

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR# 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>404</u>	Skilled (SNF)	<u>404</u>	<u>147,460</u>	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	<u>404</u>	TOTALS	<u>404</u>	<u>147,460</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>93,800</u>	<u>1,844</u>	<u>11,428</u>	<u>107,072</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>93,800</u>	<u>1,844</u>	<u>11,428</u>	<u>107,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.61%

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)

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

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

YES NO

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

YES NO

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

Date started 4/1/05

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

YES Date 4/1/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 404 and days of care provided 9,890Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	391,268	435,312		826,580		826,580	(34)	826,546		1
2	Food Purchase										2
3	Housekeeping	21,896	4,506	533,932	560,334		560,334		560,334		3
4	Laundry	7,470	3,183		10,653		10,653		10,653		4
5	Heat and Other Utilities			370,059	370,059		370,059		370,059		5
6	Maintenance	124,391	25,180	61,770	211,341		211,341	(2,942)	208,399		6
7	Other (specify):*										7
8	TOTAL General Services	545,025	468,181	965,761	1,978,967		1,978,967	(2,976)	1,975,991		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	3,084,402	232,334	15,524	3,332,260		3,332,260		3,332,260		10
10a	Therapy			274,786	274,786		274,786		274,786		10a
11	Activities	141,548	47,118		188,666		188,666		188,666		11
12	Social Services	177,863	3,867	2,819	184,549	79,968	264,517		264,517		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,403,813	283,319	307,129	3,994,261	79,968	4,074,229		4,074,229		16
	C. General Administration										
17	Administrative	127,341			127,341		127,341		127,341		17
18	Directors Fees										18
19	Professional Services			138,350	138,350		138,350	(106,554)	31,796		19
20	Dues, Fees, Subscriptions & Promotions			4,046	4,046		4,046		4,046		20
21	Clerical & General Office Expenses	372,936	103,272	30,582	506,790	(79,968)	426,822	(44,733)	382,089		21
22	Employee Benefits & Payroll Taxes			726,132	726,132		726,132	31,675	757,807		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,974	24,974		24,974	(21,422)	3,552		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			276,098	276,098		276,098		276,098		26
27	Other (specify):*										27
28	TOTAL General Administration	500,277	103,272	1,200,182	1,803,731	(79,968)	1,723,763	(141,034)	1,582,729		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,449,115	854,772	2,473,072	7,776,959		7,776,959	(144,010)	7,632,949		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 MIDWAY NEUROLOGICAL/REHAB CTR #0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			55,461	55,461		55,461	839	56,300		30
31	Amortization of Pre-Op. & Org.			8,634	8,634		8,634		8,634		31
32	Interest			74,673	74,673		74,673		74,673		32
33	Real Estate Taxes			412,500	412,500		412,500	141,192	553,692		33
34	Rent-Facility & Grounds			1,807,250	1,807,250		1,807,250	(60,250)	1,747,000		34
35	Rent-Equipment & Vehicles			185	185		185		185		35
36	Other (specify):*										36
37	TOTAL Ownership			2,358,703	2,358,703		2,358,703	81,781	2,440,484		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		358,289		358,289		358,289		358,289		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			221,190	221,190		221,190		221,190		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		358,289	221,190	579,479		579,479		579,479		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,449,115	1,213,061	5,052,965	10,715,141		10,715,141	(62,229)	10,652,912		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 MIDWAY NEUROLOGICAL/REHAB CTR

0047175

Report Period Beginning: 1/1/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	839	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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	(13,968)	21		18
19	Entertainment				19
20	Contributions	(15,025)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,411)	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	79,290			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 34,691		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(96,920)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (96,920)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (62,229)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 MIDWAY NEUROLOGICAL/REHAB CTR

ID# 0047175
 Report Period Beginning: 1/1/06
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (2,942)	6	1
2	COMMUNTING	(21,460)	24	2
3	UNDER ACCRUAL OF PROPERTY TAXES	103,692	33	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	79,290		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MIDWAY NEUROLIGICAL/REHAB CTR

0047175

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	(34)	0	0	0	0	0	0	0	0	0	0	(34)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,942)	0	0	0	0	0	0	0	0	0	0	(2,942)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,976)	0	0	0	0	0	0	0	0	0	0	(2,976)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	(106,554)	0	0	0	0	0	0	0	0	0	(106,554)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(45,404)	671	0	0	0	0	0	0	0	0	0	(44,733)	21
22	Employee Benefits & Payroll Taxes	0	31,675	0	0	0	0	0	0	0	0	0	31,675	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(21,460)	38	0	0	0	0	0	0	0	0	0	(21,422)	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(66,864)	(74,170)	0	(141,034)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,840)	(74,170)	0	(144,010)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLIGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	839	0	0	0	0	0	0	0	0	0	0	839	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	103,692	37,500	0	0	0	0	0	0	0	0	0	141,192	33
34	Rent-Facility & Grounds	0	(60,250)	0	0	0	0	0	0	0	0	0	(60,250)	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	104,531	(22,750)	0	81,781	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	34,691	(96,920)	0	(62,229)	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 PROFESSIONAL FEES	\$ 108,400	NEW YORK BOYS MANAGEMENT	46.25%	\$	\$ (108,400)	1
2	V	19 ACCOUNTING & PROF. FEES				1,846	1,846	2
3	V	21 BANK SERVICE CHG, MISC				371	371	3
4	V	22 LIFE INSURANCE & PENSION				31,675	31,675	4
5	V	24 TRAVEL & ENTERTAINMENT				38	38	5
6	V	34 RENT	200,000	MIDWAY NEUROLOGICAL AND REHABILITATION			(200,000)	6
7	V	34 RENT		REALTY, LLC		139,750	139,750	7
8	V	33 PROPERTY TAXES				37,500	37,500	8
9	V	21 BANK SERVICE CHG, MISC				300	300	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 308,400			\$ 211,480	\$ * (96,920)	14

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

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	23.125%
MOISHE GUBIN	23.125%
AARON TOPPER	17.325%
MARTY LOEB	5.000%
JOSEPH BLISKO	5.000%
TEVI MINDICK	5.000%
HOWARD N. SUSS	3.925%
A&F GENERAL PARTNERSHIP	<u>17.500%</u>
	<u>100.000%</u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT MIDWAY NEUR. & REHAB REALTY, LLC	CROWN POINT, IN	MANAGEMENT CO. REALTY COMPANY

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number MIDWAY NEUROLIGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	ADMINISTRATOR	ADMIN	17.33		40	100.00	SALARY	\$ 99,583	17-1	1
2	MICHAEL BLISKO	DIR. OF OPERATIC	ADMIN	23.13		5	12.50				2
3	MOISHE GUBIN	TREASURER	ADMIN	23.13		15	37.50				3
4	MARTY LOEB			5.00							4
5	JOSEPH BLISKO			5.00							5
6	TEVI MINDICK			5.00							6
7	HOWARD N. SUSS			3.93							7
8	A&F GENERAL PARTNERSHIP			17.50							8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,583		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 MIDWAY NEUROLIGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

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

Facility Name & ID Number MIDWAY NEUROLIGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	BANK LEUMI USA		X	WORKING CAPITAL	NONE	4/4/06	2,500,000	800,000	3/2/07	8.5000	74,673						
7																	
8																	
9	TOTAL Facility Related						\$ 2,500,000	\$ 800,000			\$ 74,673						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 800,000			\$ 74,673						

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MIDWAY NEUROLOGICAL/REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047175

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-36-403-013-000</u>	<u>NURSING HOME</u>	\$ <u>441,192.00</u>	\$ <u>441,192.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>441,192.00</u>	\$ <u>441,192.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 MIDWAY NEUROLOGICAL/REHAB CTR

0047175 Report Period Beginning:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 112,340 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 5

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

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

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

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

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

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

1. Total Amount Incurred: 43,170 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 8,634 4. Dates Incurred: Various - April 2005 through December 2006

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **MIDWAY NEUROLOGICAL/REHAB CTR**# **0047175**

Report Period Beginning:

1/1/06

Ending:

12/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIGN		2005	6,000	400	15	400		800	9
10		AIR CONDITIONER		2005	38,280	2,552	15	2,552		5,104	10
11		5TH FLOOR RENOVATION		2005	188,856	12,590	15	12,590		25,155	11
12		TIME CLOCK		2005	5,651	377	15	377		754	12
13		ELEVATOR ITEMS		2005	17,500	1,167	15	1,167		2,334	13
14		ELEVATOR ITEMS		2005	1,761	117	15	117		234	14
15		ICE MACHINE		2005			15				15
16		WANDERGUARD SECURITY CAMERA		2005	23,000	1,533	15	1,533		3,066	16
17		WANDERGUARD SECURITY CAMERA		2005	6,000	400	15	400		800	17
18		WANDERGUARD SECURITY CAMERA		2005	673	45	15	45		90	18
19		WANDERGUARD SECURITY CAMERA		2005	5,625	375	15	375		750	19
20		TILES		2005	4,461	297	15	297		594	20
21		TILES		2005	246	16	15	16		32	21
22		TILES		2005	733	49	15	49		98	22
23		HVAC		2005	4,251	283	15	283		566	23
24		HVAC		2005	3,653	244	15	244		488	24
25		BOILERS		2005	7,850	523	15	523		1,046	25
26		ROOF REPAIRS		2005	1,500	100	15	100		200	26
27		LIGHTS		2005	6,650	443	15	443		886	27
28		TILES		2005	1,113	74	15	74		148	28
29		5th Floor Renovations		2006	39,212	2,614	15	2,614		2,614	29
30		A/C Unit		2006	7,598	507	15	507		507	30
31		A/C Unit		2006	7,598	507	15	507		507	31
32		Paving		2006	1,571	105	15	105		105	32
33		Paving		2006	2,480	165	15	165		165	33
34		Telephone System		2006	11,173	745	15	745		745	34
35		Generator		2006	923	62	15	62		62	35
36		Wanderguard		2006	2,125	142	15	142		142	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 **MIDWAY NEUROLOGICAL/REHAB CTR**

0047175

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1st floor bathrooms	2006	\$ 5,850	\$ 390	15	\$ 390	\$	\$ 390	37
38	Shower Room	2006	11,598	773	15	773		773	38
39	Kitchen Floor	2006	36,687	2,446	15	2,446		2,446	39
40	Windows	2006	2,708	181	15	181		181	40
41	A/C Units Rooftop	2006	22,273	1,485	15	1,485		1,485	41
42	Locks	2006	8,140	543	15	543		543	42
43	Parking Lot Lights	2006	1,900	127	15	127		127	43
44	Tiling in bathrooms	2006	14,083	939	15	939		939	44
45	Copy Machine	2006	9,223	615	15	615		615	45
46	Roofing work	2006	1,200	80	15	80		80	46
47	Van & air mattresses	2006	6,000	400	15	400		400	47
48	Fence	2006	16,130	1,075	15	1,075		1,075	48
49	Laundry Chute	2006	2,589	173	15	173		173	49
50	Sale of Artwork	2006	(2,714)	(282)	15	(282)		(282)	50
51	Labor for Shower Room Remodel	2006	3,000		15				51
52	Signs	2006	967	64	15	64		64	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 536,114	\$ 35,440		\$ 35,440	\$	\$ 57,000	70

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 54,679	\$ 10,097	\$ 10,936	\$ 839	5	\$ 21,098	71
72	Current Year Purchases	48,671	9,924	9,924			9,924	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 103,350	\$ 20,021	\$ 20,860	\$ 839		\$ 31,022	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	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)	\$ 639,464	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,461	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,300	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 839	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 88,022	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	N/A	\$	\$	\$	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: METROPOLITAN REAL ESTATE PARTNERSHIP

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:		404	4/1/05	\$ 1,807,250	4		3
4	Additions							4
5								5
6								6
7	TOTAL		404		\$ 1,807,250			7

10. Effective dates of current rental agreement:

Beginning 4/1/05

Ending 11/30/08

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

Fiscal Year Ending Annual Rent

12.	<u>12/2007</u>	\$ <u>1,770,000</u>
13.	<u>12/2008</u>	\$ <u>1,622,500</u>
14.	<u>12/2009</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 157,320	\$		\$ 157,320	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			18,852			18,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			98,614			98,614	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				346,085		346,085	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Radiology & Lab	39-2					12,204		12,204	13
14	TOTAL			\$		\$ 274,786	\$ 358,289		\$ 633,075	14

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (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	\$ 593,243	\$	1
2	Cash-Patient Deposits	(39,633)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,323,043		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,571		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,899,225	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	541,437		15
16	Equipment, at Historical Cost	97,060		16
17	Accumulated Depreciation (book methods)	(87,145)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(15,141)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Security Deposit</u>)	44,590		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 623,971	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,523,195	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 514,523	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	407,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	(20,442)		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	<u>Settlement Reserve</u>	575,381		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,477,176	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	800,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 800,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,277,176	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,248,018	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,525,195	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,027,992	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,027,992	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 1,791,025	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	\$ (1,570,999)	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)	\$ 220,026	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)	\$ 1,248,018	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR# 0047175Report Period Beginning: 1/1/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,590,189	1
2	Discounts and Allowances for all Levels	(255,340)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,334,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	787,224	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 787,224	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	346,542	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,510	19
20	Radiology and X-Ray	5,905	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 367,957	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	0	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	13,194	27
28	Miscellaneous	2,942	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,136	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,506,166	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,978,968	31
32	Health Care	3,994,261	32
33	General Administration	1,803,730	33
B. Capital Expense			
34	Ownership	2,358,703	34
C. Ancillary Expense			
35	Special Cost Centers	358,289	35
36	Provider Participation Fee	221,190	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,715,141	40
41	Income before Income Taxes (line 30 minus line 40)**	1,791,025	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,791,025	43

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

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

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

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

Facility Name & ID Number **MIDWAY NEUROLOGICAL/REHAB CTR**

0047175

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	4,886	5,412	\$ 226,479	\$ 41.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,373	20,516	568,988	27.73	3
4	Licensed Practical Nurses	45,918	50,015	1,231,983	24.63	4
5	CNAs & Orderlies	91,971	99,351	981,606	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,128	5,406	47,679	8.82	8
9	Activity Director	10,981	12,634	141,548	11.20	9
10	Activity Assistants					10
11	Social Service Workers	12,759	13,961	177,863	12.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,106	41,278	391,268	9.48	15
16	Dishwashers					16
17	Maintenance Workers	7,423	8,162	124,391	15.24	17
18	Housekeepers	733	2,668	21,896	8.21	18
19	Laundry	233	758	7,470	9.85	19
20	Administrator	2,728	2,948	127,341	43.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,420	21,805	372,936	17.10	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	2,513	2,842	27,667	9.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	262,172	287,756	\$ 4,449,115 *	\$ 15.46	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	\$		35	
36	Medical Director			36	
37	Medical Records Consultant	184	6,425	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	81	2,819	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	265	\$ 9,244		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	182	\$ 9,100	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	182	\$ 9,100		53

Facility Name & ID Number **MIDWAY NEUROLIGICAL/REHAB CTR**

0047175

Report Period Beginning: **1/1/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
AARON TOPPER	ADMIN	17.325	\$ 99,583	Workers' Compensation Insurance	\$ 90,610	IDPH License Fee	\$ 1,144	
MELANIE PARKS	ASST ADMIN		27,758	Unemployment Compensation Insurance	92,963	Advertising: Employee Recruitment		
				FICA Taxes	330,125	Health Care Worker Background Check		
				Employee Health Insurance	163,666	(Indicate # of checks performed)		
				Employee Meals		ILLINOIS SECRETARY OF STATE	400	
				Illinois Municipal Retirement Fund (IMRF)*		VILLIAGE OF BRIDGEVIEW	1,515	
				UNIFORMS	48,769	COOK COUNTY COLLECTOR	173	
				LIFE INSURANCE/PENSION	31,675	BRIDGEVIEW CHAMBER	250	
						CITY OF CHICAGO	100	
						JO ANNE BRUCE AND ASS IHCA, OTHER	464	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 127,341			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 757,807	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$			\$ 4,046		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)								
C. Professional Services				Description			Amount	
Vendor/Payee	Type		Amount	Line #	Amount	G. Schedule of Travel and Seminar**		
MEYER MAGENCE	LEGAL		1,597			Description		
ABRAHAM GUTNICKI	LEGAL		3,260			Amount		
DELENY LAW OFFICES	LEGAL		976			Out-of-State Travel		
BRADLEY & ASSOCIATES	ACCOUNTING		9,882			\$		
JOHNSON, GOLDBERG, BROWN	ACCOUNTING		1,500					
NY BOYS	MGMT. CO.		108,400			In-State Travel		
FINKLE, MARTWICK & COLSON	LEGAL		13,225			AUTO ALLOWANCE		
OTHER			(491)			MILEAGE		
						21,460		
						1,245		
						Seminar Expense		
						ADMINASTAR		
						75		
						ILLINOIS COUNCIL		
						625		
						OTHER		
						1,607		
						Entertainment Expense		
						()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 138,350	TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$		\$ 25,012		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR

0047175

Report Period Beginning: 1/1/06

Ending: 12/31/06

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,219 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? N/A 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? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 221,190
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.