

		FOR BHF USE				

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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

<p><b>I. IDPH License ID Number:</b> <u>0047175</u></p> <p><b>Facility Name:</b> <u>MIDWAY NEUROLOGICAL &amp; REHABILITATION CTR</u></p> <p><b>Address:</b> <u>8540 SOUTH HARLEM AVENUE</u> <u>BRIDGEVIEW</u> <u>60455</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(708) 598-2605</u> <b>Fax #</b> <u>(708) 595-5671</u></p> <p><b>HFS ID Number:</b> <u>202040687001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>4/1/05</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>DANIEL S. GAAFAR</u> <b>Telephone Number:</b> <u>(317) 237-5500</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/08</u> to <u>12/31/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 2px;">Officer or Administrator of Provider</td> <td style="padding: 2px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Type or Print Name) <u>MOISHE GUBIN</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Title) <u>TREASURER</u></td> </tr> <tr> <td style="padding: 2px;">Paid Preparer</td> <td style="padding: 2px;">(Signed) <u>SEE ACCOUNTANTS' REPORT ATTACHED</u> (Date) _____</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Print Name and Title) <u>DANIEL S. GAAFAR PARTNER</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Firm Name &amp; Address) <u>BRADLEY &amp; ASSOCIATES, INC. 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b> </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>MOISHE GUBIN</u>		(Title) <u>TREASURER</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' REPORT ATTACHED</u> (Date) _____		(Print Name and Title) <u>DANIEL S. GAAFAR PARTNER</u>		(Firm Name & Address) <u>BRADLEY &amp; ASSOCIATES, INC. 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225</u>		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR

# 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	147,864	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	147,864	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		Other	Total	
		Recipient	Private Pay			
8	SNF	87,706	2,447	17,917	108,070	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,706	2,447	17,917	108,070	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.09%

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 6,405

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: 12/31/08 Fiscal Year: 12/31/08

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

STATE OF ILLINOIS

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABIL # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
<b>A. General Services</b>											
1	Dietary	433,275	59,268	30,174	522,717		522,717	(1,705)	521,012		1
2	Food Purchase		461,671		461,671		461,671		461,671		2
3	Housekeeping	399,046	45,084		444,130		444,130		444,130		3
4	Laundry	71,629	28,866		100,495		100,495		100,495		4
5	Heat and Other Utilities			452,748	452,748		452,748	620	453,368		5
6	Maintenance	143,420	15,222	173,343	331,985		331,985	(6,550)	325,435		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,047,370</b>	<b>610,111</b>	<b>656,265</b>	<b>2,313,746</b>		<b>2,313,746</b>	<b>(7,635)</b>	<b>2,306,111</b>		8
<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	4,077,801	845,885	35,325	4,959,011		4,959,011	10,137	4,969,148		10
10a	Therapy			624,623	624,623		624,623		624,623		10a
11	Activities	147,756	26,764		174,520		174,520		174,520		11
12	Social Services	233,314		4,359	237,673		237,673	(207)	237,466		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consultant</b>			7,929	7,929		7,929		7,929		15
16	<b>TOTAL Health Care and Programs</b>	<b>4,458,871</b>	<b>872,649</b>	<b>684,236</b>	<b>6,015,756</b>		<b>6,015,756</b>	<b>9,930</b>	<b>6,025,686</b>		16
<b>C. General Administration</b>											
17	Administrative	134,977			134,977		134,977		134,977		17
18	Directors Fees										18
19	Professional Services			271,544	271,544		271,544	(199,519)	72,025		19
20	Dues, Fees, Subscriptions & Promotions			4,448	4,448		4,448	288	4,736		20
21	Clerical & General Office Expenses	230,579	105,158	19,041	354,778		354,778	(12,494)	342,284		21
22	Employee Benefits & Payroll Taxes			1,023,209	1,023,209		1,023,209	33,374	1,056,583		22
23	Inservice Training & Education										23
24	Travel and Seminar			88,682	88,682		88,682	(70,319)	18,363		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			276,402	276,402		276,402	104,392	380,794		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>365,556</b>	<b>105,158</b>	<b>1,683,326</b>	<b>2,154,040</b>		<b>2,154,040</b>	<b>(144,278)</b>	<b>2,009,762</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,871,797</b>	<b>1,587,918</b>	<b>3,023,827</b>	<b>10,483,542</b>		<b>10,483,542</b>	<b>(141,983)</b>	<b>10,341,559</b>		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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			95,598	95,598		95,598	591,672	687,270			30
31	Amortization of Pre-Op. & Org.			2,878	2,878		2,878	522,135	525,013			31
32	Interest			89,506	89,506		89,506	1,204,041	1,293,547			32
33	Real Estate Taxes							442,627	442,627			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	<b>TOTAL Ownership</b>			2,587,982	2,587,982		2,587,982	360,475	2,948,457			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		340,801		340,801		340,801		340,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,796	221,796		221,796		221,796			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		340,801	221,796	562,597		562,597		562,597			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,871,797	1,928,719	5,833,605	13,634,121		13,634,121	218,492	13,852,613			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 C # 0047175

Report Period Beginning: 1/1/08

Ending: 12/31/08

**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	(10,343)	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	(53)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(11,000)	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	(25,851)	21		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(119,621)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (166,868)		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	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)	385,360	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 385,360		36
(sum of SUBTOTALS)				
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 218,492		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

MIDWAY NEUROLOGICAL & REHABILITATION CTR

ID# 0047175

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VENDING INCOME	\$ (6,550)	6	1
2	MISCELLANEOUS REVENUE	(33,461)	21	2
3	COMMUNITING	(79,610)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	<b>Total</b>	(119,621)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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)	
	<b>A. General Services</b>													
1	Dietary	(53)	(1,652)	0	0	0	0	0	0	0	0	0	(1,705)	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	620	0	0	0	0	0	0	0	0	0	620	5
6	Maintenance	(6,550)	0	0	0	0	0	0	0	0	0	0	(6,550)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,603)</b>	<b>(1,032)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,635)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10,137	0	0	0	0	0	0	0	0	0	10,137	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	(207)	0	0	0	0	0	0	0	0	0	(207)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>9,930</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9,930</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(215,878)	16,359	0	0	0	0	0	0	0	0	(199,519)	19
20	Fees, Subscriptions & Promotions	0	38	250	0	0	0	0	0	0	0	0	288	20
21	Clerical & General Office Expenses	(70,312)	57,668	150	0	0	0	0	0	0	0	0	(12,494)	21
22	Employee Benefits & Payroll Taxes	0	33,374	0	0	0	0	0	0	0	0	0	33,374	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(79,610)	9,291	0	0	0	0	0	0	0	0	0	(70,319)	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	104,392	0	0	0	0	0	0	0	0	0	104,392	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(149,922)</b>	<b>(11,115)</b>	<b>16,759</b>	<b>0</b>	<b>(144,278)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(156,525)</b>	<b>(2,217)</b>	<b>16,759</b>	<b>0</b>	<b>(141,983)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

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)	
	<b>D. Ownership</b>													
30	Depreciation	(10,343)	602,015	0	0	0	0	0	0	0	0	0	591,672	30
31	Amortization of Pre-Op. & Org.	0	0	522,135	0	0	0	0	0	0	0	0	522,135	31
32	Interest	0	0	1,204,041	0	0	0	0	0	0	0	0	1,204,041	32
33	Real Estate Taxes	0	0	442,627	0	0	0	0	0	0	0	0	442,627	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	<b>TOTAL Ownership</b>	<b>(10,343)</b>	<b>(1,797,985)</b>	<b>2,168,803</b>	<b>0</b>	<b>360,475</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(166,868)	(1,800,202)	2,185,562	0	0	0	0	0	0	0	0	218,492	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	\$ 248,902	NEW YORK BOYS	46.25%	\$ 33,024	\$ (215,878)	1
2	V	10	NURSING & MED REC	24,000	NEW YORK BOYS		34,137	10,137	2
3	V	21	ADMIN WAGES		NEW YORK BOYS		62,026	62,026	3
4	V	5	TELEPHONE		NEW YORK BOYS		620	620	4
5	V	21	OTHER ADMIN EXP	8,652	NEW YORK BOYS		4,294	(4,358)	5
6	V	22	FRINGE BENEFITS	625	NEW YORK BOYS		33,999	33,374	6
7	V	24	TRAVEL	267	NEW YORK BOYS		9,558	9,291	7
8	V	1	DIETARY	11,400	NEW YORK BOYS		9,748	(1,652)	8
9	V	12	SOCIAL SERVICES	207	NEW YORK BOYS			(207)	9
10	V	20	LICENSE & FEES		NEW YORK BOYS		38	38	10
11	V	34	RENT	2,400,000	MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC			(2,400,000)	11
12	V	30	DEPRECIATION		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		602,015	602,015	12
13	V	26	LIABILITY INSURANCE		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		104,392	104,392	13
14	Total		\$ 2,694,053			\$ 893,851	\$ *	(1,800,202)	14

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

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 INTEREST	\$	MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		\$ 1,204,041	\$	1,204,041	15
16	V	19 PROFESSIONAL FEES		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		16,359		16,359	16
17	V	33 REALESTATE TAXES		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		442,627		442,627	17
18	V	31 AMORTIZATION		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		522,135		522,135	18
19	V	20 LICENSES & FEES		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		250		250	19
20	V	21 OTHER ADMIN EXP		MIDWAY NEUROLOGICAL AND REHAB. REALTY, LLC		150		150	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		\$			\$ 2,185,562	\$ *	2,185,562	39

\* 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 NEUROLOGICAL & REHABIL      #      0047175      Report Period Beginning:      1/1/08      Ending:      12/31/08

## 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									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CT # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILI # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

## 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	
						Original	Balance					
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										
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	PRUDENTIAL FINANCIAL	x	MORTGAGE OF FACILITY	\$95,507.00	11/30/07	\$ 17,255,000	\$ 17,096,962	10/31/37	5.7500	\$ 988,041	1	
2	3G	x	FINANCING	INTREST ONL	11/30/07	2,400,000	2,400,000	10/31/17	9.0000	216,000	2	
3											3	
4											4	
5											5	
<b>Working Capital</b>												
6	BANK LEUMI USA	x	WORKING CAPITAL	NONE	3/2/07	2,500,000	2,000,000	2/26/09	8.5000	89,506	6	
7											7	
8											8	
9	TOTAL Facility Related			\$95,507.00		\$ 22,155,000	\$ 21,496,962			\$ 1,293,547	9	
<b>B. Non-Facility Related*</b>												
10											10	
11											11	
12											12	
13											13	
14	TOTAL Non-Facility Related					\$	\$			\$	14	
15	TOTALS (line 9+line14)					\$ 22,155,000	\$ 21,496,962			\$ 1,293,547	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**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.                 </div>																																
1. Real Estate Tax accrual used on 2007 report.		\$ 504,444	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.)		\$ 462,092	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ (42,352)	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 484,979	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 442,627	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td></td><td style="text-align: center;">8</td></tr> <tr><td>2004</td><td></td><td style="text-align: center;">9</td></tr> <tr><td>2005</td><td style="text-align: right;">337,500</td><td style="text-align: center;">10</td></tr> <tr><td>2006</td><td style="text-align: right;">456,275</td><td style="text-align: center;">11</td></tr> <tr><td>2007</td><td style="text-align: right;">462,092</td><td style="text-align: center;">12</td></tr> </table>	2003		8	2004		9	2005	337,500	10	2006	456,275	11	2007	462,092	12	<table border="1"> <tr><td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td style="text-align: center;">13</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td style="text-align: center;">14</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6 \$</td><td style="text-align: center;">15</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td style="text-align: center;">16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003		8																														
2004		9																														
2005	337,500	10																														
2006	456,275	11																														
2007	462,092	12																														
<b>FOR BHF USE ONLY</b>																																
13	FROM R. E. TAX STATEMENT FOR 2007 \$	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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

**2007 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 Costs**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 2007.

(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>18-36-403-013-0000</u>	<u>NURSING FACILITY</u>	\$ <u>228,137.57</u>	\$ <u>228,137.57</u>
2. <u>18-36-403-013-0000</u>	<u>NURSING FACILITY</u>	\$ <u>233,954.70</u>	\$ <u>233,954.70</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>462,092.27</u>	\$ <u>462,092.27</u>

**B. Real Estate Tax Cost Allocation:**

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        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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

**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.

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 ground (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)

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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: 2,878 4. Dates Incurred: VARIOUS - 4/05 - 12/08

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	FACILITY		2007	\$ 950,000	1
2					2
3	TOTALS			\$ 950,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08

**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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	404			\$ 7,600,000	\$ 194,872	39	\$ 194,872	\$	\$ 211,111	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	SIGN		2005	6,000	400	15	400		1,600	9
10	AIR CONDITIONER		2005	38,280	2,552	15	2,552		10,208	10
11	5TH FLOOR RENOVATION		2005	188,856	12,590	15	12,590		50,393	11
12	TIME CLOCK		2005	5,651	377	15	377		1,508	12
13	ELEVATOR ITEMS		2005	17,500	1,167	15	1,167		4,668	13
14	ELEVATOR ITEMS		2005	1,761	117	15	117		468	14
15						15				15
16	WANDERGUARD SECURITY CAMERA		2005	23,000	1,533	15	1,533		6,132	16
17	WANDERGUARD SECURITY CAMERA		2005	6,000	400	15	400		1,600	17
18	WANDERGUARD SECURITY CAMERA		2005	673	45	15	45		180	18
19	WANDERGUARD SECURITY CAMERA		2005	5,625	375	15	375		1,500	19
20	TILES		2005	4,461	297	15	297		1,188	20
21	TILES		2005	246	16	15	16		64	21
22	TILES		2005	733	49	15	49		196	22
23	HVAC		2005	4,251	283	15	283		1,132	23
24	HVAC		2005	3,653	244	15	244		976	24
25	BOILERS		2005	7,850	523	15	523		2,092	25
26	ROOF REPAIRS		2005	1,500	100	15	100		400	26
27	LIGHTS		2005	6,650	443	15	443		1,772	27
28	TILES		2005	1,113	74	15	74		296	28
29										29
30	A/C Unit		2006	7,598	507	15	507		1,521	30
31	A/C Unit		2006	7,598	507	15	507		1,521	31
32	Paving		2006	1,571	105	15	105		315	32
33	Paving		2006	2,480	165	15	165		495	33
34	Telephone System		2006	11,173	745	15	745		2,235	34
35	Generator		2006	923	62	15	62		186	35
36	Wanderguard		2006	2,125	142	15	142		426	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

## STATE OF ILLINOIS

Page 12A

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08**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	Ist floor bathrooms	2006	\$ 5,850	\$ 390	15	\$ 390	\$	\$ 1,170		37
38	Shower Room	2006	11,598	773	15	773		2,319		38
39	Kitchen Floor	2006	36,687	2,446	15	2,446		7,338		39
40	Windows	2006	2,708	181	15	181		543		40
41	A/C Units Rooftop	2006	22,273	1,485	15	1,485		4,455		41
42	Locks	2006	8,140	543	15	543		1,629		42
43	Parking Lot Lights	2006	1,900	127	15	127		381		43
44	Tiling in bathrooms	2006	14,083	939	15	939		2,817		44
45	Roofing work	2006	1,200	80	15	80		240		45
46	Fence	2006	16,130	1,075	15	1,075		3,225		46
47	Laundry Chute	2006	2,589	173	15	173		519		47
48	Labor for Shower Room Remodel	2006	3,000	200	15	200		400		48
49	Signs	2006	967	64	15	64		128		49
50	Painting & supplies (5th floor renovations)	2006	541	36	15	36		108		50
51	Floor supplies & fixtures (5th floor renovations)	2006	337	22	15	22		66		51
52	Hardware (5th floor renovations)	2006	588	39	15	39		117		52
53	Floor tile, installation, paint & fixtures (5th Floor ren.)	2006	34,059	2,271	15	2,271		6,813		53
54	Bathroom fixtures & installation (5th floor renovations)	2006	3,687	246	15	246		738		54
55	Air Conditioner	2007	10,330	265	39	265		1,378		55
56	Fire Sprinkler	2007	4,775	122	39	122		636		56
57	Fire System	2007	1,290	33	39	33		172		57
58	Auto Transfer Switch	2007	838	21	39	21		112		58
59	Video Security Cameras	2007	3,900	100	39	100		520		59
60	Shower Room Tile	2007	9,010	231	39	231		1,202		60
61	Shower Room Tile	2007	3,543	91	39	91		472		61
62	Cubicle curtains	2007	4,059	104	39	104		542		62
63	Shower Room Tile	2007	5,497	141	39	141		732		63
64	Air Conditioner	2007	500	13	39	13		66		64
65	Air Conditioner	2007	500	13	39	13		66		65
66	Signage	2007	1,692	43	39	43		226		66
67	Fire Sprinkler	2007	1,373	35	39	35		184		67
68	Electrical work in reception area	2007	490	13	39	13		66		68
69	Painting - Shower Room	2007	1,000	26	39	26		134		69
70	TOTAL (lines 4 thru 69)		\$ 8,172,401	\$ 231,030		\$ 231,030	\$	\$ 343,697		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number MIDWAY NEUROLOGICAL &amp; REHABILITATION CTR

# 0047175

Report Period Beginning:

1/1/08

Ending:

Page 12B

12/31/08

## 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	\$ 231,030		\$ 231,030	\$	\$ 343,697		1
2	Painting - Shower Room	2007 2,000	51	39	51		266		2
3	Painting - Shower Room	2007 3,000	77	39	77		400		3
4	Painting - Shower Room	2007 3,000	77	39	77		400		4
5	toner	2007 13	0	39	0		2		5
6	Freezer maint	2007 3,188	82	39	82		426		6
7	Doors	2007 1,595	41	39	41		212		7
8	Doors	2007 1,595	41	39	41		212		8
9	Air Conditioner	2007 500	13	39	13		66		9
10	Locks on Gate	2007 3,509	90	39	90		468		10
11	Parking Lot Paving	2007 20,000	513	39	513		2,666		11
12	Parking Lot Paving	2007 21,410	549	39	549		2,854		12
13	Fencing	2007 1,550	40	39	40		206		13
14	Fencing	2007 1,500	38	39	38		200		14
15	Asbestos removal	2007 2,370	61	39	61		316		15
16	Pump	2008 1,498	100	39	38	(62)	100		16
17	Sprinkler Systems	2008 12,457	830	39	160	(670)	830		17
18	Sprinkler Systems	2008 1,625	42	39	10	(32)	42		18
19	Smoke Detectors	2008 1,342	34	39	17	(17)	34		19
20	Refrigeration	2008 4,250	109	39	64	(45)	109		20
21	Refrigeration	2008 5,291	136	39	79	(57)	136		21
22	Refrigeration	2008 3,735	96	39	48	(48)	96		22
23	Refrigeration	2008 6,950	178	39	74	(104)	178		23
24	Refrigeration	2008 2,455	63	39	26	(37)	63		24
25	Refrigeration	2008 971	25	39	8	(17)	25		25
26	Refrigeration	2008 1,678	43	39	11	(32)	43		26
27	Refrigeration	2008 2,865	73	39	18	(55)	73		27
28	Tiling for Shower Room	2008 276	7	39	1	(6)	7		28
29	Elevator	2008 1,270	33	39		(33)	33		29
30	Roof	2008 4,094	105	39	96	(9)	105		30
31	Fire Doors	2008 2,670	68	39	46	(22)	68		31
32	Fire Doors	2008 907	23	39	14	(9)	23		32
33	Hot Water Heater	2008 8,875	228	39	171	(57)	228		33
34	TOTAL (lines 1 thru 33)	\$ 8,300,839	\$ 234,896		\$ 233,584	\$ (1,312)	\$ 354,584		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATION CTR # 0047175 Report Period Beginning: 1/1/08 Ending: 12/31/08 Page 12C

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 12B, Carried Forward	\$ 8,300,839	\$ 234,896		\$ 233,584	\$ (1,312)	\$ 354,584		1
2	Elevator	2008 3,008	77	39	51	(26)	77		2
3	Roof	2008 35,700	915	39	458	(457)	915		3
4	Brick Work	2008 17,850	458	39	114	(344)	458		4
5	Windows	2008 135,000	4,079	39	1,731	(2,348)	4,079		5
6	2nd and 3rd floor tiling nurses station	2008 80,000	2,051	39	513	(1,538)	2,051		6
7	Renovation	2008 41,403	1,062	39	177	(885)	1,062		7
8	CATV Wiring	2008 8,000	205	39	68	(137)	205		8
9	CATV Wiring	2008 8,000	205	39	68	(137)	205		9
10	CATV Wiring	2008 8,000	205	39	68	(137)	205		10
11	CATV Wiring	2008 8,000	205	39	68	(137)	205		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	TOTAL (lines 1 thru 33)	\$ 8,645,800	\$ 244,358		\$ 236,900	\$ (7,458)	\$ 364,046		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: **1/1/08** Ending: **12/31/08**

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	\$ 3,007,244	\$ 447,663	\$ 447,663	\$	Various	\$ 740,697	71
72	Current Year Purchases	31,414	5,592	2,707	(2,885)	Various	5,592	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,038,658	\$ 453,255	\$ 450,370	\$ (2,885)		\$ 746,289	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				\$	\$	\$	\$		\$	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)	\$ 12,634,458	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 697,613	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 687,270	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,343)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,110,335	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: NOT APPLICABLE

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	<b>TOTAL</b>				\$			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.                      /2009                      \$                     

13.                      /2010                      \$                     

14.                      /2011                      \$                     

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	<b>TOTAL</b>		\$	\$	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.

**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 299,991	\$		\$ 299,991	1
2	Licensed Speech and Language Development Therapist		hrs			68,031			68,031	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			256,601			256,601	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				329,180		329,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>LAB &amp; X-RAY</b>						11,621		11,621	13
14	<b>TOTAL</b>			\$		\$ 624,623	\$ 340,801		\$ 965,424	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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number MIDWAY NEUROLOGICAL &amp; REHABILITATION CTI# 0047175 Report Period Beginning: 1/1/08

Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 1,248,631	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,886,798	4,192,781	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,068	57,068	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,943,866	\$ 5,498,480	10
<b>B. Long-Term Assets</b>				
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	1,063,631	1,063,631	15
16	Equipment, at Historical Cost	169,860	3,019,860	16
17	Accumulated Depreciation (book methods)	(282,849)	(1,104,674)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,875,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,897)	(586,543)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spSECURITY DEP)	40,480	40,480	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,013,395	\$ 18,857,940	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,957,261	\$ 24,356,420	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 743,619	\$ 1,043,619	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,189	303,189	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>SETTLEMENT RESERVE</u>	575,381	575,381	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,622,189	\$ 1,922,189	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,000,000	2,000,000	39
40	Mortgage Payable		17,096,962	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,000,000	\$ 19,096,962	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,622,189	\$ 21,019,151	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,335,072	\$ 3,337,269	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,957,261	\$ 24,356,420	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>917,777</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>917,777</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,421,168	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(1,003,873)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>417,295</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,335,072</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number **MIDWAY NEUROLOGICAL & REHABILITATI** # **0047175** Report Period Beginning: **1/1/08** Ending: **12/31/08**

**VII. 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,172,593	1
2	Discounts and Allowances for all Levels	(399,517)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,773,076	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,036,215	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,036,215	8
<b>C. Other Operating Revenue</b>			
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	189,491	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,627	19
20	Radiology and X-Ray	2,870	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 205,988	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING</b>	6,550	28
28a	<b>MISCELLANEOUS</b>	33,461	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 40,011	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,055,290	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,313,746	31
32	Health Care	6,007,828	32
33	General Administration	2,161,969	33
<b>B. Capital Expense</b>			
34	Ownership	2,587,982	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	340,801	35
36	Provider Participation Fee	221,796	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,634,122	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,421,168	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,421,168	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: **1/1/08** Ending: **12/31/08**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,013	2,260	\$ 91,346	\$ 40.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,108	19,566	671,796	34.33	3
4	Licensed Practical Nurses	63,781	68,609	1,791,546	26.11	4
5	CNAs & Orderlies	113,476	120,386	1,333,397	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,603	9,642	102,672	10.65	8
9	Activity Director	12,074	12,779	147,756	11.56	9
10	Activity Assistants					10
11	Social Service Workers	13,907	14,940	233,314	15.62	11
12	Dietician	40,073	43,823	433,275	9.89	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,890	8,575	143,420	16.73	17
18	Housekeepers	40,268	43,943	399,046	9.08	18
19	Laundry	6,445	7,220	71,629	9.92	19
20	Administrator	3,658	3,946	134,977	34.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,668	14,757	230,579	15.63	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	6,319	6,660	87,044	13.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	350,283	377,106	\$ 5,871,797 *	\$ 15.57	34

**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	536	\$ 18,774	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	227	11,325	10-3	38
39	Pharmacist Consultant	159	7,929	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	119	4,152	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,041	\$ 42,180		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

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

\*\* See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL & REHABILITATIO

# 0047175

Report Period Beginning: 1/1/08

Ending: 12/31/08

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	
Melody Parks	Admin	0%	\$ 37,794	Workers' Compensation Insurance	\$ 99,785	IDPH License Fee	\$ 1,990	
Tamara StoneBerger	Admin	0%	44,542	Unemployment Compensation Insurance	104,459	Advertising: Employee Recruitment		
David Hajouch	Admin	0%	52,641	FICA Taxes	474,540	Health Care Worker Background Check		
				Employee Health Insurance	257,898	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Village of Bridgeview	1,740	
				UNIFORMS	19,942	Cook County Collector	218	
				PHYSICALS	1,170	Secretary of State	250	
				LIFE INSURANCE/PENSION	98,789	Bridgeview Chamber of Membership	250	
						Misc Licenses & Fees	288	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 134,977	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,056,583	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,736	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Auto Expense	8,654
							Mileage	6,430
							Other travel	636
							Seminar Expense	2,243
							Education	400
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 18,363
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
NEW YORK BOYS	MGMT CO		\$ 246,000					
ABRAHAM GUTNICKI	LEGAL		3,532					
MEYER MAGENCE	LEGAL		3,975					
HARRISON MOBERLY	LEGAL		676					
NEAL,GERBER, EISENBERG	LEGAL		600					
STONE, MCGUIRE, SIEGEL	LEGAL		310					
SWANSON, MARTIN & BELL	LEGAL		5,000					
BRADLEY & ASSOCIATES	ACCOUNTING		11,451					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 271,544					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* 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	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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 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. \$ 32,551 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. \$ 221,796  
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 benefit: 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**