

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR

0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	404	Skilled (SNF)	404	147,460	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	404	TOTALS	404	147,460	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	94,760	2,420	13,287	110,467	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	94,760	2,420	13,287	110,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.91%

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

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

NONE

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

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

YES NO

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 7,779

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	408,858	477,509	31,125	917,492		917,492	(139)	917,353		1
2	Food Purchase										2
3	Housekeeping	358,644	53,716		412,360		412,360		412,360		3
4	Laundry	72,444	22,780		95,224		95,224		95,224		4
5	Heat and Other Utilities			365,234	365,234		365,234	740	365,974		5
6	Maintenance	128,494	18,579	161,745	308,818		308,818	(3,748)	305,070		6
7	Other (specify):*										7
8	TOTAL General Services	968,440	572,584	558,104	2,099,128		2,099,128	(3,147)	2,095,981		8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	3,870,894	299,029	11,354	4,181,277		4,181,277	(12,828)	4,168,449		10
10a	Therapy			627,481	627,481		627,481		627,481		10a
11	Activities	142,028	30,309		172,337		172,337		172,337		11
12	Social Services	249,828	36		249,864		249,864	(17)	249,847		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,262,750	329,374	651,835	5,243,959		5,243,959	(12,845)	5,231,114		16
	C. General Administration										
17	Administrative	151,294			151,294		151,294	34,236	185,530		17
18	Directors Fees										18
19	Professional Services			250,667	250,667		250,667	(156,352)	94,315		19
20	Dues, Fees, Subscriptions & Promotions			2,290	2,290		2,290		2,290		20
21	Clerical & General Office Expenses	212,686	113,283	62,319	388,288		388,288	(79,530)	308,758		21
22	Employee Benefits & Payroll Taxes			946,663	946,663		946,663	2,221	948,884		22
23	Inservice Training & Education										23
24	Travel and Seminar			23,029	23,029		23,029	(201)	22,828		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			298,821	298,821		298,821	68,158	366,979		26
27	Other (specify):*										27
28	TOTAL General Administration	363,980	113,283	1,583,789	2,061,052		2,061,052	(131,468)	1,929,584		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,595,170	1,015,241	2,793,728	9,404,139		9,404,139	(147,460)	9,256,679		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR #0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			102,984	102,984	102,984	263,321	366,305				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,263	74,263	74,263	2,723	76,986				32
33	Real Estate Taxes						384,610	384,610				33
34	Rent-Facility & Grounds			2,400,000	2,400,000	2,400,000	(2,400,000)					34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,577,247	2,577,247	2,577,247	(1,749,346)	827,901				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		320,705		320,705	320,705		320,705				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,917	223,917	223,917		223,917				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		320,705	223,917	544,622	544,622		544,622				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,595,170	1,335,946	5,594,892	12,526,008	12,526,008	(1,896,806)	10,629,202				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	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				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	(47)	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	(20,000)	21		18
19	Entertainment				19
20	Contributions	(40,000)	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	(19,672)	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	(91,694)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (171,413)		\$	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)	(1,725,393)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,725,393)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,896,806)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
 MIDWAY NEUROLOGICAL/REHABILITATION CTR

ID# 0047175

Report Period Beginning: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	VENDING INCOME	\$ (3,064)	6	1
2	COMMUTING	(11,804)	24	2
3	Miscellaneous Income - Social Service	(17)	12	3
4	Miscellaneous Income - RN Consultant	(2,828)	10	4
5	Miscellaneous Income - Raw Food	(92)	1	5
6	Miscellaneous Income - Liability Insurance	(434)	26	6
7	Miscellaneous Income - Maintenance	(684)	6	7
8	Miscellaneous Income - Office	(165)	21	8
9	Miscellaneous Income - Employee	(12,689)	22	9
10	OVER ACCRUAL OF PROPERTY TAXES	(59,917)	33	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	(91,694)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR# 0047175

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	(139)	0	0	0	0	0	0	0	0	0	0	(139)	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	740	0	0	0	0	0	0	0	0	0	740	5
6	Maintenance	(3,748)	0	0	0	0	0	0	0	0	0	0	(3,748)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,887)	740	0	(3,147)	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	(2,828)	(10,000)	0	0	0	0	0	0	0	0	0	(12,828)	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	(17)	0	0	0	0	0	0	0	0	0	0	(17)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,845)	(10,000)	0	(12,845)	16								
	C. General Administration													
17	Administrative	0	34,236	0	0	0	0	0	0	0	0	0	34,236	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(156,352)	0	0	0	0	0	0	0	0	0	(156,352)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(79,837)	307	0	0	0	0	0	0	0	0	0	(79,530)	21
22	Employee Benefits & Payroll Taxes	(12,689)	14,910	0	0	0	0	0	0	0	0	0	2,221	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,804)	11,603	0	0	0	0	0	0	0	0	0	(201)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(434)	68,592	0	0	0	0	0	0	0	0	0	68,158	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(104,764)	(26,704)	0	(131,468)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,496)	(35,964)	0	(147,460)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR# 0047175

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	263,321	0	0	0	0	0	0	0	0	0	263,321	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,723	0	0	0	0	0	0	0	0	2,723	32
33	Real Estate Taxes	(59,917)	444,527	0	0	0	0	0	0	0	0	0	384,610	33
34	Rent-Facility & Grounds	0	(2,400,000)	0	0	0	0	0	0	0	0	0	(2,400,000)	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	(59,917)	(1,692,152)	2,723	0	(1,749,346)	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)	(171,413)	(1,728,116)	2,723	0	(1,896,806)	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
<u>SEE ATTACHMENT #1</u>						

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	<u>PROFESSIONAL FEES</u>	\$ 212,500	<u>NEW YORK BOYS MANAGEMENT</u>	46.25%	\$ 2,198	\$ (210,302)	1
2	V	10	<u>NURSING & MED REC</u>	10,000				(10,000)	2
3	V	17	<u>ADMIN WAGES</u>			34,236		34,236	3
4	V	5	<u>TELEPHONE</u>			740		740	4
5	V	21	<u>OTHER ADMIN EXPENSE</u>			41		41	5
6	V	22	<u>FRINGE BENEFITS</u>			14,910		14,910	6
7	V	24	<u>TRAVEL</u>			11,603		11,603	7
8	V	34	<u>RENT</u>	2,400,000	<u>MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC</u>			(2,400,000)	8
9	V	33	<u>REAL ESTATE TAXES</u>			444,527		444,527	9
10	V	30	<u>DEPRECIATION & AMORT</u>			263,321		263,321	10
11	V	21	<u>BANK SVC CHARGES</u>			266		266	11
12	V	19	<u>PROFESSIONAL FEES</u>			53,950		53,950	12
13	V	26	<u>LIABILITY INSURANCE</u>			68,592		68,592	13
14	Total		\$ 2,622,500			\$ 894,384	\$ *	(1,728,116)	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.

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	32		\$	MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		\$ 2,723	\$ 2,723	15	
16	V								16	
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								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			\$			\$ 2,723	\$ *	2,723	39

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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		20	50.00	SALARY	\$ 70,417	17-1	1
2	MICHAEL BLISKO	DIRECTOR OF OP	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	\$ 70,417		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	PRUDENTIAL FINANCIAL		X	MORTGAGE OF FACILITY	\$99,000.00	11/30/07	\$ 17,255,000	\$ 17,255,000	10/31/37	5.7500	\$ 2,756	1								
2	3G		X	FINANCING	Interest Only	11/30/07	2,400,000	2,400,000	10/31/17	9.0000		2								
3												3								
4												4								
5												5								
Working Capital																				
6	BANK LEUMI USA		X	WORKING CAPITAL	None	3/2/07	2,500,000	1,300,000	2/26/08	8.5000	74,263	6								
7												7								
8												8								
9	TOTAL Facility Related				\$99,000.00		\$ 22,155,000	\$ 20,955,000			\$ 77,019	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 22,155,000	\$ 20,955,000			\$ 77,019	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

1. Real Estate Tax accrual used on 2006 report.		\$	516,192	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.)		\$	456,275	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(59,917)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	504,444	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.		\$	444,527	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	_____	10
	2005	337,500	11
	2006	456,275	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MIDWAY NEUROLOGICAL/REHABILITATION CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047175

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>456,275.00</u>	\$ <u>456,275.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>456,275.00</u>	\$ <u>456,275.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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/REHABILITATION CTR

0047175 Report Period Beginning:

1/1/07 Ending:

12/31/07

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 - 4/05 - 12/07

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	<u>FACILITY</u>		<u>2007</u>	<u>\$ 950,000</u>	1
2					2
3	TOTALS			\$ 950,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	404				\$ 7,600,000	\$ 16,239	39	\$ 16,239	\$	\$ 16,239	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIGN		2005	6,000	400	15	400		1,200	9
10		AIR CONDITIONER		2005	38,280	2,552	15	2,552		7,656	10
11		5TH FLOOR RENOVATION		2005	188,856	12,590	15	12,590		37,803	11
12		TIME CLOCK		2005	5,651	377	15	377		1,131	12
13		ELEVATOR ITEMS		2005	17,500	1,167	15	1,167		3,501	13
14		ELEVATOR ITEMS		2005	1,761	117	15	117		351	14
15				2005			15				15
16		WANDERGUARD SECURITY CAMERA		2005	23,000	1,533	15	1,533		4,599	16
17		WANDERGUARD SECURITY CAMERA		2005	6,000	400	15	400		1,200	17
18		WANDERGUARD SECURITY CAMERA		2005	673	45	15	45		135	18
19		WANDERGUARD SECURITY CAMERA		2005	5,625	375	15	375		1,125	19
20		TILES		2005	4,461	297	15	297		891	20
21		TILES		2005	246	16	15	16		48	21
22		TILES		2005	733	49	15	49		147	22
23		HVAC		2005	4,251	283	15	283		849	23
24		HVAC		2005	3,653	244	15	244		732	24
25		BOILERS		2005	7,850	523	15	523		1,569	25
26		ROOF REPAIRS		2005	1,500	100	15	100		300	26
27		LIGHTS		2005	6,650	443	15	443		1,329	27
28		TILES		2005	1,113	74	15	74		222	28
29											29
30		A/C Unit		2006	7,598	507	15	507		1,014	30
31		A/C Unit		2006	7,598	507	15	507		1,014	31
32		Paving		2006	1,571	105	15	105		210	32
33		Paving		2006	2,480	165	15	165		330	33
34		Telephone System		2006	11,173	745	15	745		1,490	34
35		Generator		2006	923	62	15	62		124	35
36		Wanderguard		2006	2,125	142	15	142		284	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	\$	\$ 780	37
38	Shower Room	2006	11,598	773	15	773		1,546	38
39	Kitchen Floor	2006	36,687	2,446	15	2,446		4,892	39
40	Windows	2006	2,708	181	15	181		362	40
41	A/C Units Rooftop	2006	22,273	1,485	15	1,485		2,970	41
42	Locks	2006	8,140	543	15	543		1,086	42
43	Parking Lot Lights	2006	1,900	127	15	127		254	43
44	Tiling in bathrooms	2006	14,083	939	15	939		1,878	44
45	Roofing work	2006	1,200	80	15	80		160	45
46	Fence	2006	16,130	1,075	15	1,075		2,150	46
47	Laundry Chute	2006	2,589	173	15	173		346	47
48	Labor for Shower Room Remodel	2006	3,000	200	15	200		200	48
49	Signs	2006	967	64	15	64		64	49
50	Painting & supplies (5th floor renovations)	2006	541	36	15	36		72	50
51	Floor supplies & fixtures (5th floor renovations)	2006	337	22	15	22		44	51
52	Hardware (5th floor renovations)	2006	588	39	15	39		78	52
53	Floor tile, installation, paint & fixtures (5th Floor ren.)	2006	34,059	2,271	15	2,271		4,542	53
54	Bathroom fixtures & installation (5th floor renovations)	2006	3,687	246	15	246		492	54
55	Air Conditioner	2007	10,330	689	15	689		689	55
56	Fire Sprinkler	2007	4,775	318	15	318		318	56
57	Fire System	2007	1,290	86	15	86		86	57
58	Auto Transfer Switch	2007	838	56	15	56		56	58
59	Video Security Cameras	2007	3,900	260	15	260		260	59
60	Shower Room Tile	2007	9,010	601	15	601		601	60
61	Shower Room Tile	2007	3,543	236	15	236		236	61
62	Cubicle curtains	2007	4,059	271	15	271		271	62
63	Shower Room Tile	2007	5,497	366	15	366		366	63
64	Air Conditioner	2007	500	33	15	33		33	64
65	Air Conditioner	2007	500	33	15	33		33	65
66	Signage	2007	1,692	113	15	113		113	66
67	Fire Sprinkler	2007	1,373	92	15	92		92	67
68	Electrical work in reception area	2007	490	33	15	33		33	68
69	Painting - Shower Room	2007	1,000	67	15	67		67	69
70	TOTAL (lines 4 thru 69)		\$ 8,172,401	\$ 54,399		\$ 54,399	\$	\$ 110,663	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12A, Carried Forward		\$ 8,172,401	\$ 54,399		\$ 54,399	\$	\$ 110,663	1
2	Painting - Shower Room	2007	2000	133	15	133		133	2
3	Painting - Shower Room	2007	3000	200	15	200		200	3
4	Painting - Shower Room	2007	3000	200	15	200		200	4
5	toner	2007	13	1	15	1		1	5
6	Freezer maint	2007	3188	213	15	213		213	6
7	Doors	2007	1595	106	15	106		106	7
8	Doors	2007	1595	106	15	106		106	8
9	Air Conditioner	2007	500	33	15	33		33	9
10	Locks on Gate	2007	3509	234	15	234		234	10
11	Parking Lot Paving	2007	20000	1,333	15	1,333		1,333	11
12	Parking Lot Paving	2007	21410	1,427	15	1,427		1,427	12
13	Fencing	2007	1550	103	15	103		103	13
14	Fencing	2007	1500	100	15	100		100	14
15	Asbestos removal	2007	2370	158	15	158		158	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	TOTAL (lines 1 thru 33)		\$ 8,237,631	\$ 58,748		\$ 58,748	\$	\$ 115,010	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 103,350	\$ 21,875	\$ 21,875	\$		\$ 52,897	71
72	Current Year Purchases	2,903,894	275,514	285,682	10,168		275,514	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,007,244	\$ 297,389	\$ 307,557	\$ 10,168		\$ 328,411	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)	\$ 12,194,875	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 356,137	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 366,305	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,168	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 443,421	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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			\$ _____	\$ _____	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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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		hrs	\$		\$ 348,876	\$		\$ 348,876	1
2	Licensed Speech and Language Development Therapist		hrs			9,661			9,661	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			268,945			268,945	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				308,415		308,415	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB & XRAY						12,289		12,289	13
14	TOTAL			\$		\$ 627,482	\$ 320,704		\$ 948,186	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ 1,371,059	\$	1
2	Cash-Patient Deposits	(70,669)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,655,289		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,402		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,000,081	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	950,000		13
14	Buildings, at Historical Cost	7,600,000		14
15	Leasehold Improvements, at Historical Cost	655,463		15
16	Equipment, at Historical Cost	2,988,446		16
17	Accumulated Depreciation (book methods)	(407,061)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,875,186		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(61,530)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>SECURITY DEP</u>)	44,590		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,645,094	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,645,175	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 741,285	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	469,271		30
31	Accrued Taxes Payable (excluding real estate taxes)	(13,539)		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)	\$ 1,772,398	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,700,000		39
40	Mortgage Payable	17,255,000		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)	\$ 20,955,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,727,398	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 917,777	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 23,645,175	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,248,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,248,018	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,267,922	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	(1,598,163)	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)	\$ (330,241)	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)	\$ 917,777	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 12,886,624	1
2	Discounts and Allowances for all Levels	(779,222)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,107,402	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,373,326	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,373,326	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	259,702	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,771	19
20	Radiology and X-Ray	6,170	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 283,643	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	1,126	27
28	VENDING	3,064	28
28a	MISCELLANEOUS	25,334	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,524	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,793,928	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,099,127	31
32	Health Care	5,243,959	32
33	General Administration	2,061,051	33
B. Capital Expense			
34	Ownership	2,577,247	34
C. Ancillary Expense			
35	Special Cost Centers	320,705	35
36	Provider Participation Fee	223,917	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,526,006	40
41	Income before Income Taxes (line 30 minus line 40)**	1,267,922	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,267,922	43

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

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

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

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

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

0047175

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	5,837	6,287	\$ 292,747	\$ 46.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,988	20,484	614,974	30.02	3
4	Licensed Practical Nurses	56,665	61,698	1,590,434	25.78	4
5	CNAs & Orderlies	107,283	114,879	1,270,199	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,473	6,942	63,077	9.09	8
9	Activity Director	10,590	11,693	142,028	12.15	9
10	Activity Assistants					10
11	Social Service Workers	14,408	16,349	249,828	15.28	11
12	Dietician	39,174	42,867	408,858	9.54	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,381	8,046	128,494	15.97	17
18	Housekeepers	35,983	39,965	358,644	8.97	18
19	Laundry	6,845	7,540	72,444	9.61	19
20	Administrator	3,483	3,640	151,294	41.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,349	13,832	212,686	15.38	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	3,873	4,051	39,463	9.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,332	358,273	\$ 5,595,170 *	\$ 15.62	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	736	\$ 25,748	1-3	35
36	Medical Director				36
37	Medical Records Consultant	39	1,354	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	108	5,377	1-3	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	883	\$ 32,479		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			52
53	TOTAL (lines 50 - 52)			53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **MIDWAY NEUROLOGICAL/REHABILITATION**

0047175

Report Period Beginning: **1/1/07**

Ending: **12/31/07**

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 TOPER	ADMIN	17.325	\$ 70,417	Workers' Compensation Insurance	\$ 92,557	IDPH License Fee	\$ 995	
MELODY PARKS	ADMIN/ASST		69,546	Unemployment Compensation Insurance	85,561	Advertising: Employee Recruitment		
DAVID LENZO	ADMIN/ASST		11,331	FICA Taxes	426,945	Health Care Worker Background Check		
				Employee Health Insurance	248,858	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	353	
				Illinois Municipal Retirement Fund (IMRF)*		Village of Bridgeview	340	
				UNIFORMS	15,606	Cook County Colector	82	
				PHYSICALS	225	Secretary of State	250	
				LIFE INSURANCE / PENSION	79,132	State Fire Marshall	120	
						CLIA Lab Program	150	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 151,294			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 948,884	
Description				Amount				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							\$ 2,290	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
NEW YORK BOYS	MGMT CO		\$ 212,500				Out-of-State Travel	\$
ABRAHAM GUTNICKI	LEGAL		12,848					
MEYER MAGENCE	LEGAL		4,049					
HARRISON, MOBERLY	LEGAL		2,217				In-State Travel	
BRADLEY & ASSOCIATES	ACCOUNTING		15,053				AUTO EXPENSE	11,079
JOHNSON, GOLDBERG	ACCOUNTING		4,000				MILEAGE	7,362
							Seminar Expense	4,385
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	
							\$ 22,826	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CTR# 0047175Report Period Beginning: 1/1/07Ending: 12/31/07**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. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,548 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 223,917
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A 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? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT