROFESSIONAL FEES		Infinity Healthcare Management				12
13	V	32	interest		Infinity Healthcare Management		205	205	13
14	Total			$ 329,518			$ 225,833	$ * (103,685)	14

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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18								18
19								19
20								20
21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Banco Popular		x	Mortgage	Interest Only	6/28/13	$ 8,400,000	$ 8,400,000	6/28/16	4.8000	$ 365,013	1
2	Meisels Ltd partnership		x	Loan			2,254,553		4/1/14	9.0000	149,888	2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	Working Capital	none	8/31/12	1,592,478	1,592,478	8/31/15	2.7500	43,085	6
7	Infinity Funding	x		Working Capital	none	various	3,055,484	3,055,484	various	various	227,050	7
8												8
9	TOTAL Facility Related						$ 15,302,515	$ 13,047,962			$ 785,036	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,302,515	$ 13,047,962			$ 785,036	15

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr **#** 0049932 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 173,042	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.)		$ 254,921	2
3. Under or (over) accrual (line 2 minus line 1).		$ 81,879	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 176,548	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.		$ 258,427	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	252,842	8
	2009	167,629	9
	2010	221,007	10
	2011	220,088	11
	2012	254,921	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049932

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #:

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-226-006-0000	Nursing Home	$ 214,340.77	$ 214,340.77
2.	13-12-226-007-0000	Nursing Home	$ 35,206.08	$ 35,206.08
3.	13-12-226-008-0000	Nursing Home	$ 5,374.05	$ 5,374.05
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 254,920.90	$ 254,920.90

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	2008		2008	1976	$ 4,000,000	$ 102,564	39	$ 102,564	$	$ 589,743	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing			12/21/2008	1,106	28	39	28		163	9
10	TV System			8/14/2008	4,000	103	39	103		590	10
11	Alarm			8/5/2008	695	18	39	18		102	11
12	Alarm			8/5/2008	682	17	39	17		101	12
13	Alarm			8/5/2008	741	19	39	19		109	13
14	Alarm Service			8/18/2008	537	14	39	14		79	14
15	Waste Disposal Machine			6/19/2009	833	21	39	21		107	15
16	Cooling Tower			7/22/2009	3,274	84	39	84		420	16
17	Roofwork			4/1/2009	4,500	116	39	115	(1)	578	17
18	New Water Heater			5/19/2010	15,928	409	39	408	(1)	1,634	18
19	Sprinkler Heads			8/24/2010	7,900	203	39	203		811	19
20	Railing for Patio and Stairwells			7/31/2010	10,434	268	39	268		1,071	20
21	Repair Roof			5/18/2010	550	14	39	14		56	21
22	Paint concrete, floor, ceiling, & balcony			8/16/2010	1,500	38	39	38		154	22
23	Roof Repair			9/3/2010	2,000	51	39	51		205	23
24	Roof Repair			11/12/2010	2,000	51	39	51		205	24
25	Hot Water Storage Tank Replacement			9/6/2011	11,900	305	39	305		916	25
26	Repairment of Pipe Leaks			3/1/2011	2,287	59	39	59		176	26
27	Cooling Tower Evaporator Pads			5/24/2011	1,510	39	39	39		116	27
28	Cooling Tower Evaporator Pads			5/24/2011	470	12	39	12		36	28
29	Window/Sign/Lighting/Sidewalk Work			12/1/2011	1,050	27	39	27		81	29
30	Lighting Retrofit for Facility			4/28/2011	15,762	404	39	404		1,213	30
31	System Installation			5/31/2011	1,524	39	39	39		117	31
32	New Mechanical Room Partition Wall			9/26/2011	15,920	408	39	408		1,225	32
33	Construction Permit/Drawings			9/22/2011	1,588	41	39	41		122	33
34	Communication system and booster			12/31/2011	7,960	204	39	204		612	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Sprinkler heads installation	8/10/2012	$ 1,643	$ 42	39	$ 42	$	$ 84	37
38	New drains and water supply in Dialysis room	9/13/2012	10,000	256	39	256		513	38
39	Replace windows	2/7/2012	1,500	38	39	38		77	39
40	Contrete sidewalks and stairs	10/23/2012	4,800	123	39	123		246	40
41	Carpet Installation for front office and administration area	11/21/2012	3,200	82	39	82		164	41
42	Plumbing chase and wall cabinets in Dialysis room	11/24/2012	8,704	223	39	223		446	42
43									43
44	2nd floor: corridor - ceiling tile, lighting, cove base, floor, paint, wall								44
45	coverings, room signs, artwork, nurses station cabinet tops, dayroom								45
46	ceilings, lighting								46
47	3rd floor: corridor - ceiling tile, lighting, cove base, flooring, paint,								47
48	wall coverings, room signs, nurses station cabinet tops								48
49	4th floor: corridor - ceiling tile, lighting, cove base, flooring, paint,								49
50	wall coverings, room signs, nurses station wall coverings, paint doors								50
51	Dining room chairs, tables, blinds	10/17/2012	294,602	7,555	39	7,554	(1)	15,108	51
52									52
53	Mounted fixtures 4th floor dayroom	2/7/2013	1,716	22	39	44	22	22	53
54	Chller condenser	5/15/2013	3,700	47	39	95	48	47	54
55	Chiller condenser couplings	5/15/2013	2,871	37	39	74	37	37	55
56	Sprinkler system	2/6/2013	2,101	27	39	54	27	27	56
57	Piping valves	5/31/2013	5,300	68	39	136	68	68	57
58	boiler	10/16/2013	1,682	22	39	43	21	22	58
59	Caulking windows/buidling base	5/8/2013	2,900	37	39	74	37	37	59
60	4 sided smoking shelter	2/19/2013	5,422	70	39	139	69	70	60
61	4 sided smoking shelter	5/31/2013	1,000	13	39	26	13	13	61
62	Wiring on first floor	10/31/2013	16,697	214	39	428	214	214	62
63	Wallpaper, door trims, paint	11/8/2013	17,745	228	39	455	227	228	63
64	Sliding door system	12/10/2013	27,100	346	39	695	349	346	64
65	Electrical Wiring 4th floor dialysis unit,	2013	6,815	87	39	175	88	87	65
66	Cove base/vinyl 4th floor dialysis room,	2013	8,121	105	39	208	103	105	66
67	Door Alarm system	2013	2,595	33	39	67	34	33	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,546,864	$ 115,231		$ 116,585	$ 1,354	$ 618,736	70

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 559,639	$ 82,261	$ 111,928	$ 29,667	5	$ 431,588	71
72	Current Year Purchases	45,652	25,044	9,130	(15,914)	5	25,044	72
73	Fully Depreciated Assets	116,779		23,356	23,356	5	116,779	73
74								74
75	TOTALS	$ 722,070	$ 107,305	$ 144,414	$ 37,109		$ 573,411	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)	$ 5,568,934	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,536	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 260,999	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 38,463	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,192,147	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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.	/2014	$
13.	/2015	$
14.	/2016	$

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.

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 353,608	$		$ 353,608	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			123,852			123,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			285,424			285,424	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				290,658		290,658	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): lab radiology ambulan	39-2					18,641		18,641	12
13	Other (specify):									13
14	TOTAL			$		$ 762,884	$ 309,299		$ 1,072,183	14

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 17,976	$ 116,279	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,920,447	3,920,447	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	427,759	427,759	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)**	$ 4,366,182	$ 4,464,485	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	546,865	546,865	15
16	Equipment, at Historical Cost	222,070	722,070	16
17	Accumulated Depreciation (book methods)	(191,831)	(1,192,290)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,144	6,364,804	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(679)	(2,439,697)	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)**	$ 578,569	$ 8,301,752	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,944,751	$ 12,766,237	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,253,482	$ 1,442,910	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	782,621	782,621	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 notes	4,647,962	4,647,962	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,684,065	$ 6,873,493	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,400,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,400,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,684,065	$ 15,273,493	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,739,314)	$ (2,507,256)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,944,751	$ 12,766,237	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (561,399)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (561,399)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,101,672)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)	(76,243)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,177,915)	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)**	$ (1,739,314)	24	*

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,060,443	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,060,443	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	212,467	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 212,467	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,166	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Related Party Property Co Income	1,575,348	28
28a	Misc Income	(1,531)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,573,817	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,854,893	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,528,233	31
32	Health Care	4,467,814	32
33	General Administration	2,170,884	33
	B. Capital Expense		
34	Ownership	3,270,573	34
	C. Ancillary Expense		
35	Special Cost Centers	309,299	35
36	Provider Participation Fee	418,940	36
	D. Other Expenses (specify):		
37	bad debt exp	790,822	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,956,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,101,672)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,101,672)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,591,689	44
45	Private Pay - Net Inpatient Revenue	200,218	45
46	Medicare - Net Inpatient Revenue	2,205,491	46
47	Other-(specify) Commercial Net Inpatient Revenue	63,045	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,060,443	49

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

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

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

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

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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	1,944	2,274	$ 126,384	$ 55.58	1
2	Assistant Director of Nursing	1,868	2,256	82,852	36.73	2
3	Registered Nurses	28,090	31,788	965,514	30.37	3
4	Licensed Practical Nurses	29,101	32,172	834,049	25.92	4
5	CNAs & Orderlies	85,382	94,349	1,054,981	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,665	9,553	108,717	11.38	9
10	Activity Assistants					10
11	Social Service Workers	6,786	7,400	130,045	17.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,762	24,807	311,766	12.57	15
16	Dishwashers					16
17	Maintenance Workers	4,303	4,846	107,672	22.22	17
18	Housekeepers	16,083	18,043	221,301	12.27	18
19	Laundry	4,371	5,011	65,221	13.02	19
20	Administrator	1,992	2,145	115,905	54.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,114	7,716	110,440	14.31	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	1,944	2,235	38,290	17.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,405	244,595	$ 4,273,137 *	$ 17.47	34

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

** See instructions.

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	430	$ 21,505	1-3	35
36	Medical Director		36,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	740	37,024	10-3	38
39	Pharmacist Consultant	323	16,164	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	103	5,146	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,596	$ 116,339		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrie Giroux	Admin		$ 78,765
John Marc Sianghio	Admin		35,452
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,217

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	$ 102,995
Infinity Funding	Legal	4,246
Infinity Healthcare	Professional Fees	237,553
Stirs	Professional Fees	47,500
Johnson Goldberg	Accounting	2,500
Bradley & Associates	Accounting	12,936
MTS consulting	Consulting	1,243
Michael Feldman	Consulting	750
Dolly Ford	Consulting	500
varios	legal	26,691
varios	Consulting	27,715
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 464,629

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,156
Unemployment Compensation Insurance	142,558
FICA Taxes	352,975
Employee Health Insurance	226,847
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension expense	61,481
employee expense	14,011
TOTAL (agree to Schedule V, line 22, col.8)	$ 908,028

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

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	
illinois council	22,314
IDPH	3,980
secretary of state	150
city of chicago	992
other	729
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,165

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	4,681
auto allownace	462
Seminar Expense	
seminars	1,000
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,143

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **illinois council**

(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. $ **34,076** 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. $ **418,940**
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. n/a
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 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.