

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr

0047175 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	<u>404</u>	Skilled (SNF)	<u>404</u>	<u>147,460</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>404</u>	TOTALS	<u>404</u>	<u>147,460</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>91,278</u>	<u>5,459</u>	<u>9,494</u>	<u>106,231</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>91,278</u>	<u>5,459</u>	<u>9,494</u>	<u>106,231</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.04%

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 4,877

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr # 0047175 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	481,378	45,829	15,000	542,207		542,207	(6,096)	536,111		1
2	Food Purchase		453,204		453,204		453,204		453,204		2
3	Housekeeping	453,946	76,209		530,155		530,155		530,155		3
4	Laundry	65,761	40,308		106,069		106,069		106,069		4
5	Heat and Other Utilities			428,061	428,061		428,061	(3,690)	424,371		5
6	Maintenance	132,608	24,878	165,890	323,376		323,376	(3,381)	319,995		6
7	Other (specify):*										7
8	TOTAL General Services	1,133,693	640,428	608,951	2,383,072		2,383,072	(13,167)	2,369,905		8
	B. Health Care and Programs										
9	Medical Director			17,000	17,000		17,000		17,000		9
10	Nursing and Medical Records	3,966,440	746,696	36,939	4,750,075		4,750,075	19,197	4,769,272		10
10a	Therapy			611,749	611,749		611,749		611,749		10a
11	Activities	225,004	47,389		272,393		272,393		272,393		11
12	Social Services	281,468	4,539	281	286,288		286,288		286,288		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consult			30,215	30,215		30,215		30,215		15
16	TOTAL Health Care and Programs	4,472,912	798,624	696,184	5,967,720		5,967,720	19,197	5,986,917		16
	C. General Administration										
17	Administrative	151,692			151,692		151,692	(6,278)	145,414		17
18	Directors Fees										18
19	Professional Services			328,780	328,780		328,780	(286,712)	42,068		19
20	Dues, Fees, Subscriptions & Promotions			2,743	2,743		2,743	496	3,239		20
21	Clerical & General Office Expenses	217,381	111,421	18,307	347,109		347,109	63,630	410,739		21
22	Employee Benefits & Payroll Taxes			950,590	950,590		950,590	28,859	979,449		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,756	11,756		11,756	(10,307)	1,449		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			295,767	295,767		295,767	105,562	401,329		26
27	Other (specify):*										27
28	TOTAL General Administration	369,073	111,421	1,607,943	2,088,437		2,088,437	(104,750)	1,983,687		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,975,678	1,550,473	2,913,078	10,439,229		10,439,229	(98,720)	10,340,509		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			296,752	296,752		296,752	235,945	532,697			30
31	Amortization of Pre-Op. & Org.			2,878	2,878		2,878	522,135	525,013			31
32	Interest			123,525	123,525		123,525	1,115,815	1,239,340			32
33	Real Estate Taxes							552,174	552,174			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,399,187)	813			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,823,155	2,823,155		2,823,155	26,882	2,850,037			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		331,306		331,306		331,306		331,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,190	221,190		221,190		221,190			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		331,306	221,190	552,496		552,496		552,496			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,975,678	1,881,779	5,957,423	13,814,880		13,814,880	(71,838)	13,743,042			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

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	359	30		9
10	Interest and Other Investment Income	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	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	(25)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,142)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,720)	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	(66,379)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,036)		\$	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)	2,198	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,198		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (71,838)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Midway Neurological/Rehabilitation Ctr

ID# 0047175

Report Period Beginning: 1/1/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (3,453)	6	1
2	Comuting	(10,742)	24	2
3	DIETARY MISC REV	(3,914)	1	3
4	MEDICAL RECORDS MISC REV	(501)	10	4
5	ADMINISTRATIVE MISC REV	(6,278)	17	5
6	GENERAL OFFICE MISC REV	(37,801)	21	6
7	RENT INCOME	(3,690)	5	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(66,379)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr# 0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(4,029)	(2,067)	0	0	0	0	0	0	0	0	0	(6,096)	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	(3,690)	0	0	0	0	0	0	0	0	0	0	(3,690)	5
6	Maintenance	(3,453)	72	0	0	0	0	0	0	0	0	0	(3,381)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,172)	(1,995)	0	0	0	0	0	0	0	0	0	(13,167)	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	(501)	19,698	0	0	0	0	0	0	0	0	0	19,197	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(501)	19,698	0	0	0	0	0	0	0	0	0	19,197	16
	C. General Administration													
17	Administrative	(6,278)	0	0	0	0	0	0	0	0	0	0	(6,278)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,142)	(289,470)	3,900	0	0	0	0	0	0	0	0	(286,712)	19
20	Fees, Subscriptions & Promotions	0	246	250	0	0	0	0	0	0	0	0	496	20
21	Clerical & General Office Expenses	(44,546)	108,067	109	0	0	0	0	0	0	0	0	63,630	21
22	Employee Benefits & Payroll Taxes	0	28,859	0	0	0	0	0	0	0	0	0	28,859	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,742)	435	0	0	0	0	0	0	0	0	0	(10,307)	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	105,562	0	0	0	0	0	0	0	0	0	105,562	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(62,708)	(46,301)	4,259	0	(104,750)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,381)	(28,598)	4,259	0	(98,720)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr# 0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	359	235,586	0	0	0	0	0	0	0	0	0	235,945	30
31	Amortization of Pre-Op. & Org.	0	0	522,135	0	0	0	0	0	0	0	0	522,135	31
32	Interest	(14)	0	1,115,829	0	0	0	0	0	0	0	0	1,115,815	32
33	Real Estate Taxes	0	0	552,174	0	0	0	0	0	0	0	0	552,174	33
34	Rent-Facility & Grounds	0	(2,399,187)	0	0	0	0	0	0	0	0	0	(2,399,187)	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	345	(2,163,601)	2,190,138	0	26,882	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(74,036)	(2,192,199)	2,194,397	0	0	0	0	0	0	0	0	(71,838)	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	1 Dietary	\$ 15,000	Infinity Management		\$ 12,933	\$ (2,067)	1
2	V	6 Maintenance		Infinity Management		72	72	2
3	V	10 Nursing	25,200	Infinity Management		44,898	19,698	3
4	V	19 Professional Fees	290,000	Infinity Management		530	(289,470)	4
5	V	20 License & Fees		Infinity Management		246	246	5
6	V	21 Clerical & Office	27,729	Infinity Management		135,796	108,067	6
7	V	22 Benefits	3,510	Infinity Management		32,369	28,859	7
8	V	24 Travel	372	Infinity Management		807	435	8
9	V	26 Insurance		Infinity Management		497	497	9
10	V	34 Rent		Infinity Management		813	813	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		235,586	235,586	12
13	V	26 Liability Insurance		Midway Neurological And Rehab. Realty, LLC		105,065	105,065	13
14	Total		\$ 2,761,811			\$ 569,612	\$ * (2,192,199)	14

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

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		\$ 1,115,829	\$ 1,115,829
16	V	19 Professional Fees		Midway Neurological And Rehab. Realty, LLC		3,900	3,900
17	V	33 Real Estate Taxes		Midway Neurological And Rehab. Realty, LLC		552,174	552,174
18	V	31 Amortization		Midway Neurological And Rehab. Realty, LLC		522,135	522,135
19	V	20 Licenses & Fees		Midway Neurological And Rehab. Realty, LLC		250	250
20	V	21 Other Admin Exp		Midway Neurological And Rehab. Realty, LLC		109	109
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 2,194,397	\$ * 2,194,397

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

ATTACHMENT #1

OWNERS

OTHER RELATED BUSINESS ENTITIES

NAME	OWNERSHIP %	NAME	CITY	TYPE OF BUSINESS
MICHAEL BLISKO	27.823%	INFINITY MANAGEMENT MIDWAY NEUR. & REHAB REALTY, LLC	HILLSIDE	MANAGEMENT CO. REALTY COMPANY
MOISHE GUBIN	27.822%			
JOSEPH & RIKA MEISELS	4.250%			
MARTY LOEB	5.000%			
JOSEPH BLISKO	5.000%			
TEVI MINDICK	5.000%			
HOWARD N. SUSS	3.925%			
A&F GENERAL PARTNERSHIP	<u>21.180%</u>			
	<u>100.000%</u>			

NOTE: INFINITY MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr # 0047175 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Ctr

0047175

Report Period Beginning:

1/1/10

Ending: 12/31/10

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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 Ctr # 0047175 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	\$95,507.00	11/30/07	\$ 17,255,000	\$ 16,752,344	10/31/37	5.7500	\$ 968,829	1								
2	3G		X	Financing	Interest Only	11/30/07	2,400,000	1,600,000	10/31/17	9.0000	147,000	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Bank Leumi		X	Working Capital	None	4/24/09	3,000,000	2,300,000	04/15/11	5.5000	123,525	6								
7												7								
8												8								
9	TOTAL Facility Related				\$95,507.00		\$ 22,655,000	\$ 20,652,344			\$ 1,239,354	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 22,655,000	\$ 20,652,344			\$ 1,239,354	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 2009 report.		\$	532,361	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.)		\$	592,327	2
3. Under or (over) accrual (line 2 minus line 1).		\$	59,966	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	492,208	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.		\$	552,174	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	337,500	8	
	2006	456,275	9	
	2007	462,092	10	
	2008	504,542	11	
	2009	592,327	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	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

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr

0047175

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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: 2,878 4. Dates Incurred: Various - 4/05 - 12/09

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2007</u>	<u>\$ 950,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 950,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr

0047175

Report Period Beginning:

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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	2009		\$ 7,600,000	\$ 194,872	39	\$ 194,872	\$	\$ 600,855	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sign		2005	6,000	400	15	400		2,400	9
10	A/C		2005	38,280	2,552	15	2,552		15,312	10
11	5th Floor renovations		2005	188,856	12,590	15	12,590		75,573	11
12	Time Clock		2005	5,651	377	15	377		2,262	12
13	Elevator items		2005	17,500	1,167	15	1,167		7,002	13
14	Elevator items		2005	1,761	117	15	117		702	14
15	Wandeguard Security Camera		2005	23,000	1,533	15	1,533		9,198	15
16	Wandeguard Security Camera		2005	6,000	400	15	400		2,400	16
17	Wandeguard Security Camera		2005	673	45	15	45		270	17
18	Wandeguard Security Camera		2005	5,625	375	15	375		2,250	18
19	Tiles		2005	4,461	297	15	297		1,782	19
20	Tiles		2005	246	16	15	16		96	20
21	Tiles		2005	733	49	15	49		294	21
22	HVAC		2005	4,251	283	15	283		1,698	22
23	HVAC		2005	3,653	244	15	244		1,464	23
24	Boilers		2005	7,850	523	15	523		3,138	24
25	Roof Repairs		2005	1,500	100	15	100		600	25
26	Lights		2005	6,650	443	15	443		2,658	26
27	Tiles		2005	1,113	74	15	74		444	27
28										28
29	5th Floor Renovations		2006	39,212	2,614	15	2,614		13,070	29
30	A/C Unit		2006	7,598	507	15	507		2,535	30
31	A/C Unit		2006	7,598	507	15	507		2,535	31
32	Paving		2006	1,571	105	15	105		525	32
33	Paving		2006	2,480	165	15	165		825	33
34	Telephone System		2006	11,173	745	15	745		3,725	34
35	Generator		2006	923	62	15	62		310	35
36	Wandeguard		2006	2,125	142	15	142		710	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

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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	\$	\$ 1,950	37
38	Shower Room	2006	11,598	773	15	773		3,865	38
39	Kitchen Floor	2006	36,687	2,446	15	2,446		12,230	39
40	Windows	2006	2,708	181	15	181		905	40
41	A/C Units Rooftop	2006	22,273	1,485	15	1,485		7,425	41
42	Locks	2006	8,140	543	15	543		2,715	42
43	Parking Lot Lights	2006	1,900	127	15	127		635	43
44	Tiling in bathrooms	2006	14,083	939	15	939		4,695	44
45	Roofing work	2006	1,200	80	15	80		400	45
46	Fence	2006	16,130	1,075	15	1,075		5,375	46
47	Laundry Chute	2006	2,589	173	15	173		865	47
48									48
49	Air Conditioner	2007	10,330	265	15	265		1,484	49
50	Fire Sprinkler	2007	4,775	122	15	122		684	50
51	Fire System	2007	1,290	33	15	33		185	51
52	Auto Transfer Switch	2007	838	21	15	21		119	52
53	Video SecurityCameras	2007	3,900	100	15	100		560	53
54	Shower Room Tile	2007	9,010	231	15	231		1,294	54
55	Shower Room Tile	2007	3,543	91	15	91		509	55
56	Cubicle curtains	2007	4,059	104	15	104		583	56
57	Shower Room Tile	2007	5,497	141	15	141		789	57
58	Air Conditioner	2007	500	13	15	13		72	58
59	Air Conditioner	2007	500	13	15	13		72	59
60	Signage	2007	1,692	43	15	43		242	60
61	Fire Sprinkler	2007	1,373	35	15	35		197	61
62	Electrical work in reception area	2007	490	13	15	13		72	62
63	Painting - Shower Room	2007	1,000	26	15	26		145	63
64	Painting - Shower Room	2007	2,000	51	15	51		286	64
65	Painting - Shower Room	2007	3,000	77	15	77		431	65
66	Painting - Shower Room	2007	3,000	77	15	77		431	66
67	Toner	2007	13		15			1	67
68	Freezer maint	2007	3,188	82	15	82		459	68
69	Doors	2007	1,595	41	15	41		229	69
70	TOTAL (lines 4 thru 69)		\$ 8,181,230	\$ 231,095		\$ 231,095	\$	\$ 804,537	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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		\$ 8,181,230	\$ 231,095		\$ 231,095	\$	\$ 804,537	1
2	Doors	2007	1,595	41	15	41		229	2
3	Air Conditioner	2007	500	13	15	13		72	3
4	Locks on Gate	2007	3,509	90	15	90		504	4
5	Parking Lot Paving	2007	20,000	513	15	513		2,872	5
6	Parking Lot Paving	2007	21,410	549	15	549		3,074	6
7	Fencing	2007	1,550	40	15	40		223	7
8	Fencing	2007	1,500	38	15	38		214	8
9	Asbestos removal	2007	2,370	61	15	61		341	9
10									10
11	Pump	2008	1,498	38	15	38		114	11
12	Sprinkler Systems	2008	12,457	319	15	319		798	12
13	Sprinkler Systems	2008	1,625	42	15	42		94	13
14	Smoke Detector	2008	1,342	34	15	34		85	14
15	Refrigeration	2008	4,250	109	15	109		282	15
16	Refrigeration	2008	5,291	136	15	136		351	16
17	Refrigeration	2008	3,735	96	15	96		240	17
18	Refrigeration	2008	6,950	178	15	178		430	18
19	Refrigeration	2008	2,455	63	15	63		152	19
20	Refrigeration	2008	971	25	15	25		58	20
21	Refrigeration	2008	1,678	43	15	43		97	21
22	Refrigeration	2008	2,865	73	15	73		164	22
23	Tiling for Shower room	2008	276	7	15	7		15	23
24	Elevator	2008	1,270	33	15	33		66	24
25	Roof	2008	4,094	105	15	105		306	25
26	Fire Doors	2008	2,670	68	15	68		182	26
27	Fire Doors	2008	907	23	15	23		60	27
28	Hot Water Heater	2008	8,875	228	15	228		627	28
29	Elevator	2008	3,008	77	15	77		205	29
30	Roof	2008	35,700	915	15	915		2,288	30
31	Brick work on Bldg	2008	17,850	458	15	458		1,030	31
32	Windows	2008	135,000	3,462	15	3,462		8,655	32
33	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	15	2,051		4,615	33
34	TOTAL (lines 1 thru 33)		\$ 8,568,430	\$ 241,023		\$ 241,023	\$	\$ 832,980	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 Ctr

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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		\$ 8,568,430	\$ 241,023		\$ 241,023	\$	\$ 832,980	1
2	Renovation	2008	41,403	1,062	15	1,062		2,301	2
3	CATV wiring	2008	8,000	205	15	205		478	3
4	CATV wiring	2008	8,000	205	15	205		478	4
5	CATV wiring	2008	8,000	205	15	205		478	5
6	CATV wiring	2008	8,000	205	15	205		478	6
7									7
8	Alarm System	2009	629	16	15	16		32	8
9	Wiring	2009	6,300	162	15	162		175	9
10	Room Signs	2009	5,405	139	15	139		151	10
11	Nurse Call Light System	2009	8,721	224	15	224		429	11
12	Brickwork	2009	39,000	1,000	15	1,000		1,583	12
13					15				13
14	Construction Supplies	2010	2,000	52	15	21	(31)	21	14
15	Locks, Door Handles, Misc Items	2010	650	18	15	6	(12)	6	15
16	Park Bench, Drill, Door Closer, 231 Oradar, etc	2010	11,018	284	15	188	(96)	188	16
17	Powerwasher, Paint, Tool kit, etc	2010	5,898	152	15	88	(64)	88	17
18	General Contractor Fees	2010	10,000	257	15	107	(150)	107	18
19	Wall Base, Vinyl Tile, Shelf Unit, etc	2010	12,346	318	15	79	(239)	79	19
20	Paper Filter, Liquid Nail, Microwave, Refrigerator, etc	2010	2,471	64	15	11	(53)	11	20
21	Curtain Tracks	2010	848	23	15	11	(12)	11	21
22	Curtain Tracks	2010	663	18	15	7	(11)	7	22
23	Wall Sheeting	2010	3,597	93	15	38	(55)	38	23
24	Wall Sheeting	2010	10,249	264	15	66	(198)	66	24
25	Install Convector Unit in Vestibule	2010	2,036	53	15	4	(49)	4	25
26	Inspection of Boiler Units	2010	936	25	15	2	(23)	2	26
27	Building Sewer Unclogging	2010	3,379	88	15	22	(66)	22	27
28	Lock Cylinders and Master Key System	2010	12,388	319	15	159	(160)	159	28
29	HUD Improvement	2010	452,720	11,609	15	4,952	(6,657)	4,952	29
30	Shadowgray Field, Mortar, Tile Space	2010	713	19	15	8	(11)	8	30
31	8' 2 1/2 Reno Remp	2010	81	2	15	1	(1)	1	31
32	Thin Lip Cove Base	2010	1,038	28	15	9	(19)	9	32
33	Adhesive Ceramic 4 Gallon	2010	64	2	15	1	(1)	1	33
34	TOTAL (lines 1 thru 33)		\$ 9,234,980	\$ 258,134		\$ 250,226	\$ (7,908)	\$ 845,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12C, Carried Forward		\$ 9,234,980	\$ 258,134		\$ 250,226	\$ (7,908)	\$ 845,343	1
2	2X2 Vitra Gray Tile	2010	41	1	15		(1)		2
3	Door Replacements	2010	3,340	87	15	50	(37)	50	3
4	Door Replacements	2010	3,340	87	15	43	(44)	43	4
5	Door Replacements	2010	11,830	304	15	126	(178)	126	5
6	Doors, Frames, Hardware	2010	12,291	316	15	26	(290)	26	6
7	Faucet Handles, Ceiling Plates, Heater	2010	1,264	33	15	16	(17)	16	7
8	Red/Grn LED Exit Signs	2010	2,303	60	15	30	(30)	30	8
9	Wall Anchors, Cove Bases	2010	430	12	15	6	(6)	6	9
10	Switch Plates, Light Fixtures	2010	911	24	15	12	(12)	12	10
11	Ceiling Plates and Toilet Parts	2010	1,817	48	15	23	(25)	23	11
12	Bath Faucets	2010	557	15	15	7	(8)	7	12
13	Red/Grn LED Exit Signs	2010	1,923	50	15	25	(25)	25	13
14	Value Stackers	2010	1,577	41	15	20	(21)	20	14
15	Emergency Fixtures	2010	778	21	15	10	(11)	10	15
16	Light Fixtures and Bulbs	2010	764	21	15	10	(11)	10	16
17	Red/Grn LED Exit Signs	2010	723	20	15	9	(11)	9	17
18	Bath Faucets	2010	557	15	15	7	(8)	7	18
19	Red/Grn LED Exit Signs	2010	4,398	114	15	56	(58)	56	19
20	Toilet Seats	2010	483	13	15	6	(7)	6	20
21	Toilet Seats	2010	178	5	15	2	(3)	2	21
22	Doorstops, Mirror, Light Bulb	2010	1,421	37	15	18	(19)	18	22
23	Window Bracket	2010	1	0	15		(0)		23
24	Angle Stops, Towel Rings, Strainers, etc	2010	2,975	77	15	38	(39)	38	24
25	Angle Stops and Towel Rings	2010	250	6	15	3	(3)	3	25
26	Air Grilles and Wall Anchors	2010	417	12	15	5	(7)	5	26
27	Toilet Tank, Bowel, Seat	2010	2,081	54	15	22	(32)	22	27
28	"In Case of Fire" Signs	2010	27	1	15		(1)		28
29	Ceiling Plates, Cove Base, Adhesive	2010	1,139	30	15	12	(18)	12	29
30	Floor/Ceiling Plates	2010	113	3	15	1	(2)	1	30
31	Basin and Pedestal for Lavatory	2010	91	2	15	1	(1)	1	31
32	Air Grille	2010	131	3	15	1	(2)	1	32
33	Trash Cans With Ash Trays	2010	880	24	15	9	(15)	9	33
34	TOTAL (lines 1 thru 33)		\$ 9,294,011	\$ 259,670		\$ 250,820	\$ (8,850)	\$ 845,937	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12D, Carried Forward		\$ 9,294,011	\$ 259,670		\$ 250,820	\$ (8,850)	\$ 845,937	1
2	Wall Anchor		98	3	15	1	(2)	1	2
3	20 Amp Spec Grade Quiet Switch		163	4	15	2	(2)	2	3
4	Overbed Lights with White Shield		3,088	83	15	33	(50)	33	4
5	Titanium Drill Bit, PVC Tailpiece		164	4	15	2	(2)	2	5
6	Seasons Predestal Lavatory		45	1	15		(1)		6
7	Towel Rings		362	9	15	4	(5)	4	7
8	Toilet Seats		352	9	15	4	(5)	4	8
9	20 Amp Receptacle, Adhesive		816	23	15	9	(14)	9	9
10	Wall Hung Lavatory		484	12	15	5	(7)	5	10
11	Wall Fixtures and Light Bulbs		2,231	61	15	24	(37)	24	11
12	Overbed Lights with White Shield		1,311	34	15	14	(20)	14	12
13	Door Cover, Security Bar, Sliding Door		416	11	15	4	(7)	4	13
14	Amerex Fire Exiting		178	5	15	2	(3)	2	14
15	Toilet Seats		736	19	15	8	(11)	8	15
16	"No Smoking Signs" , Bulbs		234	6	15	2	(4)	2	16
17	Toilet Parts, Door Knobs, Faucets		6,319	170	15	68	(102)	68	17
18	Ceiling Plates, Exit Sign, Lavatory		1,793	46	15	19	(27)	19	18
19	Shower Rods and Brackets		257	7	15	3	(4)	3	19
20	Air Grilles		44	1	15		(1)		20
21	Credit for Open Front Toilet Seats		(138)	(4)	15	(1)	3	(1)	21
22	Drains, Faucets, Flapper, Cleaners		640	16	15	7	(9)	7	22
23	Lavatory, Toilet Parts		1,157	33	15	12	(21)	12	23
24	Striker Plates, Toilet Parts		1,737	49	15	19	(30)	19	24
25	Chrome Angle Stop Handles		69	2	15	1	(1)	1	25
26	Locksmith Strike Plates, Toilet Bowl		347	9	15	4	(5)	4	26
27	Surface Mount Ceiling Heater		826	21	15	9	(12)	9	27
28	Brass Tube		100	3	15	1	(2)	1	28
29	Lubricant, Power Strip, Heater, etc		826	23	15	9	(14)	9	29
30	Mimiblinds		621	16	15	7	(9)	7	30
31	Utility Carts, Hose Torch		1,209	33	15	13	(20)	13	31
32	Door Cover, Tool Sets, Phone Jack		823	23	15	9	(14)	9	32
33	Multi Purpose Test Kit		219	6	15	2	(4)	2	33
34	TOTAL (lines 1 thru 33)		\$ 9,321,535	\$ 260,407		\$ 251,116	\$ (9,291)	\$ 846,233	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 Ctr

0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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 12E, Carried Forward		\$ 9,321,535	\$ 260,407		\$ 251,116	\$ (9,291)	\$ 846,233	1
2	20 Amp Switches		864	24	15	9	(15)	9	2
3	Credit for Elongated Bowl		(66)	(2)	15	(1)	1	(1)	3
4	Open Front Toilet Seats		690	20	15	6	(14)	6	4
5	Door Holders, Air Grilles, Seals		357	9	15	3	(6)	3	5
6	Smoke Alarms		1,940	55	15	17	(38)	17	6
7	Credit from Lavatory		(45)	(1)	15		1		7
8	File Cabinet		571	16	15	5	(11)	5	8
9	Brass Tube		67	2	15	1	(1)	1	9
10	Toilet Safety Frames		148	4	15	1	(3)	1	10
11	In-Sink-Erator Badger		110	3	15	1	(2)	1	11
12	Lamp, Showerhead, Cables		510	14	15	3	(11)	3	12
13	CAM Lock Keyed Alike		202	5	15	1	(4)	1	13
14	New Car Sill on East Elevator		2,200	59	15	24	(35)	24	14
15	Reroofed Building		3,450	92	15	52	(40)	52	15
16	Roof Patch		950	26	15	10	(16)	10	16
17	Roof Repair		1,250	35	15	13	(22)	13	17
18	Roof Repair		650	18	15	4	(14)	4	18
19	Restore Nurse Call System		2,330	64	15	25	(39)	25	19
20	Parts for Nurse Call System		433	11	15	5	(6)	5	20
21	Concrete Removal and Pouring		8,870	240	15	114	(126)	114	21
22	Prep and Paint Rooms		13,000	350	15	167	(183)	167	22
23	Prep and Paint Rooms		11,970	330	15	128	(202)	128	23
24	Concrete Work		6,735	185	15	72	(113)	72	24
25	Concrete Work		8,870	240	15	95	(145)	95	25
26	Prep and Paint Work		11,250	300	15	120	(180)	120	26
27	Concrete Work		8,996	245	15	96	(149)	96	27
28	Wall Repair, Painting, Vinyl Base		15,170	420	15	162	(258)	162	28
29	Concrete Work		8,996	241	15	77	(164)	77	29
30	Epoxy Application		6,175	168	15	53	(115)	53	30
31	Painting		500	14	15	12	(2)	12	31
32	Bathroom Sink Lens and Set-up		2,741	74	15	29	(45)	29	32
33	Fence Installation		6,500	180	15	97	(83)	97	33
34	TOTAL (lines 1 thru 33)		\$ 9,447,918	\$ 263,848		\$ 252,517	\$ (11,331)	\$ 847,634	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 Ctr

0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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 12F, Carried Forward		\$ 9,447,918	\$ 263,848		\$ 252,517	\$ (11,331)	\$ 847,634	1
2	Fence Installation		6,730	173	39	100	(73)	100	2
3	Plumbing Repair and Replacement		11,970	307	39	152	(155)	152	3
4	Fence Removal and Replacement		4,715	121	39	59	(62)	59	4
5	Plumbing Repair and Replacement		15,333	393	39	163	(230)	163	5
6	Insulation on Boiler Tanks		3,700	95	39	39	(56)	39	6
7	Replace Heaters & Electrical Outlets		1,600	41	39	26	(15)	26	7
8	Fixed Parking Lot Light		1,660	43	39	24	(19)	24	8
9	Fix Outside Sign Light		2,150	55	39	31	(24)	31	9
10	New Electrical Circuits		1,275	33	39	15	(18)	15	10
11	Replace Trim and Burned Outlets		896	23	39	10	(13)	10	11
12	Replace Signs and Light Fixtures		9,135	234	39	97	(137)	97	12
13	Replace Connections and Circuits		1,635	42	39	16	(26)	16	13
14	Replace Roof Top Compressor		9,400	241	39	99	(142)	99	14
15	Install Fluorescent Fixtures		1,285	33	39	13	(20)	13	15
16	Miscellaneous Construction Items		3,405	87	39	28	(59)	28	16
17	Murals and Room Detailing		12,825	329	39	192	(137)	192	17
18	Faux Porch Mural and Sealant		875	22	39	2	(20)	2	18
19	Murals and Room Detailing		1,725	44	39	4	(40)	4	19
20	Miscellaneous Construction Items		518	13	39	7	(6)	7	20
21	5th Floor Construction including Bathroom/Closet Demolition		5,000	128	39	64	(64)	64	21
22	Prep Walls, Replace Flooring/Fixtures, Other Interior Work		118,917	3,049	39	1,315	(1,734)	1,315	22
23	Painting & Interior Work		29,520	757	39	315	(442)	315	23
24	Painting, Floors, Plumbing, and other various repairs		20,698	531	39	177	(354)	177	24
25	Paint		34,858	894	39	383	(511)	383	25
26	Touch ups for final inspections/maintenance		7,172	184	39	61	(123)	61	26
27	Replacement Acoustic Ceiling Tiles and Vinyl Bases		12,774	328	39	109	(219)	109	27
28	Paint & CS Pink Knit 2PKs		388	10	39	5	(5)	5	28
29	Paint, White Doves 9X3/8, Covers		1,216	31	39	16	(15)	16	29
30	Paint, Sand, and Thinner		413	11	39	5	(6)	5	30
31	Paint & Tack Cloth		491	13	39	6	(7)	6	31
32	Paint & 9-inch Purdy WD9X3/8 2PK		857	22	39	9	(13)	9	32
33	Paint & Adhesion		1,802	46	39	19	(27)	19	33
34	TOTAL (lines 1 thru 33)		\$ 9,772,855	\$ 272,180		\$ 256,078	\$ (16,102)	\$ 851,195	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 Ctr

0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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 12G, Carried Forward		\$ 9,772,855	\$ 272,180		\$ 256,078	\$ (16,102)	\$ 851,195	1
2	Paint & 11 oz. Acry Ltx Clk C850A		978	25	39	9	(16)	9	2
3	Paint & Util. Pans.		321	8	39	3	(5)	3	3
4	Paint & Drywall		952	24	39	9	(15)	9	4
5	Skid Comp, Plastic, and Red Rosin		992	25	39	7	(18)	7	5
6	Paint & Rust Treatment		240	6	39	2	(4)	2	6
7	Various Painting Supplies		2,250	58	39	15	(43)	15	7
8	Powerhouse Tint Base & Bulk Gun		211	5	39	1	(4)	1	8
9	Painter's 10-N-1 Tools		78	2	39	1	(1)	1	9
10	2nd Floor & Dining Room Renovations		31,419	806	39	374	(432)	374	10
11	Renovations, Carpeting, Plumbing, Tiles, Windows, etc.		20,651	604	39	220	(384)	220	11
12	Renovation & Repair Work on 2nd Floor		5,160	172	39	54	(118)	54	12
13	Carpet		6,000	185	39	76	(109)	76	13
14	Carpet		3,000	90	39	37	(53)	37	14
15	Carpet		1,450	45	39	8	(37)	8	15
16	Pipe Work		3,056	92	39	38	(54)	38	16
17	New Sliding Doors		7,475	237	39	111	(126)	111	17
18	New Sliding Doors		14,950	412	39	127	(285)	127	18
19	New Sliding Doors		149	4	39	1	(3)	1	19
20	New 50-Ton A/C Unit		22,323	621	39	333	(288)	333	20
21	Elevator Room Exhaust Fan Repairs		1,945	50	39	24	(26)	24	21
22	Duct Work Repairs for Clothes Driers		246	6	39	3	(3)	3	22
23	New Through-the-Wall Sidewall Mounted Fan		2,341	60	39	29	(31)	29	23
24	Air Duct Repairs		403	10	39	4	(6)	4	24
25	New Roof-Mounted 24-inch Exhaust Fan		2,293	59	39	23	(36)	23	25
26	New 50-Ton A/C Unit		22,323	603	39	285	(318)	285	26
27	Air Conditioner Repairs		582	15	39	7	(8)	7	27
28	New Exhaust Fan		1,745	45	39	21	(24)	21	28
29	Paint/Plaster Work & Sprinkler Repairs		13,150	352	39	168	(184)	168	29
30	Paint/Plaster Work & New Bathroom Supplies/Equipment		13,000	356	39	138	(218)	138	30
31	Electrical Work, Paint/Plaster Work, Bathroom Repairs, etc.		10,500	269	39	111	(158)	111	31
32	Bathroom Repairs/Installations, Paint/Plaster Work, Lights		5,750	147	39	60	(87)	60	32
33	New Toilet, Plaster/Paint Work, Electric Work, etc.		3,750	96	39	39	(57)	39	33
34	TOTAL (lines 1 thru 33)		\$ 9,972,536	\$ 277,671		\$ 258,416	\$ (19,255)	\$ 853,533	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 Ctr

0047175

Report Period Beginning:

1/1/10

Ending:

12/31/10

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 12H, Carried Forward		\$ 9,972,536	\$ 277,671		\$ 258,416	\$ (19,255)	\$ 853,533	1
2	Paint/Plaster Work, Bathroom Installations, Electric Repairs	2010	4,000	130	39	33	(97)	33	2
3	Paint/Plaster Work & Replacement Ceiling Tiles	2010	3,500	102	39	29	(73)	29	3
4	Walk-Thru Inspections	2010	930	29	39	11	(18)	11	4
5	Walk-Thru Inspections	2010	1,050	35	39	12	(23)	12	5
6	Walk-Thru Inspections	2010	2,265	65	39	23	(42)	23	6
7	2nd Floor Repairs & on deficiencies from HUD Inspections	2010	1,740	54	39	18	(36)	18	7
8	Maintenance/Repairs on deficiencies from HUD Inspections	2010	1,328	42	39	13	(29)	13	8
9	Maintenance/Repairs on deficiencies from HUD Inspections	2010	1,583	49	39	16	(33)	16	9
10	Maintenance/Repairs on deficiencies from HUD Inspections	2010	1,718	52	39	14	(38)	14	10
11	Maintenance/Repairs on deficiencies from HUD Inspections	2010	2,460	72	39	20	(52)	20	11
12	Plumbing Repairs to Hair Salon, Laundry Room, Bathrooms	2010	2,080	62	39	21	(41)	21	12
13	Plumbing Repairs	2010	715	25	39	7	(18)	7	13
14	Stainless Steel Legs/Wall Channels & Weld Backsplash	2010	1,942	63	39	20	(43)	20	14
15	Stainless Steel Wall Panels & Conveyor Cover	2010	3,715	112	39	39	(73)	39	15
16	Construction Items	2010	700	22	39	6	(16)	6	16
17	Construction Items	2010	1,201	41	39	12	(29)	12	17
18	Repairs to Sewer Line	2010	980	32	39	7	(25)	7	18
19	Post-Construction Cleaning of Bedrooms, Boiler Rooms, etc.	2010	15,889	450	39	203	(247)	203	19
20	Welding Work on Doors	2010	1,255	42	39	10	(32)	10	20
21	Plumbing Repairs	2010	21,183	598	39	225	(373)	225	21
22	Asphalt Removal/Replacement & Lot Marking Layout/Restripe	2010	2,867	85	39	24	(61)	24	22
23	Property Consultation	2010	600	19	39	1	(18)	1	23
24	Construction Items	2010	2,975	88	39	24	(64)	24	24
25	Construction Items	2010	5,285	167	39	78	(89)	78	25
26	Construction Supplies	2010	17,000	461	39	217	(244)	217	26
27	Construction Supplies	2010	22,000	600	39	187	(413)	187	27
28	Construction Supplies	2010	11,094	296	39	23	(273)	23	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,104,590	\$ 281,464		\$ 259,709	\$ (21,755)	\$ 854,826	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 3,080,697	\$ 44,361	\$ 247,894	\$ 203,533		\$ 1,457,472	71
72	Current Year Purchases	203,635	203,635	22,216	(181,419)		22,216	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,284,332	\$ 247,996	\$ 270,110	\$ 22,114		\$ 1,479,688	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)	\$ 14,338,922	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 529,460	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 529,819	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 359	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,334,514	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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

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

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

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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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>
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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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$	260,338	\$			\$	260,338	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs				127,451					127,451	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a-3	hrs				223,961					223,961	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-2	# of prescripts						316,584			316,584	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): _____												12	
13	Other (specify): <u>Radiology & Lab</u>	39-2							14,722			14,722	13	
14	TOTAL			\$		\$	611,749	\$	331,306	\$		943,055	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: 1/1/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	\$ 201,307	\$ 1,255,601	1
2	Cash-Patient Deposits	(3,700)	(3,700)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,759,942	4,259,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,210	157,210	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)	\$ 4,114,759	\$ 5,669,053	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	2,519,511	2,519,511	15
16	Equipment, at Historical Cost	303,883	3,384,249	16
17	Accumulated Depreciation (book methods)	(580,489)	(2,239,915)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,875,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,653)	(1,636,569)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Security Deposit</u>)	21,367	21,367	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,280,789	\$ 18,473,829	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,395,548	\$ 24,142,882	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,297,827	\$ 1,597,827	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	409,871	409,871	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
Other Current Liabilities(specify):				
36	<u>Settlement Reserve</u>	574,381	574,381	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,282,079	\$ 2,582,079	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,300,000	2,300,000	39
40	Mortgage Payable		18,352,344	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)	\$ 2,300,000	\$ 20,652,344	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,582,079	\$ 23,234,423	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,813,469	\$ 908,459	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,395,548	\$ 24,142,882	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,915,052	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,915,052	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	405,416	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	(506,999)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (101,583)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,813,469	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Midway Neurological/Rehabilitation Ctr

0047175

Report Period Beginning: 1/1/10

Ending: 12/31/10

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	\$ 13,403,279	1
2	Discounts and Allowances for all Levels	(770,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,633,279	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,017,157	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,017,157	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	3,690	16
17	Sale of Drugs	325,441	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,333	19
20	Radiology and X-Ray	3,597	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 355,061	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	3,453	28
28a	<u>Miscellaneous Revenue</u>	211,332	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 214,785	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,220,296	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,383,071	31
32	Health Care	5,967,719	32
33	General Administration	2,088,437	33
B. Capital Expense			
34	Ownership	2,823,155	34
C. Ancillary Expense			
35	Special Cost Centers	331,306	35
36	Provider Participation Fee	221,190	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,814,880	40
41	Income before Income Taxes (line 30 minus line 40)**	405,416	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 405,416	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:

1/1/10

Ending:

12/31/10

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	1,897	2,059	\$ 90,114	\$ 43.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,172	22,264	696,944	31.30	3
4	Licensed Practical Nurses	62,260	66,685	1,819,910	27.29	4
5	CNAs & Orderlies	107,893	115,974	1,247,865	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,160	2,358	27,614	11.71	8
9	Activity Director	16,790	18,167	225,004	12.39	9
10	Activity Assistants					10
11	Social Service Workers	15,367	16,583	281,468	16.97	11
12	Dietician	41,872	45,956	481,378	10.47	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,426	8,074	132,608	16.42	17
18	Housekeepers	42,953	47,115	453,946	9.63	18
19	Laundry	5,132	5,958	65,761	11.04	19
20	Administrator	3,262	3,411	151,692	44.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,453	11,689	217,381	18.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,860	6,370	83,993	13.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,497	372,663	\$ 5,975,678 *	\$ 16.04	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	235	11,739	10-3	38
39	Pharmacist Consultant	604	30,215	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	8	281	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	847	\$ 42,235		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

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	
Eli Barnett	ADMIN	0	\$ 6,352	Workers' Compensation Insurance	\$ 119,013	IDPH License Fee	\$ 995	
Lynn Blakemore	ADMIN	0	110,789	Unemployment Compensation Insurance	70,891	Advertising: Employee Recruitment		
Karla Ismay	ADMIN	0	34,551	FICA Taxes	455,963	Health Care Worker Background Check		
				Employee Health Insurance	240,980	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Village of Bridgeview	1,280	
				Uniforms	7,173	Cook County Collector	218	
				Employee Expense	56,571	Secretary of State	250	
				Infinity Management Employee Benefits	28,858	Infinity License Fees	496	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 151,692			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 979,449	\$ 3,239		
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
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
Infinity	Mgmt Co.		\$ 298,499				Out-of-State Travel	\$
Meyer Magence	Legal		125					
Swanson, Martin, Bell	Legal		21,142					
Mattie Presley	Legal		(5,000)				In-State Travel	
Bradley & Associates	Accounting		10,014				Mileage	82
Johnson, Goldberg & Br	Accounting		4,000					
							Seminar Expense	
							Business Seminar Expense	932
							Infinity Seminar Expense	435
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 328,780				TOTAL	\$ 1,449

* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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

0047175

Report Period Beginning:

1/1/10

Ending: 12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,882 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. \$ 221,190
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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