FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: (708) 449-1900 **Fax #** (708) 449-1500

HFS ID Number:

Date of Initial License for Current Owners: 03/01/08

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 01/01/15 to 12/31/15 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 235-5503

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**

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	55,755	21	6,560	62,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,755	21	6,560	62,336	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.11%

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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 03/31/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/31/08 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 6,560

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,766		52,134	374,900		374,900	(7,994)	366,906			1
2	Food Purchase		324,044		324,044		324,044		324,044			2
3	Housekeeping	227,919	43,506		271,425		271,425		271,425			3
4	Laundry	50,251	32,290		82,541		82,541		82,541			4
5	Heat and Other Utilities			264,464	264,464		264,464	2,402	266,866			5
6	Maintenance	110,257	95,774	107,020	313,051		313,051	1,653	314,704			6
7	Other (specify):*											7
8	TOTAL General Services	711,193	495,614	423,618	1,630,425		1,630,425	(3,939)	1,626,486			8
	B. Health Care and Programs											
9	Medical Director			35,650	35,650		35,650		35,650			9
10	Nursing and Medical Records	3,519,882	333,627	37,146	3,890,655		3,890,655	(2,363)	3,888,292			10
10a	Therapy			967,111	967,111		967,111		967,111			10a
11	Activities	92,040	32,013		124,053		124,053		124,053			11
12	Social Services	158,039		8,494	166,533		166,533		166,533			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			18,423	18,423		18,423		18,423			15
16	TOTAL Health Care and Programs	3,769,961	365,640	1,066,824	5,202,425		5,202,425	(2,363)	5,200,062			16
	C. General Administration											
17	Administrative	100,436			100,436		100,436		100,436			17
18	Directors Fees											18
19	Professional Services			461,914	461,914		461,914	(271,518)	190,396			19
20	Dues, Fees, Subscriptions & Promotions			5,695	5,695		5,695		5,695			20
21	Clerical & General Office Expenses	305,162	170,484	(144,128)	331,518		331,518	125,242	456,760			21
22	Employee Benefits & Payroll Taxes			1,049,907	1,049,907		1,049,907	32,744	1,082,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,150	8,150		8,150	2,347	10,497			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			599,975	599,975		599,975	103,936	703,911			26
27	Other (specify):*											27
28	TOTAL General Administration	405,598	170,484	1,981,513	2,557,595		2,557,595	(7,249)	2,550,346			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,886,752	1,031,738	3,471,955	9,390,445		9,390,445	(13,551)	9,376,894			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: 01/01/15 Ending: 12/31/15

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			43,859	43,859		43,859	122,449	166,308			30
31	Amortization of Pre-Op. & Org.			143	143		143	424,177	424,320			31
32	Interest			261,248	261,248		261,248	319,914	581,162			32
33	Real Estate Taxes							96,659	96,659			33
34	Rent-Facility & Grounds			1,591,848	1,591,848		1,591,848	(1,585,827)	6,021			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,897,098	1,897,098		1,897,098	(622,628)	1,274,470			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			31,896	31,896		31,896		31,896			38
39	Ancillary Service Centers		268,185		268,185		268,185		268,185			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			456,367	456,367		456,367		456,367			42
43	Other (specify):* Bad Debt Exp.			1,110,000	1,110,000		1,110,000	(1,110,000)				43
44	TOTAL Special Cost Centers		268,185	1,598,263	1,866,448		1,866,448	(1,110,000)	756,448			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,886,752	1,299,923	6,967,316	13,153,991		13,153,991	(1,746,179)	11,407,812			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: 01/01/15 Ending: 12/31/15

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	2,030	30		9
10	Interest and Other Investment Income	(4,220)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,435)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,110,000)	43		24
25	Fund Raising, Advertising and Promotional	(19,113)	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	(14,767)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,147,506)		$	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)	(598,673)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (598,673)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,746,179)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Continental Nsg & Rehab Ctr

ID# **0049932**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (14,767)	21	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				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**	(14,767)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Continental Nsg & Rehab Ctr **#** 0049932 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1)	(7,993)	0	0	0	0	0	0	0	0	0	(7,994)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,402	0	0	0	0	0	0	0	0	0	2,402	5
6	Maintenance	0	1,653	0	0	0	0	0	0	0	0	0	1,653	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1)	(3,938)	0	0	0	0	0	0	0	0	0	(3,939)	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	(2,363)	0	0	0	0	0	0	0	0	0	(2,363)	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	(2,363)	0	0	0	0	0	0	0	0	0	(2,363)	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	(307,768)	36,250	0	0	0	0	0	0	0	0	(271,518)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(35,315)	160,283	274	0	0	0	0	0	0	0	0	125,242	21
22	Employee Benefits & Payroll Taxes	0	32,744	0	0	0	0	0	0	0	0	0	32,744	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,347	0	0	0	0	0	0	0	0	0	2,347	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	2,834	101,102	0	0	0	0	0	0	0	0	103,936	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,315)	(109,560)	137,626	0	0	0	0	0	0	0	0	(7,249)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,316)	(115,861)	137,626	0	0	0	0	0	0	0	0	(13,551)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	2,030	0	120,419	0	0	0	0	0	0	0	0	122,449	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	(4,220)	0	324,134	0	0	0	0	0	0	0	0	319,914	32
33	Real Estate Taxes	0	4,166	92,493	0	0	0	0	0	0	0	0	96,659	33
34	Rent-Facility & Grounds	0	6,021	(1,591,848)	0	0	0	0	0	0	0	0	(1,585,827)	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	(2,190)	10,187	(630,625)	0	0	0	0	0	0	0	0	(622,628)	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):*	(1,110,000)	0	0	0	0	0	0	0	0	0	0	(1,110,000)	43
44	TOTAL Special Cost Centers	(1,110,000)	0	0	0	0	0	0	0	0	0	0	(1,110,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,147,506)	(105,674)	(492,999)	0	0	0	0	0	0	0	0	(1,746,179)	45

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 18,054	Infinity Healthcare Management of Illinois		$ 10,061	$ (7,993)	1
2	V	5	Utilities		Infinity Healthcare Management of Illinois		2,402	2,402	2
3	V	6	Maintenance		Infinity Healthcare Management of Illinois		1,653	1,653	3
4	V	10	Nursing	49,966	Infinity Healthcare Management of Illinois		47,603	(2,363)	4
5	V	19	Professional Fees	308,802	Infinity Healthcare Management of Illinois		1,034	(307,768)	5
6	V	21	Office Expense	53,059	Infinity Healthcare Management of Illinois		213,342	160,283	6
7	V	22	Employee Expenses	3,469	Infinity Healthcare Management of Illinois		36,213	32,744	7
8	V	24	Travel	299	Infinity Healthcare Management of Illinois		2,646	2,347	8
9	V	26	Insurance		Infinity Healthcare Management of Illinois		2,834	2,834	9
10	V	33	Property Tax		Infinity Healthcare Management of Illinois		4,166	4,166	10
11	V	34	Rent Expense		Infinity Healthcare Management of Illinois		6,021	6,021	11
12	V								12
13	V								13
14	Total			$ 433,649			$ 327,975	$ * (105,674)	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: 01/01/15 Ending: 12/31/15

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	19	Professional Fees	$	Forest View Nursing Realty, LLC		$ 36,250	$ 36,250	15
16	V	21	Office Expense		Forest View Nursing Realty, LLC		274	274	16
17	V	26	Insurance		Forest View Nursing Realty, LLC		101,102	101,102	17
18	V	30	Depreciation		Forest View Nursing Realty, LLC		120,419	120,419	18
19	V	31	Amortization		Forest View Nursing Realty, LLC		424,177	424,177	19
20	V	32	Interest		Forest View Nursing Realty, LLC		324,134	324,134	20
21	V	33	RE Taxes		Forest View Nursing Realty, LLC		92,493	92,493	21
22	V	34	Rent	1,591,848	Forest View Nursing Realty, LLC			(1,591,848)	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			$ 1,591,848			$ 1,098,849	$ * (492,999)	39

* 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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	HUD Loan		X	Mortgage	$37,313.00	9/24/14	$ 8,720,000	$ 8,576,216	10/1/49	3.7500	$ 324,134	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	1,184,348	8/31/18	2.7500	72,248	6
7	Infintiy Funding	X		Working Capital	None	Various	3,098,224	3,098,224	Various	Various	189,000	7
8												8
9	TOTAL Facility Related				$37,313.00		$ 37,818,224	$ 12,858,788			$ 585,382	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 37,818,224	$ 12,858,788			$ 585,382	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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 177,406	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.)		$ 263,575	2
3. Under or (over) accrual (line 2 minus line 1).		$ 86,169	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,490	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.		$ 96,659	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	221,007	8
	2011	220,088	9
	2012	254,921	10
	2013	258,371	11
	2014	263,575	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Continental Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049932

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 235-5503

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-226-006-0000	Nursing Facility	$ 221,618.00	$ 221,618.00
2.	13-12-226-007-0000	Nursing Facility	$ 36,401.00	$ 36,401.00
3.	13-12-226-018-0000	Nursing Facility	$ 5,556.00	$ 5,556.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 263,575.00	$ 263,575.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,228 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [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).

None

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:
(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	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: 01/01/15 Ending: 12/31/15

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	$	$ 794,871	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing			2008	1,106	28	39	28		219	9
10	TV System			2008	4,000	103	39	103		796	10
11	Alarm			2008	695	18	39	18		138	11
12	Alarm			2008	682	17	39	17		135	12
13	Alarm			2008	741	19	39	19		147	13
14	Alarm Service			2008	537	14	39	14		107	14
15	Waste Disposal Machine			2009	833	21	39	21		149	15
16	Cooling Tower			2009	3,274	84	39	84		588	16
17	Roofwork			2009	4,500	116	39	115	(1)	810	17
18	New Water Heater			2010	15,928	408	39	408		2,451	18
19	Sprinkler Heads			2010	7,900	203	39	203		1,217	19
20	Railing for Patio and Stairwells			2010	10,434	269	39	268	(1)	1,608	20
21	Repair Roof			2010	550	14	39	14		84	21
22	Paint concrete, floor, ceiling, & balcony			2010	1,500	38	39	38		230	22
23	Roof Repair			2010	2,000	51	39	51		307	23
24	Roof Repair			2010	2,000	51	39	51		307	24
25	Hot Water Storage Tank Replacement			2011	11,900	305	39	305		1,526	25
26	Repairment of Pipe Leaks			2011	2,287	59	39	59		294	26
27	Cooling Tower Evaporator Pads			2011	1,510	39	39	39		194	27
28	Cooling Tower Evaporator Pads			2011	470	12	39	12		60	28
29	Window/Sign/Lighting/Sidewalk Work			2011	1,050	27	39	27		135	29
30	Lighting Retrofit for Facility			2011	15,762	404	39	404		2,021	30
31	System Installation			2011	1,524	39	39	39		195	31
32	New Mechanical Room Partition Wall			2011	15,920	408	39	408		2,041	32
33	Construction Permit/Drawings			2011	1,588	41	39	41		204	33
34	Communication system and booster			2011	7,960	204	39	204		1,020	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: 01/01/15 Ending: 12/31/15

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	2012	$ 1,643	$ 42	39	$ 42	$	$ 168	37
38	New drains and water supply in Dialysis room	2012	10,000	256	39	256		1,025	38
39	Replace windows	2012	1,500	38	39	38		153	39
40	Contrete sidewalks and stairs	2012	4,800	123	39	123		492	40
41	Carpet Installation for front office and administration area	2012	3,200	82	39	82		328	41
42	Plumbing chase and wall cabinets in Dialysis room	2012	8,704	223	39	223		892	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	2012	294,602	7,554	39	7,555	1	30,218	51
52									52
53	Mounted fixtures 4th floor dayroom	2013	1,716	44	39	44		110	53
54	Chller condenser	2013	3,700	95	39	95		237	54
55	Chiller condenser couplings	2013	2,871	74	39	74		185	55
56	Sprinkler system	2013	2,101	54	39	54		135	56
57	Piping valves	2013	5,300	136	39	136		340	57
58	boiler	2013	1,682	43	39	43		108	58
59	Caulking windows/buidling base	2013	2,900	74	39	74		185	59
60	4 sided smoking shelter	2013	5,422	139	39	139		348	60
61	4 sided smoking shelter	2013	1,000	26	39	26		65	61
62	Wiring on first floor	2013	16,697	428	39	428		1,070	62
63	Wallpaper, door trims, paint for resident rooms on 4th floor	2013	17,745	455	39	455		1,137	63
64	Sliding door system	2013	27,100	694	39	695	1	1,735	64
65	Electrical Wiring 4th floor dialysis unit,	2013	6,815	175	39	175		437	65
66	Cove base/vinyl 4th floor dialysis room,	2013	8,121	208	39	208		521	66
67	Door Alarm system	2013	2,595	67	39	67		167	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,546,864	$ 116,586		$ 116,586	$	$ 851,910	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,546,864	$ 116,586		$ 116,586	$	$ 851,910	1
2	Ceiling ligh fixtures in corridors	2014	2,053	53	39	53		106	2
3	Security Door release	2014	2,225	57	39	57		114	3
4	Electric, plumbing, drywall and painting in Dialysis Room	2014	4,060	104	39	104		208	4
5	Shield straight passage lever and vertical ejector pump	2014	4,759	122	39	122		244	5
6	Parking garage structure, lights and concrete	2014	53,182	1,364	39	1,364		2,728	6
7	Chiller barrels, cooler, thermostat, desealer for kitchen	2014	13,327	342	39	342		684	7
8	Sprinkler in admin office	2014	2,683	69	39	69		138	8
9	Structual engineering	2014	2,814	72	39	72		144	9
10	Waterproofing upper deck and concrete	2014	16,604	426	39	426		852	10
11	Valve repair	2014	2,235	57	39	57		114	11
12	install grab bars	2014	9,374	240	39	240		480	12
13									13
14									14
15	New canopy in smoking area	2015	7,900	202	39	202		202	15
16	Clean and service chiller	2015	4,118	106	39	106		106	16
17	Remove wallpaper, sand, paint 25 rooms on 3rd floor	2015	12,500	321	39	321		321	17
18	Remove damaged railing, fix, and reinstall	2015	3,220	83	39	83		83	18
19	Purchase, deliver, & install new fire rated door	2015	2,500	64	39	64		64	19
20									20
21	Resurface 1 side of exterior bldg in stucco & stone, apply								21
22	liquid "gold coat", install base coat w/ fiberglass mesh,								22
23	apply acrylic coat, install approx 800 sq ft of stone, install								23
24	aluminum flashing, replace framing where needed	2015	73,350	1,881	39	1,881		1,881	24
25									25
26	Resurface rest of the exterior bldg in stucco & stone, apply								26
27	liquid "gold coat", install base coat w/ fiberglass mesh,								27
28	apply acrylic coat, install approx 800 sq ft of stone, install								28
29	aluminum flashing, replace framing where needed	2015	210,000	5,384	39	5,385	1	5,384	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,973,768	$ 127,533		$ 127,534	$ 1	$ 865,763	34

**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: 01/01/15 Ending: 12/31/15

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	$ 735,803	$ 11,082	$ 29,346	$ 18,264	5	$ 684,715	71
72	Current Year Purchases	47,139	25,663	9,428	(16,235)	5	25,663	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 782,942	$ 36,745	$ 38,774	$ 2,029		$ 710,378	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,056,710	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,308	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,030	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,576,141	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 01/01/15 Ending: 12/31/15

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.

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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	$	6,675	$ 386,609	$	6,675	$ 386,609	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,083	137,109		2,083	137,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		7,309	443,393		7,309	443,393	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				252,571		252,571	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39-2					15,614		15,614	12
13	Other (specify):									13
14	TOTAL			$	16,067	$ 967,111	$ 268,185	16,067	$ 1,235,296	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.

STATE OF ILLINOIS

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ (264,984)	$ 209,858	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,471,150	3,570,150	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	118,328	118,328	6
7	Other Prepaid Expenses		2,736	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		173,991	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,324,494	$ 4,075,063	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	973,768	973,768	15
16	Equipment, at Historical Cost	282,942	782,942	16
17	Accumulated Depreciation (book methods)	(281,270)	(1,576,141)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,144	6,364,803	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,108)	(3,288,480)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Security Deposit		247,464	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 976,476	$ 7,804,356	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,300,970	$ 11,879,419	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,489,645	$ 1,638,606	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,888	35,888	28
29	Short-Term Notes Payable		127,589	29
30	Accrued Salaries Payable	174,129	174,129	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,120	23,120	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		26,802	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	1,184,348	1,184,348	36
37	Working Capital	3,078,224	3,078,224	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,985,354	$ 6,288,706	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,448,626	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)**	$	$ 8,448,626	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,985,354	$ 14,737,332	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,684,384)	$ (2,857,913)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,300,970	$ 11,879,419	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,041,182)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,041,182)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(489,274)	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	(153,928)	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)**	$ (643,202)	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)**	$ (1,684,384)	24	*

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 11,568,569	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,568,569	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	918,900	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 918,900	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	159,146	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,188	19
20	Radiology and X-Ray	519	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,853	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,628	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,628	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	14,767	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,767	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,664,717	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,630,425	31
32	Health Care	5,202,425	32
33	General Administration	2,557,595	33
	B. Capital Expense		
34	Ownership	1,897,098	34
	C. Ancillary Expense		
35	Special Cost Centers	300,081	35
36	Provider Participation Fee	456,367	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	1,110,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,153,991	40
41	**Income before Income Taxes (line 30 minus line 40)****	(489,274)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (489,274)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,295,620	44
45	Private Pay - Net Inpatient Revenue	7,564	45
46	Medicare - Net Inpatient Revenue	1,989,484	46
47	Other-(specify)	1,275,901	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,568,569	49

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

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

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

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

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,984	2,409	$ 131,158	$ 54.44	1
2	Assistant Director of Nursing	5,871	6,772	229,004	33.82	2
3	Registered Nurses	25,486	30,012	934,452	31.14	3
4	Licensed Practical Nurses	29,941	34,339	849,830	24.75	4
5	CNAs & Orderlies	91,051	105,385	1,200,367	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,074	8,460	119,996	14.18	8
9	Activity Director	6,368	7,036	92,040	13.08	9
10	Activity Assistants					10
11	Social Service Workers	8,388	9,029	158,039	17.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,563	24,955	322,766	12.93	15
16	Dishwashers					16
17	Maintenance Workers	4,417	4,738	110,257	23.27	17
18	Housekeepers	16,158	18,350	227,919	12.42	18
19	Laundry	2,900	5,737	50,251	8.76	19
20	Administrator	2,009	2,112	100,436	47.55	20
21	Assistant Administrator					21
22	Other Administrative	1,175	1,267	13,104	10.34	22
23	Office Manager					23
24	Clerical	13,923	15,100	305,162	20.21	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	1,910	2,313	41,971	18.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,218	278,014	$ 4,886,752 *	$ 17.58	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	516	$ 18,054	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,061	37,146	10-3	38
39	Pharmacist Consultant	368	18,423	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	243	8,494	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,188	$ 82,117		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
Jonathan Dixon	Administrator		$ 8,416
John Sianghio	Administrator		92,020
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,436

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
Bradley Associates	Accounting Fees	$ 8,662
Johnson, Goldburg	Accounting Fees	2,500
Infinity Healthcare	Mgmt/Professional Fees	313,818
Clausen Miller	Legal Fees	120,480
Johnson & Bell	Legal Fees	16,404
Secretary of State	Professional Fees	50
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 461,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 199,830
Unemployment Compensation Insurance	135,910
FICA Taxes	338,677
Employee Health Insurance	355,216
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	50,896
Uniforms	2,122
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,082,651

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)	
City of Chicago	1,715
Ill Dept. of Public Health	3,980
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,695

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	2,531
Mileage	6,658
Seminar Expense	
Education & Seminars	1,093
Business Seminar Expense	215
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,497

**See instructions.

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Continental Nsg & Rehab Ctr # 0049932 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. $ **31,578** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **456,367**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.