		FOR BHF USE				

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: Aaron Mauer Telephone Number: 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/20 to 12/31/20 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)	Paresh Vipani
	(Title)	CFO
Paid Preparer	(Signed)	3/5/2021 (Date)
	(Print Name and Title)	Aaron Mauer President
	(Firm Name & Address)	GGM Associates, Inc. 6101 Nimtz Parkway South Bend IN 46628
	(Telephone)	773-747-4506 Fax # 773-747-4725

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: 1/1/20 Ending: 12/31/20

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 NA

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	208	Skilled (SNF)	208	75,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	208	TOTALS	208	75,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	46,441	538	5,526	52,505	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,441	538	5,526	52,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.16%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 03/31/08

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 4,683

Medicare Intermediary Wisconsin Physician Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number: Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	412,154	42,041	12,650	466,845		466,845	(17)	466,828			1
2	Food Purchase		378,917		378,917		378,917		378,917			2
3	Housekeeping	393,361	98,935		492,296		492,296		492,296			3
4	Laundry	84,472	37,985		122,457		122,457		122,457			4
5	Heat and Other Utilities			313,824	313,824		313,824	2,211	316,035			5
6	Maintenance	102,013	52,437		154,450		154,450	(1,121)	153,329			6
7	Other (specify):*			153,462	153,462		153,462		153,462			7
8	**TOTAL General Services**	992,000	610,315	479,936	2,082,251		2,082,251	1,072	2,083,323			8
	B. Health Care and Programs											
9	Medical Director			60,000	60,000		60,000		60,000			9
10	Nursing and Medical Records	4,372,700	361,294	63,107	4,797,101		4,797,101	(184,082)	4,613,019			10
10a	Therapy			728,815	728,815		728,815		728,815			10a
11	Activities	250,395	28,959		279,354		279,354		279,354			11
12	Social Services	130,590		4,993	135,583		135,583		135,583			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			15,336	15,336		15,336	(370)	14,966			15
16	**TOTAL Health Care and Programs**	4,753,685	390,253	872,251	6,016,189		6,016,189	(184,452)	5,831,737			16
	C. General Administration											
17	Administrative	121,985		5,919	127,904		127,904	58,870	186,774			17
18	Directors Fees											18
19	Professional Services			804,980	804,980		804,980	(26,913)	778,067			19
20	Dues, Fees, Subscriptions & Promotions			3,837	3,837		3,837	157	3,994			20
21	Clerical & General Office Expenses	176,483	59,103	468,191	703,777		703,777	72,083	775,860			21
22	Employee Benefits & Payroll Taxes			1,041,397	1,041,397		1,041,397	44,147	1,085,544			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,941	9,941		9,941		9,941			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			733,053	733,053		733,053	64,970	798,023			26
27	Other (specify):*											27
28	**TOTAL General Administration**	298,468	59,103	3,067,318	3,424,889		3,424,889	213,315	3,638,204			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,044,153	1,059,671	4,419,505	11,523,329		11,523,329	29,935	11,553,264			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: 1/1/20 Ending: 12/31/20

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			108,984	108,984		108,984	83,793	192,777			30
31	Amortization of Pre-Op. & Org.			23,129	23,129		23,129	424,177	447,306			31
32	Interest			1,499,757	1,499,757		1,499,757	282,582	1,782,339			32
33	Real Estate Taxes							291,173	291,173			33
34	Rent-Facility & Grounds			1,575,348	1,575,348		1,575,348	(1,570,004)	5,344			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,207,218	3,207,218		3,207,218	(488,279)	2,718,939			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			25,456	25,456		25,456		25,456			38
39	Ancillary Service Centers		562,892		562,892		562,892	(5,514)	557,378			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			402,578	402,578		402,578		402,578			42
43	Other (specify):*			223,665	223,665		223,665	(223,665)				43
44	TOTAL Special Cost Centers		562,892	651,699	1,214,591		1,214,591	(229,179)	985,412			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,044,153	1,622,563	8,278,422	15,945,138		15,945,138	(687,523)	15,257,615			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: 1/1/20 Ending: 12/31/20

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	(18,841)	30		9
10	Interest and Other Investment Income	(5,263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(223,665)	43		24
25	Fund Raising, Advertising and Promotional	(12,348)	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	(10,047)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (270,181)		$	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)			34
35	Other- Attach Schedule	(417,342)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (417,342)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (687,523)		37

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

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

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

STATE OF ILLINOIS

Continental Nsg Rehab Ctr

ID# 0049932

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (208)	10	1
2	RP Profit	(370)	15	2
3	RP Profit	(5,514)	39	3
4	Misc Income - Vendor Rebate	(2,265)	6	4
5	Misc Income - Med Records	(1,690)	10	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**	(10,047)		49

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses A. General Services	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)	
1	Dietary	(17)	0	0	0	0	0	0	0	0	0	0	(17)	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	2,211	0	0	0	0	0	0	0	0	0	2,211	5
6	Maintenance	(2,265)	1,143	0	0	0	0	0	0	0	0	0	(1,121)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,282)	3,354	0	0	0	0	0	0	0	0	0	1,072	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,898)	(182,183)	0	0	0	0	0	0	0	0	0	(184,082)	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):*	(370)	0	0	0	0	0	0	0	0	0	0	(370)	15
16	**TOTAL Health Care and Programs**	(2,268)	(182,183)	0	0	0	0	0	0	0	0	0	(184,452)	16
	C. General Administration													
17	Administrative	0	58,870	0	0	0	0	0	0	0	0	0	58,870	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,224	(31,137)	0	0	0	0	0	0	0	0	(26,913)	19
20	Fees, Subscriptions & Promotions	0	157	0	0	0	0	0	0	0	0	0	157	20
21	Clerical & General Office Expenses	(12,348)	84,431	0	0	0	0	0	0	0	0	0	72,083	21
22	Employee Benefits & Payroll Taxes	0	44,147	0	0	0	0	0	0	0	0	0	44,147	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	2,343	62,627	0	0	0	0	0	0	0	0	64,970	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,348)	194,173	31,490	0	0	0	0	0	0	0	0	213,315	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,898)	15,343	31,490	0	0	0	0	0	0	0	0	29,935	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(18,841)	70	102,564	0	0	0	0	0	0	0	0	83,793	30
31	Amortization of Pre-Op. & Org.	0	0	424,177	0	0	0	0	0	0	0	0	424,177	31
32	Interest	(5,263)	5,886	281,959	0	0	0	0	0	0	0	0	282,582	32
33	Real Estate Taxes	0	0	291,173	0	0	0	0	0	0	0	0	291,173	33
34	Rent-Facility & Grounds	0	5,344	(1,575,348)	0	0	0	0	0	0	0	0	(1,570,004)	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	(24,104)	11,300	(475,475)	0	0	0	0	0	0	0	0	(488,279)	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	(5,514)	0	0	0	0	0	0	0	0	0	0	(5,514)	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):*	(223,665)	0	0	0	0	0	0	0	0	0	0	(223,665)	43
44	TOTAL Special Cost Centers	(229,179)	0	0	0	0	0	0	0	0	0	0	(229,179)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(270,181)	26,643	(443,985)	0	0	0	0	0	0	0	0	(687,523)	45

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Consulting Co.
GELP	37.50	Belhaven Nursing & Rehab Center	Chicago	Continental		Realty Co.
A&F Realty LLC	5.00	City View Multicare Center	Cicero	United Rx		Pharmacy Co.
C&W Realty Investment	20.00	Forest View Nursing & Rehab 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 2,211	$ 2,211	1
2	V	6	Maintenance	115	Infinity Healthcare Management of IL LLC		1,258	1,143	2
3	V	10	Nursing and Medical Records	246,736	Infinity Healthcare Management of IL LLC		64,553	(182,183)	3
4	V	17	Administrative	2,321	Infinity Healthcare Management of IL LLC		61,191	58,870	4
5	V	19	Professional Services	653,277	Infinity Healthcare Management of IL LLC		657,501	4,224	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		157	157	6
7	V	21	Clerical & General Office Expenses	156,466	Infinity Healthcare Management of IL LLC		240,897	84,431	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		44,156	44,147	8
9	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		2,343	2,343	9
10	V	30	Depreciation		Infinity Healthcare Management of IL LLC		70	70	10
11	V	32	Interest		Infinity Healthcare Management of IL LLC		5,886	5,886	11
12	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		5,344	5,344	12
13	V								13
14	Total			$ 1,058,924			$ 1,085,567	$ * 26,643	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: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 1,575,348	Continental Nursing Realty, LLC		$	$ (1,575,348)	15
16	V	31	Amortization		Continental Nursing Realty, LLC		424,177	424,177	16
17	V	30	Depreciation		Continental Nursing Realty, LLC		102,564	102,564	17
18	V	19	Professional Services		Continental Nursing Realty, LLC		(31,137)	(31,137)	18
19	V	26	Insurance		Continental Nursing Realty, LLC		62,627	62,627	19
20	V	32	Interest		Continental Nursing Realty, LLC		281,959	281,959	20
21	V	33	Real Estate Taxes		Continental Nursing Realty, LLC		291,173	291,173	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,575,348			$ 1,131,363	$ * (443,985)	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: 1/1/20 Ending: 12/31/20

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 Nrusing & 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	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8			Landmark of Des Plaines	Des Plaines				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 ☐

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

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

	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: 1/1/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage	$36,247.00	9/24/14	$ 8,720,000	$ 7,890,878	10/1/49	3.5000	$ 284,046	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	8/31/14	26,000,000	7,491,116	3/14/2022	4.5000	123,871	6
7	Infintiy Funding	X		Working Capital	Various		Various	5,376,596	None	Various	1,375,887	7
8												8
9	TOTAL Facility Related				$36,247.00		$ 34,720,000	$ 20,758,589			$ 1,783,803	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 34,720,000	$ 20,758,589			$ 1,783,803	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 51,852 Line # 26

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

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

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	38,925	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.)	$	330,294	2
3. Under or (over) accrual (line 2 minus line 1).	$	291,369	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(196)	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.	$	291,173	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	303,118	8
	2016	331,310	9
	2017	339,815	10
	2018	324,740	11
	2019	330,294	12

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	13-12-226-006-0000	Nursing Home	$ 281,492.95	$ 281,492.95
2.	13-12-226-007-0000	Nursing Home	$ 42,123.88	$ 42,123.88
3.	13-12-226-018-0000	Nursing Home	$ 6,677.51	$ 6,677.51
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 330,294.34	$ 330,294.34

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/20 Ending: 12/31/20

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 [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 130,250
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 8,683
4. Dates Incurred:

Nature of Costs:
(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	Facility	108,000	6/30/1905	$ 300,000	1
2					2
3	TOTALS	108,000		$ 300,000	3

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 1,258,701	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing			2008	1,106	28	39	28		360	9
10	TV System			2008	4,000	103	39	103		1,310	10
11	Alarm			2008	695	18	39	18		228	11
12	Alarm			2008	682	17	39	17		221	12
13	Alarm			2008	741	19	39	19		242	13
14	Alarm Service			2008	537	14	39	14		177	14
15	Waste Disposal Machine			2009	833	21	39	21		255	15
16	Cooling Tower			2009	3,274	84	39	84		1,008	16
17	Roofwork			2009	4,500	115	39	115		1,389	17
18	New Water Heater			2010	15,928	408	39	408		4,492	18
19	Sprinkler Heads			2010	7,900	203	39	203		2,231	19
20	Railing for Patio and Stairwells			2010	10,434	268	39	268		2,950	20
21	Repair Roof			2010	550	14	39	14		154	21
22	Paint concrete, floor, ceiling, & balcony			2010	1,500	38	39	38		421	22
23	Roof Repair			2010	2,000	51	39	51		563	23
24	Roof Repair			2010	2,000	51	39	51		563	24
25	Hot Water Storage Tank Replacement			2011	11,900	305	39	305		3,051	25
26	Repairment of Pipe Leaks			2011	2,287	59	39	59		588	26
27	Cooling Tower Evaporator Pads			2011	1,510	39	39	39		388	27
28	Cooling Tower Evaporator Pads			2011	470	12	39	12		120	28
29	Window/Sign/Lighting/Sidewalk Work			2011	1,050	27	39	27		270	29
30	Lighting Retrofit for Facility			2011	15,762	404	39	404		4,041	30
31	System Installation			2011	1,524	39	39	39		390	31
32	New Mechanical Room Partition Wall			2011	15,920	408	39	408		4,081	32
33	Construction Permit/Drawings			2011	1,588	41	39	41		408	33
34	Communication system and booster			2011	7,960	204	39	204		2,040	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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sprinkler heads installation	2012	$ 1,643	$ 42	39	$ 42	$	$ 378	37
38	New drains and water supply in Dialysis room	2012	10,000	256	39	256		2,306	38
39	Replace windows	2012	1,500	38	39	38		344	39
40	Contrete sidewalks and stairs	2012	4,800	123	39	123		1,107	40
41	Carpet Installation for front office and administration area	2012	3,200	82	39	82		738	41
42	Plumbing chase and wall cabinets in Dialysis room	2012	8,704	223	39	223		2,007	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	7,554		67,991	51
52									52
53	Mounted fixtures 4th floor dayroom	2013	1,716	44	39	44		330	53
54	Chller condenser	2013	3,700	95	39	95		712	54
55	Chiller condenser couplings	2013	2,871	74	39	74		554	55
56	Sprinkler system	2013	2,101	54	39	54		405	56
57	Piping valves	2013	5,300	136	39	136		1,020	57
58	boiler	2013	1,682	43	39	43		323	58
59	Caulking windows/buidling base	2013	2,900	74	39	74		556	59
60	4 sided smoking shelter	2013	5,422	139	39	139		1,043	60
61	4 sided smoking shelter	2013	1,000	26	39	26		194	61
62	Wiring on first floor	2013	16,697	428	39	428		3,210	62
63	Wallpaper, door trims, paint for resident rooms on 4th floor	2013	17,745	455	39	455		3,412	63
64	Sliding door system	2013	27,100	695	39	695		5,207	64
65	Electrical Wiring 4th floor dialysis unit,	2013	6,815	175	39	175		1,311	65
66	Cove base/vinyl 4th floor dialysis room,	2013	8,121	208	39	208		1,561	66
67	Door Alarm system	2013	2,595	67	39	67		501	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,546,865	$ 116,586		$ 116,586	$	$ 1,385,853	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: 1/1/20 Ending: 12/31/20

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		$ 4,546,865	$ 116,586		$ 116,586	$	$ 1,385,853	1
2	Ceiling ligh fixtures in corridors	2014	2,053	53	39	53		370	2
3	Security Door release	2014	2,225	57	39	57		399	3
4	Electric, plumbing, drywall and painting in Dialysis Room	2014	4,060	104	39	104		728	4
5	Shield straight passage lever and vertical ejector pump	2014	4,759	122	39	122		854	5
6	Parking garage structure, lights and concrete	2014	53,182	2,114	39	1,364	(750)	9,547	6
7	Chiller barrels, cooler, thermostat, desealer for kitchen	2014	13,327	342	39	342		2,393	7
8	Sprinkler in admin office	2014	2,683	69	39	69		483	8
9	Structual engineering	2014	2,814	72	39	72		504	9
10	Waterproofing upper deck and concrete	2014	16,604	426	39	426		2,981	10
11	Valve repair	2014	2,235	57	39	57		400	11
12	install grab bars	2014	9,374	240	39	240		1,681	12
13									13
14									14
15	5 New canopy in smoking area	2015	7,900	203	39	203		1,213	15
16	Clean and service chiller	2015	4,118	106	39	106		635	16
17	Remove wallpaper, sand, paint 25 rooms on 3rd floor	2015	12,500	321	39	321		1,925	17
18	Remove damaged railing, fix, and reinstall	2015	3,220	83	39	83		497	18
19	Purchase, deliver, & install new fire rated door	2015	2,500	64	39	64		384	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		11,286	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	5,385	39	5,385		32,305	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,973,769	$ 128,282		$ 127,532	$ (750)	$ 1,454,440	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: 1/1/20 Ending: 12/31/20

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 12B, Carried Forward		$ 4,973,769	$ 128,282		$ 127,532	$ (750)	$ 1,454,440	1
2	New Door	2016	3,611	93	39	93		461	2
3	4th Floor Quad Outlets in Generator Panel	2016	7,500	192	39	192		954	3
4	New Flooring Resident Room #208, 301, 305, 316, 324, 402,	2016	5,495	141	39	141		699	4
5	413, 415, 43, 420 & 422								5
6	Prime, patch, paint and wallpaper in 12 Residential Rooms	2016	11,600	297	39	297		1,474	6
7	on 2nd Floor								7
8	Prime, patch, paint and wallpaper 2nd floor dining room,	2016	1,928	49	39	49		244	8
9	library, bathroom & railing 2nd Floor								9
10	Painting & Repair 12 Residential Rooms on 2nd Floor	2016	11,600	297	39	297		1,474	10
11	Install Outlets in Resident Room #205, 206, 207, 208,209, 210	2016	3,005	77	39	77		382	11
12	211 and 221. Repair light fixture in 2nd floor dining room								12
13	Paint & patch 2 hallway bathrooms, install drywall , paint,	2016	700	18	39	18		89	13
14	patch electrical wall								14
15	Emergency Panels	2016	36,000	923	39	923		4,577	15
16	Paint 1st Floor Windows & Doors, Install 3 Toilets	2016	2,589	66	39	66		329	16
17									17
18	Painting & drywall repair from broken pipe along with new	2017	2,983	76	39	76		269	18
19	tile in rooms 311, 314, 214								19
20	Painting and repairs - Room 416, 305, 316, 326	2017	5,000	128	39	128		448	20
21	410, 317, 315, 324, & 417								21
22									22
23	New Building Sign	2017	8,552	219	39	219		768	23
24	Ceiling & Bathroom repairs to Rooms 326,310,305,309	2017	4,656	119	39	119		418	24
25	318, 315, 410, 414, 405, 325								25
26	Replace Exhaust Fans 6 & 11	2017	3,690	95	39	95		331	26
27	New Phone System for Social Services Office	2017	2,478	64	39	64		223	27
28	Chiller Headers	2017	4,843	124	39	124		434	28
29	AC Switch Over	2017	4,000	103	39	103		359	29
30	Relocate 2 Fire Alarm Bells from Front Office to 3rd Floor	2017	2,475	63	39	63		222	30
31	Nursing Station								31
32	B&G Bearing Assembly fo Circulating Pump	2017	2,463	63	39	63		221	32
33	GAF TPO Roofing System at Elevator Penthouse	2017	8,290	213	39	213		744	33
34	TOTAL (lines 1 thru 33)		$ 5,107,227	$ 131,704		$ 130,954	$ (750)	$ 1,469,560	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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,107,227	$ 131,704		$ 130,954	$ (750)	$ 1,469,560	1
2	8 Resident Room Bathroom Floors	2017	2,486	64	39	64		223	2
3	Replace 6" Test Header Valve for Sprinkler System	2017	3,010	77	39	77		270	3
4									4
5	Closed Loop Water Filtration Filter	2018	2,850	73	39	73		183	5
6	New Walk-In Cooler and cooling tower circulation pump	2018	8,304	213	39	213		532	6
7	Electrical & Lighting Work Throughout Building	2018	3,240	83	39	83		208	7
8	Upgrade Fire Alarm System	2018	7,655	196	39	196		491	8
9	Reqire Computer Wires & Cabling	2018	6,110	157	39	157		391	9
10	Repair Wall Above Window in 2nd Floor Dining Room	2018	3,292	84	39	84		211	10
11	New Generator Room Louvers	2018	3,432	88	39	88		220	11
12									12
13	Install Electrical Outlets in Room 406, 416, 415, 407, 408, 409, 411,	2019	2,670	518	39	518		1,037	13
14	Convert Duplex Outlets to Quad Outlets in Rooms 403, 411, 417, 4	2019	2,800		39				14
15	New Boiler for Kitchen/Laundry	2019	11,500	767	39	767		1,534	15
16	New Exit Device for Elevator; New Wall in Back of Washers in La	2019	13,613	349	39	349		669	16
17	Repair Wall on 3rd Floor Dining Room; New Flooring for Front Office								17
18	Clean Cooling Tower	2019	3,705	95	39	95		166	18
19	Clean Chiller & Install New Ball Valve for Strainer Cap	2019	3,204	82	39	82		144	19
20	Clean Evaporator Coil on Chiller Tower	2019	3,617	93	39	93		162	20
21	Clean Chiller Barrels on Cooling Tower	2019	2,964	76	39	76		127	21
22	Rewire Electrical Outlets & Switches on 2nd Floor Nurse's Station	2019	2,500	64	39	64		101	22
23	Convert Duplex Outlets to Quad Outlets in Rooms 402, 423, 424 &	2019	2,520	65	39	65		102	23
24	2nd, 3rd and 4th Floor Restrooms	2019	7,800	200	39	200		283	24
25	Install Floor Tiles & Wall Base for 2nd Floor Nurse's Station & M	2019	4,300	110	39	110		156	25
26	Install New Vinyl Floor Tiles in 2nd Floor Conference Room & Re	2019	6,400	164	39	164		232	26
27	2nd Floor Physicians Office Floor	2019	3,500	90	39	90		120	27
28	1st Floor Visitors Restroom repairs	2019	2,800	72	39	72		96	28
29	Remove Damaged Floor Tile & Install New Floor Tile, Install New	2019	3,000	77	39	77		103	29
30	Install New Flooring in 3rd Floor Sunshine Room; Paint Walls	2019	3,600	92	39	92		123	30
31	Clean Heating Boiler #1	2019	2,274	58	39	58		78	31
32	Install New Flooring in 1st Floor Lounge Room; Install New Dry V	2019	4,600	118	39	118		147	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,234,974	$ 135,830		$ 135,080	$ (750)	$ 1,477,670	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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,234,974	$ 135,830		$ 135,080	$ (750)	$ 1,477,670	1
2	Install New Flooring in 4th Floor DON Office; Paint Walls	2019	3,600	92	39	92		115	2
3	Install New Flooring in 1st Floor Accounting Office; Paint Walls	2019	3,500	90	39	90		112	3
4	Installation of New Call Lights for 2nd Floor West Nursing Statio	2019	10,103	259	39	259		324	4
5	Replace Faulty Pressure Relief Valve & Replace Faulty Gate Valv	2019	3,129	80	39	80		100	5
6	Install New Flooring in 3rd Floor Social Services Office #1; Paint	2019	3,200	82	39	82		103	6
7	Install New Flooring in 3rd Floor Social Services Office #1; Paint	2019	3,200	82	39	82		103	7
8	Replace Existing Phone System to Add More Lines	2019	5,455	140	39	140		175	8
9	Install Metal Framing & Studding on Kitchen Ceiling, Install Dry	2019	3,200	82	39	82		103	9
10	Install New Flooring & Replace Damage Wall in 1st Floor Admiss	2019	3,400	87	39	87		109	10
11	Installl New Vinyl Flooring, Redo Plumbing System, Replace Dam	2019	3,800	97	39	97		122	11
12	Install New Porcelain Floors, Install Redd Plumbing System, Pain	2019	3,800	97	39	97		122	12
13	Install New Vinyl Flooring, Paint Walls & Ceiling, Install New Wi	2019	4,200	108	39	108		126	13
14	Install New Vinyl Flooring, Paint Walls & Ceiling in MDS Office	2019	3,800	97	39	97		114	14
15	Repair Broken 3/4" Pipe in Kitchen. Replace Filters for Kitchen &	2019	2,407	62	39	62		72	15
16	Replace Section of Leaking Heating Pipe & Install New Air Vent o	2019	1,889	48	39	48		57	16
17	Install New Electric Unit Heater for the Generator Room	2019	2,071	53	39	53		62	17
18	Install New Vinyl Flooring, Paint Walls & Ceiling in 2md Floor Li	2019	3,800	97	39	97		114	18
19	Bathroom Flooring	2019	2,800	72	39	72		78	19
20	Remove & Replace Existing Floor & Wall Tiles, Redo Plumbing in	2019	15,600	400	39	400		433	20
21	Remove & Replace Existing Floor & Wall Tiles, Redo Plumbing in	2019	15,600	400	39	400		433	21
22	Remove & Replace Existing Floor & Wall Tiles, Redo Plumbing in	2019	15,600	400	39	400		433	22
23	Remove & Replace Existing Floor & Wall Tiles, Replace Toilet Bo	2019	2,800	72	39	72	(0)	78	23
24	Remove & Replace Existing Floor & Wall Tiles, Replace Toilet Bo	2019	2,800	72	39	72		78	24
25	Remove & Replace Existing Floor & Wall Tiles, Replace Toilet Bo	2019	2,800	72	39	72		78	25
26	Remove & Replace Existing Floor & Wall Tiles, Replace Toilet Bo	2019	2,800	72	39	72		78	26
27	Remove & Replace Existing Floor Tile, Paint & Patch Wall in 4th	2019	6,400	164	39	164		178	27
28									28
29	Remove Existing Floor & Wall Tiles, Remove Plumbing System, I	2020	1,300	33	39	33		33	29
30	Replace Broken 1" Broken Valve on Hot Water Line Riser for Sh	2020	3,400	87	39	87		87	30
31	Boiler Room Combustion Fresh Air Louver Upgrade	2020	7,500	192	39	192		192	31
32	Install 2 Temping and 2 Pressure Boosting Pumps for Exisiting Pi	2020	9,938	255	39	234	(21)	255	32
33	Replace 1" Hot Water Pipes from Laundry Room to 2nd Floor Sh	2020	2,401	62	39	56	(5)	62	33
34	TOTAL (lines 1 thru 33)		$ 5,391,268	$ 139,838		$ 139,061	$ (777)	$ 1,482,196	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: 1/1/20 Ending: 12/31/20

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 12E, Carried Forward		$ 5,391,268	$ 139,838		$ 139,061	$ (777)	$ 1,482,196	1
2	Repair , Patch and Paint Damaged Walls on 34d & 4th Floor Roor	2020	4,395	113	39	103	(9)	113	2
3	Replace Laundry Circulating Pump	2020	3,747	96	39	88	(8)	96	3
4	Chiller Heat Exchanger Cleaning	2020	4,196	108	39	99	(9)	108	4
5	Chiller Condensor Cleaning	2020	3,966	102	39	93	(8)	102	5
6	Replace Cold Water Feed in 1st Floor Shower Room Above Laund	2020	2,429	62	39	52	(10)	62	6
7	Repair Main Air Handler Coil	2020	2,831	73	39	60	(12)	73	7
8	Chiller Heat Exchanger Cleaning	2020	3,996	102	39	85	(17)	102	8
9	Replace Motors on Elevator Room and Dishwasher Exhaust Fans	2020	2,537	65	39	38	(27)	65	9
10	Install New RPZ to Sprinkler System	2020	2,968	76	39	63	(13)	76	10
11	Parts and Labor to Repair Generator	2020	2,142	55	39	32	(23)	55	11
12	Magnetic Lock at East Exit Door. Run Data Cables to 1st floor Re	2020	2,805	72	39	36	(36)	72	12
13	New Comfort-Aire Heating/Cooling Unit for 2nd floor Nurse's Sta	2020	6,750	173	39	58	(115)	173	13
14	Tiled New Shower in Room 220 - reroute drain pipe for shower dr	2020	7,500	192	39	64	(128)	192	14
15	Cooling Tower Cleaning	2020	3,402	87	39	22	(65)	87	15
16	Replace Side Wall Exhaust Fan for Kitchen & Dish Washing Mac	2020	3,923	101	39	25	(75)	101	16
17	Drywall and paint Rooms 302, 308, 309, 310, 313, 316, 317, 318, 31	2020	6,300	162	39	40	(121)	162	17
18	Chiller Evaporator Side Cleanings	2020	4,680	120	39	20	(100)	120	18
19	Tile Bathroom & Shower on 2nd floor by Room 220	2020	11,760	302	39	25	(276)	302	19
20	Remove Wallpaper, Repair & Paint Walls in Lobby Area	2020	2,750	71	39	6	(65)	71	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,474,345	$ 141,968		$ 140,072	$ (1,896)	$ 1,484,327	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: 1/1/20 Ending: 12/31/20

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	$ 253,217	$ 42,899	$ 50,643	$ 7,744	5	$ 157,391	71
72	Current Year Purchases	27,432	27,432	2,743	(24,689)	5	27,432	72
73	Fully Depreciated Assets	735,803				5	735,803	73
74								74
75	TOTALS	$ 1,016,452	$ 70,331	$ 53,387	$ (16,944)		$ 920,626	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)	$ 6,790,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,299	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,458	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,841)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,404,953	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 1/1/20 Ending: 12/31/20

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,683	$ 254,833	$	4,683	$ 254,833	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,740	123,202		1,740	123,202	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,514	350,780		5,514	350,780	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				228,608		228,608	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					8,580		8,580	12
13	Other (specify): Lab	39-2					325,703		325,703	13
14	TOTAL			$	11,936	$ 728,815	$ 562,892	11,936	$ 1,291,707	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: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ (160,298)	$ (159,282)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,868,961	3,868,961	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,400	241,400	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		283,926	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,950,063	$ 4,235,005	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		(108,884)	13
14	Buildings, at Historical Cost		4,000,000	14
15	Leasehold Improvements, at Historical Cost	1,474,345	1,474,345	15
16	Equipment, at Historical Cost	516,453	6,751,006	16
17	Accumulated Depreciation (book methods)	(644,997)	(7,305,635)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	181,125	481,125	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(58,548)	69,559	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		550,651	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,468,378	$ 5,912,167	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,418,441	$ 10,147,172	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,335,291	$ 1,575,989	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,045	39,045	28
29	Short-Term Notes Payable	14,099,112	14,260,474	29
30	Accrued Salaries Payable	302,507	302,507	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,823	34,823	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 15,810,778	$ 16,212,838	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,729,516	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)**	$	$ 7,729,516	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,810,778	$ 23,942,354	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (10,392,337)	$ (13,795,182)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,418,441	$ 10,147,172	48

*(See instructions.)

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (8,608,687)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (8,608,687)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,783,649)	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) Rounding Error	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,783,650)	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)**	$ (10,392,337)	24 *

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

Facility Name & ID Number Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 12,339,635	1
2	Discounts and Allowances for all Levels	34,220	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,373,855	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,283	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,283	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,478,824	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	8,379	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,915	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,515,118	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,263	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,263	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Misc Income	17,970	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,970	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,161,489	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,082,251	31
32	Health Care	6,016,189	32
33	General Administration	3,424,889	33
	B. Capital Expense		
34	Ownership	3,207,218	34
	C. Ancillary Expense		
35	Special Cost Centers	1,214,591	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,945,138	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,783,649)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,783,649)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,975,697	44
45	Private Pay - Net Inpatient Revenue	157,320	45
46	Medicare - Net Inpatient Revenue	2,922,250	46
47	Other-(specify) Net Patient Revenue	318,588	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,373,855	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: 1/1/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,405	2,670	$ 152,231	$ 57.02	1
2	Assistant Director of Nursing	5,055	5,364	214,787	40.04	2
3	Registered Nurses	25,723	31,735	1,204,288	37.95	3
4	Licensed Practical Nurses	23,554	29,144	1,039,947	35.68	4
5	CNAs & Orderlies	71,569	89,699	1,678,092	18.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,017	13,744	250,395	18.22	10
11	Social Service Workers	5,515	6,028	130,590	21.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,502	24,119	412,154	17.09	15
16	Dishwashers					16
17	Maintenance Workers	3,514	3,738	102,013	27.29	17
18	Housekeepers	19,149	21,093	330,296	15.66	18
19	Laundry	3,878	4,203	84,472	20.10	19
20	Administrator	2,608	2,716	121,985	44.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,928	9,601	176,483	18.38	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	5,003	4,323	146,420	33.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,420	248,177	$ 6,044,153 *	$ 24.35	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	264	$ 12,650	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	889	47,451	10-3	38
39	Pharmacist Consultant	307	15,336	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	70	4,518	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,530	$ 79,955		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	77	15,656	10-2	52
53	TOTAL (lines 50 - 52)	77	$ 15,656		53

Facility Name & ID Number: Continental Nsg Rehab Ctr # 0049932 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Zuckerman, Yaniv	ADMINISTRATOR	0	$ 26,542
Adams, Mandy S	ADMINISTRATOR	0	72,286
Ramirez, Angie T	ADMINISTRATOR	0	23,157
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,985

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
Ashman & Stein	Legal	$ 41,481
Dutton Casey & Mesoloras P.C.	Legal	2,500
Infinity Funding / Sedgwick	Legal	38,427
Infinity Healthcare Management of Il	Legal	392
Klauke Law Group LLC	Legal	26
McGuire Woods LLP - 10/12/20	Legal	2,099
Infinity Healthcare Management of Il	Management fees	639,229
See attached schedule		80,826
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 804,980

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,016
Unemployment Compensation Insurance	59,704
FICA Taxes	494,896
Employee Health Insurance	320,757
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	3,908
Pension	50,667
Employee backround checks	2,380
Other Employee Benefits	22,216
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,085,544

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
City if Chicago	805
Other Licenses and dues	1,199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,994

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel Reimbursement	5,673
Seminar Expense	
Education and Seminars	4,268
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,941

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Abbey Road Tax Consultants	Professional Fees	9,944
Century Executive Search	Professional Fees	16,500
Elevate Energy	Professional Fees	550
Empire Risk Management Services, I	Professional Fees	12,000
Genex Services, LLC.	Professional Fees	82
Global Fiscal Midwest LLC	Professional Fees	4,204
Infinity Healthcare Management of Il	Professional Fees	1,548
Credit Suisse	Professional Fees	8,876
Nava Healthcare Recruitment	Professional Fees	13,800
USA Risk Management Inc	Professional Fees	1,195
Premier Destine	Professional Fees	704
People Powered LLC	Professional Fees	2,000
Infinity H Funding	Professional Fees	423
GGM	Accounting Fees	6,000
Johnson and Goldburg	Accounting Fees	3,000
See attached schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 80,826

Facility Name & ID Number **Continental Nsg Rehab Ctr** **# 0049932** **Report Period Beginning: 1/1/20** **Ending: 12/31/20**

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? ______ If YES, have these costs been properly adjusted out of the cost report? **YES**

(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? ______

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **60,159** Line **10**

(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. $ **402,578**
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. $ ______

(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? ______
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? **YES**

(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.