



Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	113,911	672	8,335	122,918	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	113,911	672	8,335	122,918	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.36%

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 04/01/2005

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

YES  Date 04/01/2005 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 5,902

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name &amp; ID Number

Midway Neurological Reh Ctr

# 0047175

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

**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
	<b>A. General Services</b>										
1	Dietary	595,051		19,454	614,505		614,505	(6,559)	607,946		1
2	Food Purchase		610,905		610,905		610,905		610,905		2
3	Housekeeping	504,598	66,934		571,532		571,532		571,532		3
4	Laundry	56,432	53,491		109,923		109,923		109,923		4
5	Heat and Other Utilities			409,379	409,379		409,379	1,066	410,445		5
6	Maintenance	159,844	38,743	239,564	438,151		438,151	1	438,152		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,315,925	770,073	668,397	2,754,395		2,754,395	(5,492)	2,748,903		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			32,000	32,000		32,000		32,000		9
10	Nursing and Medical Records	4,863,503	497,127	67,408	5,428,038		5,428,038	7,488	5,435,526		10
10a	Therapy			877,012	877,012		877,012		877,012		10a
11	Activities	447,650	106,299		553,949		553,949		553,949		11
12	Social Services	318,385		7,230	325,615		325,615		325,615		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* rx consultant			26,978	26,978		26,978		26,978		15
16	<b>TOTAL Health Care and Programs</b>	5,629,538	603,426	1,010,628	7,243,592		7,243,592	7,488	7,251,080		16
	<b>C. General Administration</b>										
17	Administrative	190,009			190,009		190,009		190,009		17
18	Directors Fees										18
19	Professional Services			508,987	508,987		508,987	(297,224)	211,763		19
20	Dues, Fees, Subscriptions & Promotions			26,154	26,154		26,154		26,154		20
21	Clerical & General Office Expenses	351,004	208,076	37,833	596,913		596,913	(20,954)	575,959		21
22	Employee Benefits & Payroll Taxes			1,446,270	1,446,270		1,446,270	33,231	1,479,501		22
23	Inservice Training & Education										23
24	Travel and Seminar			66,566	66,566		66,566	(53)	66,513		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			436,467	436,467		436,467	1,063	437,530		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	541,013	208,076	2,522,277	3,271,366		3,271,366	(283,937)	2,987,429		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,486,476	1,581,575	4,201,302	13,269,353		13,269,353	(281,941)	12,987,412		29

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

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

## 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			698,108	698,108		698,108	336,958	1,035,066			30
31	Amortization of Pre-Op. & Org.			509,548	509,548		509,548	(506,667)	2,881			31
32	Interest			1,687,105	1,687,105		1,687,105	(100,017)	1,587,088			32
33	Real Estate Taxes			802,445	802,445		802,445		802,445			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,383,278)	16,722			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* replacement tax			8,998	8,998		8,998		8,998			36
37	<b>TOTAL Ownership</b>			6,106,204	6,106,204		6,106,204	(2,653,004)	3,453,200			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		245,998		245,998		245,998		245,998			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			933,043	933,043		933,043		933,043			42
43	Other (specify):* bad debt expense			866,318	866,318		866,318	(866,318)				43
44	<b>TOTAL Special Cost Centers</b>		245,998	1,799,361	2,045,359		2,045,359	(866,318)	1,179,041			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,486,476	1,827,573	12,106,867	21,420,916		21,420,916	(3,801,263)	17,619,653			45

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

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	336,958	30		9
10	Interest and Other Investment Income	(100,017)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(866,318)	43		24
25	Fund Raising, Advertising and Promotional	(26,386)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule various	(2,968,624)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (3,624,387)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(176,876)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (176,876)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (3,801,263)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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>			<b>\$</b>	<b>47</b>

<b>BHF USE ONLY</b>					
48		49		50	51
					52

Midway Neurological Reh Ctr

ID# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	vending income	\$ (2,331)	6	1
2	misc income	(59,626)	21	2
3	rent	(2,400,000)	34	3
4	amort of goodwill	(506,667)	31	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(2,968,624)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Midway Neurological Reh Ctr# 0047175

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## 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	0	(6,559)	0	0	0	0	0	0	0	0	0	(6,559)	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	1,066	0	0	0	0	0	0	0	0	0	1,066	5
6	Maintenance	(2,331)	2,332	0	0	0	0	0	0	0	0	0	1	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,331)</b>	<b>(3,161)</b>	<b>0</b>	<b>(5,492)</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	7,488	0	0	0	0	0	0	0	0	0	7,488	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>7,488</b>	<b>0</b>	<b>7,488</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	(297,224)	0	0	0	0	0	0	0	0	0	(297,224)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(86,012)	65,058	0	0	0	0	0	0	0	0	0	(20,954)	21
22	Employee Benefits & Payroll Taxes	0	33,231	0	0	0	0	0	0	0	0	0	33,231	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(53)	0	0	0	0	0	0	0	0	0	(53)	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	1,063	0	0	0	0	0	0	0	0	0	1,063	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(86,012)</b>	<b>(197,925)</b>	<b>0</b>	<b>(283,937)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(88,343)</b>	<b>(193,598)</b>	<b>0</b>	<b>(281,941)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Midway Neurological Reh Ctr# 0047175

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

## 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	336,958	0	0	0	0	0	0	0	0	0	0	336,958	30
31	Amortization of Pre-Op. & Org.	(506,667)	0	0	0	0	0	0	0	0	0	0	(506,667)	31
32	Interest	(100,017)	0	0	0	0	0	0	0	0	0	0	(100,017)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,400,000)	16,722	0	0	0	0	0	0	0	0	0	(2,383,278)	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>(2,669,726)</b>	<b>16,722</b>	<b>0</b>	<b>(2,653,004)</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):*	(866,318)	0	0	0	0	0	0	0	0	0	0	(866,318)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(866,318)</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>(866,318)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(3,624,387)</b>	<b>(176,876)</b>	<b>0</b>	<b>(3,801,263)</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<a href="#">See Attached Listing</a>						

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	\$ 19,454	<a href="#">Infinity Healthcare Management</a>		\$ 12,895	\$ (6,559)	1
2	V	2 food		<a href="#">Infinity Healthcare Management</a>				2
3	V	5 utilities		<a href="#">Infinity Healthcare Management</a>		1,066	1,066	3
4	V	6 maintenance		<a href="#">Infinity Healthcare Management</a>		2,332	2,332	4
5	V	10 nursing	53,094	<a href="#">Infinity Healthcare Management</a>		60,582	7,488	5
6	V	17 administrative		<a href="#">Infinity Healthcare Management</a>				6
7	V	19 prof fees	303,971	<a href="#">Infinity Healthcare Management</a>		6,747	(297,224)	7
8	V	21 office	146,751	<a href="#">Infinity Healthcare Management</a>		211,809	65,058	8
9	V	22 benefits	2,309	<a href="#">Infinity Healthcare Management</a>		35,540	33,231	9
10	V	24 travel	799	<a href="#">Infinity Healthcare Management</a>		746	(53)	10
11	V	26 insurance		<a href="#">Infinity Healthcare Management</a>		1,063	1,063	11
12	V	32 interest		<a href="#">Infinity Healthcare Management</a>				12
13	V	34 rent		<a href="#">Infinity Healthcare Management</a>		16,722	16,722	13
14	Total		\$ 526,378			\$ 349,502	\$ * (176,876)	14

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

Facility Name & ID Number

Midway Neurological Reh Ctr

# 0047175

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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								25
26								26
27								27
28								28
29								29
30								30

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

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175 Report Period Beginning: 01/01/2014

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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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	first midwest bank		x	mortgage	int only	5/1/14	\$ 22,640,000	\$ 22,640,000	4/1/17	3.4170	\$ 1,656,653					
2																
3																
4																
5																
<b>Working Capital</b>																
6	capitua one		x	working capital	none	08/31/2014	15,000,000	439,219	08/31/2018	4.2500	30,452					
7																
8																
9	<b>TOTAL Facility Related</b>						\$ 37,640,000	\$ 23,079,219			\$ 1,687,105					
<b>B. Non-Facility Related*</b>																
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$ 37,640,000	\$ 23,079,219			\$ 1,687,105					

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>635,847</u>		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.)		\$	<u>799,313</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>163,466</u>		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>638,979</u>		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.		\$	<u>802,445</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>592,327</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>636,451</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>832,041</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>776,295</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>799,313</u>	12	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.**



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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**

**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).

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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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>land</u>		<u>2005</u>	<u>\$ 950,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 950,000</b>	3

Facility Name &amp; ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning:

01/01/2014 Ending:

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**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 194,868	39	\$ 194,868	\$	\$ 1,380,327	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Combined 2005 Building Improvements		2005	323,803	21,587	15	21,587		215,866	9
10										10
11	Combined 2006 Building Improvements		2006	195,836	13,056	15	13,056		118,122	11
12										12
13	Air Conditioner		2007	10,330	265	39	265		2,119	13
14	Fire Sprinkler		2007	4,775	122	39	122		980	14
15	Fire System		2007	1,290	33	39	33		265	15
16	Auto Transfer Switch		2007	838	21	39	21		172	16
17	Video SecurityCameras		2007	3,900	100	39	100		800	17
18	Shower Room Tile		2007	9,010	231	39	231		1,848	18
19	Shower Room Tile		2007	3,543	91	39	91		727	19
20	Cubicle curtains		2007	4,059	104	39	104		833	20
21	Shower Room Tile		2007	5,497	141	39	141		1,128	21
22	Air Conditioner		2007	500	13	39	13		103	22
23	Air Conditioner		2007	500	13	39	13		103	23
24	Signage		2007	1,692	43	39	43		347	24
25	Fire Sprinkler		2007	1,373	35	39	35		282	25
26	Electrical work in reception area		2007	490	13	39	13		101	26
27	Painting - Shower Room		2007	1,000	26	39	26		205	27
28	Painting - Shower Room		2007	2,000	51	39	51		410	28
29	Painting - Shower Room		2007	3,000	77	39	77		615	29
30	Painting - Shower Room		2007	3,000	77	39	77		615	30
31	Toner		2007	13		39			3	31
32	Freezer maint		2007	3,188	82	39	82		654	32
33	Doors		2007	1,595	41	39	41		327	33
34	Doors		2007	1,595	41	39	41		327	34
35	Air Conditioner		2007	500	13	39	13		103	35
36	Locks on Gate		2007	3,509	90	39	90		720	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

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**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	Parking Lot Paving	2007	\$ 20,000	\$ 513	39	\$ 513		\$ 4,103	37
38	Parking Lot Paving	2007	21,410	549	39	549		4,392	38
39	Fencing	2007	1,550	40	39	40		318	39
40	Fencing	2007	1,500	38	39	38		308	40
41	Asbestos removal	2007	2,370	61	39	61		486	41
42									42
43	Pump	2008	1,498	38	39	38		269	43
44	Sprinkler Systems	2008	12,457	319	39	319		2,236	44
45	Sprinkler Systems	2008	1,625	42	39	42		292	45
46	Smoke Detector	2008	1,342	34	39	34		241	46
47	Refrigeration	2008	4,250	109	39	109		763	47
48	Refrigeration	2008	5,291	136	39	136		950	48
49	Refrigeration	2008	3,735	96	39	96		670	49
50	Refrigeration	2008	6,950	178	39	178		1,247	50
51	Refrigeration	2008	2,455	63	39	63		441	51
52	Refrigeration	2008	971	25	39	25		174	52
53	Refrigeration	2008	1,678	43	39	43		301	53
54	Refrigeration	2008	2,865	73	39	73		514	54
55	Tiling for Shower room	2008	276	7	39	7		50	55
56	Elevator	2008	1,270	33	39	33		228	56
57	Roof	2008	4,094	105	39	105		735	57
58	Fire Doors	2008	2,670	68	39	68		479	58
59	Fire Doors	2008	907	23	39	23		163	59
60	Hot Water Heater	2008	8,875	228	39	228		1,593	60
61	Elevator	2008	3,008	77	39	77		540	61
62	Roof	2008	35,700	915	39	915		6,408	62
63	Brick work on Bldg	2008	17,850	458	39	458		3,204	63
64	Windows	2008	135,000	3,463	39	3,462	(1)	24,231	64
65	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		14,359	65
66	Renovation	2008	41,403	1,062	39	1,062		7,431	66
67	CATV wiring	2008	8,000	205	39	205		1,436	67
68	CATV wiring	2008	8,000	205	39	205		1,436	68
69	CATV wiring	2008	16,000	410	39	410		2,872	69
70	TOTAL (lines 4 thru 69)		\$ 8,641,833	\$ 242,901		\$ 242,900	\$ (1)	\$ 1,810,972	70

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

Facility Name &amp; ID Number Midway Neurological Reh Ctr

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## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,641,833	\$ 242,901		\$ 242,900	\$ (1)	\$ 1,810,972	1
2	Alarm System	2009	629	16	39	16		97	2
3	Wiring	2009	6,300	162	39	162		969	3
4	Room Signs	2009	5,405	138	39	139	1	831	4
5									5
6	Brickwork	2009	39,000	1,000	39	1,000		6,000	6
7									7
8	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,061	39	6,062	1	30,308	8
9	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		25,067	9
10	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		7,337	10
11	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		1,969	11
12									12
13	Sewer maintenance and upgrade	2010	3,379	87	39	87		433	13
14	Re-key entire building	2010	12,388	318	39	318		1,588	14
15	New fire doors	2010	30,801	790	39	790		3,949	15
16									16
17	Patch & re-roof overhang	2010	3,450	88	39	88		442	17
18	Cabling for nurse call system	2010	2,763	71	39	71		354	18
19	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		33,225	19
20	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		6,236	20
21	Bathroom sink lens	2010	2,741	70	39	70		351	21
22									22
23	Insulation of boilers	2010	3,700	95	39	95		474	23
24	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		4,159	24
25	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		1,954	25
26	Drywall & ceiling tile work throughout facility	2010	202,079	5,181	39	5,182	1	25,907	26
27									27
28	New front doors	2010	15,099	387	39	387		1,936	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		6,949	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		6,878	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,937,413	\$ 276,120		\$ 276,122	\$ 2	\$ 1,978,385	34

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

Facility Name &amp; ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning:

01/01/2014 Ending:

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## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	<b>Totals from Page 12B, Carried Forward</b>		\$ 9,937,413	\$ 276,120		\$ 276,122	\$ 2	\$ 1,978,385	1
2	Air conditioning panels	2010	5,657	145	39	145		725	2
3	Post construction clean up	2010	15,889	407	39	407		2,037	3
4									4
5	Repair asphalt	2010	2,867	74	39	74		368	5
6	Replace, water supply lines & valves	2010	27,303	700	39	700		3,500	6
7	Drainage pipe	2010	3,056	78	39	78		392	7
8	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	543		2,716	8
9	Repair water heaters	2010	2,830	73	39	73		363	9
10									10
11									11
12	Fix Hand Rails and Water Pumps	2011	16,413	420	39	421	1	1,683	12
13	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	27		106	13
14	Replace Waste Drain and Break	2011	2,950	76	39	76		303	14
15	Install Fire Dampers	2011	6,500	167	39	167		667	15
16	Update and Refit Lighting and Fixtures	2011	33,557	860	39	860		3,442	16
17	Replace Stairs	2011	2,990	77	39	77		307	17
18	Install and Updated Cabinets	2011	6,050	155	39	155		621	18
19									19
20	Replaced IFC-320 and TM-4 controls	2012	9,460	244	39	243	(1)	728	20
21	Relocate generator panels	2012	1,883	48	39	48		145	21
22	install sprinkler head in elevator shafts	2012	5,973	153	39	153		460	22
23	Fire Panel Call, contols, pull & trim outside west stand pipe	2012	5,439	139	39	139		418	23
24	7.5T Dry AC	2012	2,734	70	39	70		210	24
25	Advantage Carpet Ware	2012	3,290	84	39	84		253	25
26									26
27	2005 Assets not allowed for increased capital reimbursement	2005	6,291	419	15	419		4,194	27
28									28
29	2006 Assets not allowed for increased capital reimbursement	2006	15,508	1,034	15	1,034		9,354	29
30									30
31	2010 Assets not allowed for increased capital reimbursement	2010	72,793	1,867	39	1,866	(1)	9,332	31
32									32
33	2011 Assets not allowed for increased capital reimbursement	2011	15,706	403	39	403		1,611	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,224,770	\$ 284,383		\$ 284,384	\$ 1	\$ 2,022,320	34

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

Facility Name &amp; ID Number Midway Neurological Reh Ctr

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 10,224,770	\$ 284,383		\$ 284,384	\$ 1	\$ 2,022,320	1
2	Flooring / Tiles / Toilets in 5th floor resident rooms	10/23/2013	3,030	78	39	78		800	2
3	Wall repair, preparation and cove base in 5th floor res. Rooms	10/7/2013	2,811	72	39	72		742	3
4	Flooring - for 5th floor resident rooms	9/25/2013	5,494	141	39	141		1,450	4
5	Replace roof Exhaust	12/3/2013	4,805	123	39	123		1,268	5
6	Elevator	12/4/2012	28,000	718	39	718		7,390	6
7	Repair Elevator	12/10/2013	3,850	99	39	99		1,016	7
8	Wall repair - 5th floor	11/20/2013	3,000	77	39	77		792	8
9	Condenser - Kitchen / Barber Shop	7/29/2013	1,325	34	39	34		350	9
10	Sprinklers	8/20/2013	2,825	72	39	72		746	10
11	Emergency Generator	9/9/2013	4,442	114	39	114		1,172	11
12									12
13	Superior Construction	2014	2,469	63	39	63		652	13
14	Suburban Elevator	2014	3,520	90	39	90		929	14
15	Precision Heating & Air	2014	25,362	650	39	650		6,694	15
16	Keith's Cartage	2014	11,604	298	39	298		3,063	16
17	Subia Construction	2014	3,085	79	39	79		814	17
18	Fence Masters	2014	16,000	410	39	410		4,223	18
19	Carrie Dipaolo	2014	7,335	188	39	188		1,936	19
20	Century Supply Co.	2014	18,184	466	39	466		4,799	20
21	Direct Supply	2014	2,139	55	39	55		564	21
22	GJ#4	2014	15,196	390	39	390		4,011	22
23	Hinsdale Tile & Carpet	2014	2,993	77	39	77		790	23
24	Maintenance	2014	3,435	88	39	88		907	24
25	Precision Heating & Air	2014	1,975	51	39	51		521	25
26	Roldan Construction	2014	13,469	345	39	345		3,555	26
27	Suburban Elevator	2014	1,650	42	39	42		435	27
28	Superior Construction	2014	29,709	762	39	762		7,841	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,442,477	\$ 289,965		\$ 289,966	\$ 1	\$ 2,079,780	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,600,444	\$ 283,089	\$ 720,089	\$ 437,000	5	\$ 3,453,053	71
72	Current Year Purchases	125,054	125,054	25,011	(100,043)	5	125,054	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,725,498	\$ 408,143	\$ 745,100	\$ 336,957		\$ 3,578,107	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,117,975	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 698,108	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,035,066	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 336,958	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,657,887	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.

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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	<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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. 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><b>3. 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	2	3	
		Drop-outs	Completed	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)	\$			

**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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		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	\$				\$ 306,954	\$		\$ 306,954	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs					87,701			87,701	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a-3	hrs					482,357			482,357	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						231,770		231,770	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>lab xray amb</u>	39-2							14,228		14,228	12
13	Other (specify):											13
14	TOTAL			\$				\$ 877,012	\$ 245,998		\$ 1,123,010	14

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

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	\$ (184,299)	\$ (126,634)	1
2	Cash-Patient Deposits	37,222	37,222	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,482,907	3,482,907	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	279,801	279,801	6
7	Other Prepaid Expenses	4,479,889	4,479,889	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>	<b>\$ 8,095,520</b>	<b>\$ 8,153,185</b>	<b>10</b>
<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	2,842,476	2,842,476	15
16	Equipment, at Historical Cost	875,498	3,725,498	16
17	Accumulated Depreciation (book methods)	(1,574,947)	(5,657,887)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,875,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(38,165)	(3,859,063)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>security deposits</u> )	21,367	57,517	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 2,169,399</b>	<b>\$ 13,533,727</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 10,264,919</b>	<b>\$ 21,686,912</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,367,768	\$ 1,667,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,085,504	2,085,504	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				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 3,453,272</b>	<b>\$ 3,753,272</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,640,000	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>	<b>\$</b>	<b>\$ 22,640,000</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 3,453,272</b>	<b>\$ 26,393,272</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 6,811,647</b>	<b>\$ (4,706,360)</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 10,264,919</b>	<b>\$ 21,686,912</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,809,094	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,809,094	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,175,148	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,460,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>related party property co net income</u>	1,287,405	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,002,553	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 6,811,647	24 *

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

Facility Name & ID Number Midway Neurological Reh Ctr# 0047175Report Period Beginning: 01/01/2014Ending: 12/31/2014

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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 19,618,720	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 19,618,720	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,370	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 415,370	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	100,017	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 100,017	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>related party rental income</b>	2,400,000	28
28a	<b>vending and misc income</b>	61,957	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,461,957	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 22,596,064	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,754,395	31
32	Health Care	7,243,592	32
33	General Administration	3,271,366	33
<b>B. Capital Expense</b>			
34	Ownership	6,106,204	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	245,998	35
36	Provider Participation Fee	933,043	36
<b>D. Other Expenses (specify):</b>			
37	<u>bad debt</u>	866,318	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 21,420,916	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,175,148	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,175,148	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 16,309,151	44
45	Private Pay - Net Inpatient Revenue	108,166	45
46	Medicare - Net Inpatient Revenue	2,662,739	46
47	Other-(specify) <u>Commercial</u>	538,664	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 19,618,720	49

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

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

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

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

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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	1,904	2,117	\$ 105,158	\$ 49.67	1
2	Assistant Director of Nursing	3,983	5,224	201,522	38.58	2
3	Registered Nurses	10,710	12,008	252,881	21.06	3
4	Licensed Practical Nurses	74,219	86,345	2,471,152	28.62	4
5	CNAs & Orderlies	136,384	154,108	1,659,686	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	22,118	24,770	447,650	18.07	9
10	Activity Assistants					10
11	Social Service Workers	16,655	18,589	318,385	17.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,311	48,468	595,051	12.28	15
16	Dishwashers					16
17	Maintenance Workers	8,406	9,432	159,844	16.95	17
18	Housekeepers	40,527	47,699	504,598	10.58	18
19	Laundry	4,390	5,047	56,432	11.18	19
20	Administrator	4,248	4,530	190,009	41.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,767	19,677	351,004	17.84	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	4,763	5,401	73,104	13.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	388,385	443,415	\$ 7,386,476 *	\$ 16.66	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	389	\$ 19,454	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,348	67,408	10-3	38
39	Pharmacist Consultant	540	26,978	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	145	7,230	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,421	\$ 121,070		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

Facility Name & ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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	
Carrie Dipaolo	Administrator		\$ 69,641	Workers' Compensation Insurance	\$ 302,520	IDPH License Fee	\$	
Josh Graber	Administrator		2,000	Unemployment Compensation Insurance	304,786	Advertising: Employee Recruitment		
Michael Perl	Administrator		69,770	FICA Taxes	536,565	Health Care Worker Background Check		
Brandin Stephenson	Administrator		48,598	Employee Health Insurance	273,643	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		illinois council	22,468	
				pension	29,668	village of bridgeview	700	
				Employee expenses	32,319	clia	150	
						various	2,836	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 190,009			Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				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
Lewis Brisbois Bisgaard	Legal fees		\$ 32,770			\$	Out-of-State Travel	\$
Polsinelli	Legal fees		113					
Scalambrino & Aronoff	Legal fees		36,128					
Infinity Healthcare	Consulting fees		329,973				In-State Travel	
Bradley & Associates	Accounting fees		5,390				seminars	1,174
MTS Consulting	Professional fees		901				continuing education	28,824
Redridge Lender Services	Professional fees		3,219				mileage	7,715
Seyfarth Shaw	Legal fees		3,150				Seminar Expense	
Johnson, Goldberg	Accounting fees		2,500				auto allowance	28,800
Optimum Bank	Finance Charges		94,843					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	( )
(For legal fee disclosure, see page 39 of instructions)			\$ 508,987				(agree to Sch. V,	
							line 24, col. 8)	\$ 66,513

\* Attach copy of IMRF notifications

\*\*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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Midway Neurological Reh Ctr

# 0047175

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## 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? yes  
If YES, give association name and amount. illinois council
- (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. \$ 82,026 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 933,043  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation. n/a
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? no  
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**ATTACHMENT #1**

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	33.390%
MOISHE GUBIN	33.390%
JOSEPH & RIKA MEISELS	4.250%
JOSEPH BLISKO	5.000%
A&F GENERAL PARTNERSHIP	<u>23.970%</u>
	<u>100.000%</u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
INFINITY MANAGEMENT MIDWAY NEUR. & REHAB REALTY, LLC	HILLSIDE	MANAGEMENT CO. REALTY CO.

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