

Facility Name & ID Number Midway Neurological Reh Ctr

0047175 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	119,364	51	8,227	127,642	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	119,364	51	8,227	127,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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 4/1/2005

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

YES Date 4/1/2005 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 5,629

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Midway Neurological Reh Ctr

0047175

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	605,484		80,188	685,672		685,672	(8,957)	676,715		1
2	Food Purchase		590,516		590,516		590,516		590,516		2
3	Housekeeping	465,665	70,206		535,871		535,871		535,871		3
4	Laundry	75,070	46,099		121,169		121,169		121,169		4
5	Heat and Other Utilities			412,783	412,783		412,783	2,507	415,290		5
6	Maintenance	164,949	129,523	182,346	476,818		476,818	1,724	478,542		6
7	Other (specify):*										7
8	TOTAL General Services	1,311,168	836,344	675,317	2,822,829		2,822,829	(4,726)	2,818,103		8
	B. Health Care and Programs										
9	Medical Director			34,000	34,000		34,000		34,000		9
10	Nursing and Medical Records	5,178,498	447,365	113,853	5,739,716		5,739,716	(23,114)	5,716,602		10
10a	Therapy			968,969	968,969		968,969		968,969		10a
11	Activities	329,330	138,723		468,053		468,053		468,053		11
12	Social Services	340,064		(3)	340,061		340,061		340,061		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			37,818	37,818		37,818		37,818		15
16	TOTAL Health Care and Programs	5,847,892	586,088	1,154,637	7,588,617		7,588,617	(23,114)	7,565,503		16
	C. General Administration										
17	Administrative	206,375			206,375		206,375	(50,000)	156,375		17
18	Directors Fees										18
19	Professional Services			493,538	493,538		493,538	(252,607)	240,931		19
20	Dues, Fees, Subscriptions & Promotions			2,732	2,732		2,732		2,732		20
21	Clerical & General Office Expenses	414,190	99,514	124,166	637,870		637,870	84,152	722,022		21
22	Employee Benefits & Payroll Taxes			1,765,880	1,765,880		1,765,880	34,334	1,800,214		22
23	Inservice Training & Education										23
24	Travel and Seminar			52,918	52,918		52,918	1,494	54,412		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			200,763	200,763		200,763	332,060	532,823		26
27	Other (specify):*										27
28	TOTAL General Administration	620,565	99,514	2,639,997	3,360,076		3,360,076	149,433	3,509,509		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,779,625	1,521,946	4,469,951	13,771,522		13,771,522	121,593	13,893,115		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	
	D. Ownership											
30	Depreciation			180,314	180,314		180,314	311,668	491,982			30
31	Amortization of Pre-Op. & Org.			2,878	2,878		2,878	457,401	460,279			31
32	Interest			1,661	1,661		1,661	821,904	823,565			32
33	Real Estate Taxes							783,883	783,883			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,393,718)	6,282			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			13,235	13,235		13,235		13,235			36
37	TOTAL Ownership			2,598,088	2,598,088		2,598,088	(18,862)	2,579,226			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,490	2,490		2,490		2,490			38
39	Ancillary Service Centers		274,746		274,746		274,746		274,746			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			965,549	965,549		965,549		965,549			42
43	Other (specify):* Bad Debt			20,500	20,500		20,500	(20,500)				43
44	TOTAL Special Cost Centers		274,746	988,539	1,263,285		1,263,285	(20,500)	1,242,785			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,779,625	1,796,692	8,056,578	17,632,895		17,632,895	82,231	17,715,126			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: 01/01/2015

Ending: 12/31/2015

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	(246,005)	30		9
10	Interest and Other Investment Income	(119,297)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(12,188)	21		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	(20,500)	43		24
25	Fund Raising, Advertising and Promotional	(28,438)	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	(35,242)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (461,671)		\$	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)	543,902		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 543,902		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 82,231		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Midway Neurological Reh Ctr

ID# 0047175

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	Misc Income	\$ (35,242)	21	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
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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		(35,242)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Midway Neurological Reh Ctr# 0047175

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1)	(8,956)	0	0	0	0	0	0	0	0	0	(8,957)	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	2,507	0	0	0	0	0	0	0	0	0	2,507	5
6	Maintenance	0	1,724	0	0	0	0	0	0	0	0	0	1,724	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1)	(4,725)	0	0	0	0	0	0	0	0	0	(4,726)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(23,114)	0	0	0	0	0	0	0	0	0	(23,114)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(23,114)	0	0	0	0	0	0	0	0	0	(23,114)	16
	C. General Administration													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(346,272)	93,665	0	0	0	0	0	0	0	0	(252,607)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(75,868)	88,830	71,190	0	0	0	0	0	0	0	0	84,152	21
22	Employee Benefits & Payroll Taxes	0	34,334	0	0	0	0	0	0	0	0	0	34,334	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,494	0	0	0	0	0	0	0	0	0	1,494	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	2,957	329,103	0	0	0	0	0	0	0	0	332,060	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,868)	(268,657)	493,958	0	149,433	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,869)	(296,496)	493,958	0	121,593	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Midway Neurological Reh Ctr# 0047175

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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	(246,005)	0	557,673	0	0	0	0	0	0	0	0	311,668	30
31	Amortization of Pre-Op. & Org.	0	0	457,401	0	0	0	0	0	0	0	0	457,401	31
32	Interest	(119,297)	0	941,201	0	0	0	0	0	0	0	0	821,904	32
33	Real Estate Taxes	0	4,347	779,536	0	0	0	0	0	0	0	0	783,883	33
34	Rent-Facility & Grounds	0	6,282	(2,400,000)	0	0	0	0	0	0	0	0	(2,393,718)	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	(365,302)	10,629	335,811	0	(18,862)	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):*	(20,500)	0	0	0	0	0	0	0	0	0	0	(20,500)	43
44	TOTAL Special Cost Centers	(20,500)	0	0	0	0	0	0	0	0	0	0	(20,500)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(461,671)	(285,867)	829,769	0	0	0	0	0	0	0	0	82,231	45

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
Michael Blisko	33.393%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt. Co.
GELP	33.392%	Belhaven Nursing & Rehab Center	Chicago			
A&F Realty	23.965%	West Suburban Nursing & Rehab Center	Bloomingtondale			
Joseph Blisko	5%	City View Multicare Center	Cicero			
Joseph Meisels	4.25%	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			

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	Infinity Healthcare Management		\$ 10,498	\$ (8,956)	1
2	V	10 Nursing wages	72,786	Infinity Healthcare Management		49,672	(23,114)	2
3	V	21 Office wages		Infinity Healthcare Management		204,877	204,877	3
4	V	5 Utilities		Infinity Healthcare Management		2,507	2,507	4
5	V	6 Maintenance		Infinity Healthcare Management		1,724	1,724	5
6	V	19 Professional Services	347,351	Infinity Healthcare Management		1,079	(346,272)	6
7	V	21 Office Expense	133,783	Infinity Healthcare Management		17,736	(116,047)	7
8	V	22 Employee Benefit	3,453	Infinity Healthcare Management		37,787	34,334	8
9	V	24 Auto/Travel expense	1,267	Infinity Healthcare Management		2,761	1,494	9
10	V	26 Insurance		Infinity Healthcare Management		2,957	2,957	10
11	V	33 Property Tax		Infinity Healthcare Management		4,347	4,347	11
12	V	34 Rent		Infinity Healthcare Management		6,282	6,282	12
13	V	17 Administrative	50,000	Infinity Healthcare Management			(50,000)	13
14	Total		\$ 628,094			\$ 342,227	\$ * (285,867)	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	21 Office Expense	\$	Midway Nuerological and Rehabilitation Realty		\$ 71,190	\$ 71,190	15
16	V	26 Insurance		Midway Nuerological and Rehabilitation Realty		329,103	329,103	16
17	V	30 Depreciation		Midway Nuerological and Rehabilitation Realty		557,673	557,673	17
18	V	31 Amortization		Midway Nuerological and Rehabilitation Realty		457,401	457,401	18
19	V	32 Interest		Midway Nuerological and Rehabilitation Realty		941,201	941,201	19
20	V	33 Property Tax		Midway Nuerological and Rehabilitation Realty		779,536	779,536	20
21	V	34 Rent	2,400,000	Midway Nuerological and Rehabilitation Realty			(2,400,000)	21
22	V	19 Professional Services		Midway Nuerological and Rehabilitation Realty		93,665	93,665	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,400,000			\$ 3,229,769	\$ * 829,769	39

* 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:

01/01/2015

Ending:

12/31/2015

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			Midway Neurological & Rehab Center	Bridgeview				1
2			Momence Meadows Nursing & Rehab Ctr	Momence				2
3			Niles Nursing & Rehab Center	Niles				3
4			Oak Lawn Respiratory & Rehab Center	Oak Lawn				4
5			Parker Nursing & Rehab Center	Streator				5
6			Parkshore Estates Nursing & Rehab Ctr	Chicago				6
7			Southpoint Nursing & Rehab Center	Chicago				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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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: 01/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HUD Loan		X	Mortgage	Interest Only	5/25/15	\$ 23,416,884	\$ 23,416,884	7/1/49	3.4000	\$ 941,201						
2																	
3																	
4																	
5																	
Working Capital																	
6	Capital One		X	Working Capital	none	8/31/14	15,000,000	1,729,902	8/31/18	4.2500	1,661						
7																	
8																	
9	TOTAL Facility Related						\$ 38,416,884	\$ 25,146,786			\$ 942,862						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 38,416,884	\$ 25,146,786			\$ 942,862						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 299,555 Line # 26

* 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.)

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Midway Neurological Reh Ctr COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0047175
 CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar
 TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-36-403-013-0000</u>	<u>Nursing Home</u>	\$ <u>921,323.00</u>	\$ <u>921,323.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>921,323.00</u></u>	\$ <u><u>921,323.00</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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).

None

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	TOTALS			\$ 950,000	3

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	\$ 194,872	39	\$ 194,872	\$	\$ 1,575,199	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Combined 2005 Building Improvements		2005	323,803	21,587	15	21,587		237,453	9
10	2005 Assets not allowed for increased capital reimbursement		2005	6,291	419	15	419		4,613	10
11										11
12	Combined 2006 Building Improvements		2006	195,836	13,056	15	13,056		131,178	12
13	2006 Assets not allowed for increased capital reimbursement		2006	15,508	1,034	15	1,034		10,388	13
14										14
15	Air Conditioner		2007	10,330	265	39	265		2,384	15
16	Fire Sprinkler		2007	4,775	122	39	122		1,102	16
17	Fire System		2007	1,290	33	39	33		298	17
18	Auto Transfer Switch		2007	838	21	39	21		193	18
19	Video SecurityCameras		2007	3,900	100	39	100		900	19
20	Shower Room Tile		2007	9,010	231	39	231		2,079	20
21	Shower Room Tile		2007	3,543	91	39	91		818	21
22	Cubicle curtains		2007	4,059	104	39	104		937	22
23	Shower Room Tile		2007	5,497	141	39	141		1,269	23
24	Air Conditioner		2007	500	13	39	13		116	24
25	Air Conditioner		2007	500	13	39	13		116	25
26	Signage		2007	1,692	43	39	43		390	26
27	Fire Sprinkler		2007	1,373	35	39	35		317	27
28	Electrical work in reception area		2007	490	13	39	13		114	28
29	Painting - Shower Room		2007	1,000	26	39	26		231	29
30	Painting - Shower Room		2007	2,000	51	39	51		461	30
31	Painting - Shower Room		2007	3,000	77	39	77		692	31
32	Painting - Shower Room		2007	3,000	77	39	77		692	32
33	Toner		2007	13		39			3	33
34	Freezer maint		2007	3,188	82	39	82		736	34
35	Doors		2007	1,595	41	39	41		368	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Midway Neurological Reh Ctr

0047175

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

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	Doors	2007	\$ 1,595	\$ 41	39	\$ 41	\$	\$ 368	37
38	Air Conditioner	2007	500	13	39	13		116	38
39	Locks on Gate	2007	3,509	90	39	90		810	39
40	Parking Lot Paving	2007	20,000	513	39	513		4,616	40
41	Parking Lot Paving	2007	21,410	549	39	549		4,941	41
42	Fencing	2007	1,550	40	39	40		358	42
43	Fencing	2007	1,500	38	39	38		346	43
44	Asbestos removal	2007	2,370	61	39	61		547	44
45									45
46	Pump	2008	1,498	38	39	38		307	46
47	Sprinkler Systems	2008	12,457	319	39	319		2,555	47
48	Sprinkler Systems	2008	1,625	42	39	42		334	48
49	Smoke Detector	2008	1,342	34	39	34		275	49
50	Refrigeration	2008	4,250	109	39	109		872	50
51	Refrigeration	2008	5,291	136	39	136		1,086	51
52	Refrigeration	2008	3,735	96	39	96		766	52
53	Refrigeration	2008	6,950	178	39	178		1,425	53
54	Refrigeration	2008	2,455	63	39	63		504	54
55	Refrigeration	2008	971	25	39	25		199	55
56	Refrigeration	2008	1,678	43	39	43		344	56
57	Refrigeration	2008	2,865	73	39	73		587	57
58	Tiling for Shower room	2008	276	7	39	7		57	58
59	Elevator	2008	1,270	33	39	33		261	59
60	Roof	2008	4,094	105	39	105		840	60
61	Fire Doors	2008	2,670	68	39	68		547	61
62	Fire Doors	2008	907	23	39	23		186	62
63	Hot Water Heater	2008	8,875	228	39	228		1,821	63
64	Elevator	2008	3,008	77	39	77		617	64
65	Roof	2008	35,700	915	39	915		7,323	65
66	Brick work on Bldg	2008	17,850	458	39	458		3,662	66
67	Windows	2008	135,000	3,462	39	3,462		27,693	67
68	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		16,410	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,590,229	\$ 242,475		\$ 242,475	\$	\$ 2,053,820	70

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

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	Totals from Page 12A, Carried Forward		\$ 8,590,229	\$ 242,475		\$ 242,475	\$	\$ 2,053,820	1
2	Renovation	2008	41,403	1,062	39	1,062		8,493	2
3	CATV wiring	2008	8,000	205	39	205		1,641	3
4	CATV wiring	2008	8,000	205	39	205		1,641	4
5	CATV wiring	2008	16,000	411	39	411		3,283	5
6									6
7	Alarm System	2009	629	16	39	16		113	7
8	Wiring	2009	6,300	162	39	162		1,131	8
9	Room Signs	2009	5,405	138	39	138		969	9
10	Brickwork	2009	39,000	1,000	39	1,000		7,000	10
11									11
12	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,062	39	6,062		36,370	12
13	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		30,080	13
14	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		8,804	14
15	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		2,363	15
16	Sewer maintenance and upgrade	2010	3,379	87	39	87		520	16
17	Re-key entire building	2010	12,388	318	39	318		1,906	17
18	New fire doors	2010	30,801	790	39	790		4,739	18
19	Patch & re-roof overhang	2010	3,450	88	39	88		530	19
20	Cabling for nurse call system	2010	2,763	71	39	71		425	20
21	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		39,870	21
22	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		7,483	22
23	Bathroom sink lens	2010	2,741	70	39	70		421	23
24	Insulation of boilers	2010	3,700	95	39	95		569	24
25	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		4,991	25
26	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		2,345	26
27	Drywall & ceiling tile work throughout facility	2010	202,079	5,182	39	5,182		31,089	27
28	New front doors	2010	15,099	387	39	387		2,323	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		8,339	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		8,254	30
31	Air conditioning panels	2010	5,657	145	39	145		870	31
32	Post construction clean up	2010	15,889	407	39	407		2,444	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,980,758	\$ 278,131		\$ 278,131	\$	\$ 2,272,826	34

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

Facility Name & ID Number Midway Neurological Reh Ctr

0047175

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

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	Totals from Page 12B, Carried Forward		\$ 9,980,758	\$ 278,131		\$ 278,131	\$	\$ 2,272,826	1
2	Repair asphalt	2010	2,867	74	39	74		442	2
3	Replace, water supply lines & valves	2010	27,303	700	39	700		4,200	3
4	Drainage pipe	2010	3,056	78	39	78		470	4
5	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	543		3,259	5
6	Repair water heaters	2010	2,830	73	39	73		436	6
7	2010 Assets not allowed for increased capital reimbursement	2010	72,793	1,865	39	1,865		11,197	7
8									8
9	Fix Hand Rails and Water Pumps	2011	16,413	421	39	421		2,104	9
10	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	27		133	10
11	Replace Waste Drain and Break	2011	2,950	76	39	76		379	11
12	Install Fire Dampers	2011	6,500	167	39	167		834	12
13	Update and Refit Lighting and Fixtures	2011	33,557	860	39	860		4,302	13
14	Replace Stairs	2011	2,990	77	39	77		384	14
15	Install and Updated Cabinets	2011	6,050	154	39	154		775	15
16	2011 Assets not allowed for increased capital reimbursement	2011	15,706	403	39	403		2,014	16
17									17
18	Replaced IFC-320 and TM-4 controls	2012	9,460	243	39	243		971	18
19	Relocate generator panels	2012	1,883	48	39	48		193	19
20	install sprinkler head in elevator shafts	2012	5,973	153	39	153		613	20
21	Fire Panel Call, contols, pull & trim outside west stand pipe	2012	5,439	140	39	140		558	21
22	7.5T Dry AC	2012	2,734	70	39	70		280	22
23	Advantage Carpet Ware	2012	3,290	84	39	84		337	23
24									24
25	Flooring / Tiles / Toilets in 5th floor resident rooms	2013	3,030	78	39	78		878	25
26	Wall repair, preparation and cove base in 5th floor res. Rooms	2013	2,811	72	39	72		814	26
27	Flooring - for 5th floor resident rooms	2013	5,494	141	39	141		1,591	27
28	Replace roof Exhaust	2013	4,805	123	39	123		1,391	28
29	Elevator	2013	28,000	718	39	718		8,108	29
30	Repair Elevator	2013	3,850	99	39	99		1,115	30
31	Wall repair - 5th floor	2013	3,000	77	39	77		869	31
32	Condenser - Kitchen / Barber Shop	2013	1,325	34	39	34		384	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,277,085	\$ 285,729		\$ 285,729	\$	\$ 2,321,857	34

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

Facility Name & ID Number Midway Neurological Reh Ctr

0047175

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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	Totals from Page 12C, Carried Forward		\$ 10,277,085	\$ 285,729		\$ 285,729	\$	\$ 2,321,857	1
2	Sprinklers	2013	2,825	72	39	72		818	2
3	Emergency Generator	2013	4,442	114	39	114		1,286	3
4									4
5	Remove wallpaper, paint wall, cove base 4th floor dining room	2014	2,469	63	39	63		715	5
6	Install door restrictors and door detectors on elevators	2014	3,520	90	39	90		1,019	6
7	Condenser in main boiler room and service roof top units	2014	25,362	650	39	650		7,344	7
8	Install new hydrant and valve in pump room	2014	11,604	298	39	298		3,361	8
9	Rod out kitchen waste line & main branch from nrsg station	2014	3,085	79	39	79		893	9
10	Replace 205 linear feet of fence on patio including gate	2014	16,000	410	39	410		4,633	10
11	5 BTU wall units for MDS, Bookkeeping, Rms 206, 318, & 323	2014	7,335	188	39	188		2,124	11
12	Golden teak flooring for hallway and dining room on 1st floor	2014	18,184	466	39	466		5,265	12
13	2 rolls of wall covering for hallway and dining room on 1st flr	2014	2,139	55	39	55		619	13
14	2700 sq ft of plank flooring for hallway and dining 1st floor	2014	2,993	77	39	77		867	14
15	Painted seven patient rooms (201, 202, 404, 408, 416, 303, 322)	2014	3,435	88	39	88		995	15
16	Install insulation on roof air handler panels and seal roof units	2014	1,975	51	39	51		572	16
17	Tuck pointing and window caulking on entire exterior facility	2014	13,469	345	39	345		3,900	17
18	3rd flr door lock on elevator 2, new infared door detector also	2014	1,650	42	39	42		477	18
19	Paint walls in 536 - 544, 503, & 504; remove therapy closet	2014	29,709	762	39	762		8,603	19
20	Non-Allowable Assets	2014	15,196	390	39	390		4,401	20
21									21
22	Hallway and dining renovation - Paint, flooring, hand rails, and otl	1/2/2015	112,702	2,890	39	2,890		2,890	22
23	Flooring for new dining room on 4th floor	1/21/2015	3,175	81	39	81		81	23
24	New flooring	1/2/2015	2,993	77	39	77		77	24
25	Remove old flooring, toilets, and countertops and install new blinds	1/25/2015	6,391	164	39	164		164	25
26	Remove wall for dining room and install light fixtures	1/25/2015	5,585	143	39	143		143	26
27	Handrails, wall coverings, signage, and blinds	2/18/2015	35,470	909	39	909		909	27
28	Elevator panel, elevator hand railing	2/20/2015	11,000	282	39	282		282	28
29	Replace 4th floor electrical wiring	2/13/2015	7,900	203	39	203		203	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,627,692	\$ 294,718		\$ 294,718	\$	\$ 2,374,498	34

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

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	Totals from Page 12D, Carried Forward		\$ 10,627,692	\$ 294,718		\$ 294,718	\$	\$ 2,374,498	1
2	Replace U-bends on boiler	3/9/2015	2,800	72	39	72		72	2
3	Plumbing - Sink faucet handles	4/27/2015	6,965	179	39	179		179	3
4	Flooring and corner guards	4/9/2015	3,660	94	39	94		94	4
5	Replace U-bends on boiler	2/28/2015	3,268	84	39	84		84	5
6	Remove flooring and install new floor on 5th floor	5/3/2015	2,857	73	39	73		73	6
7	Steel door	5/3/2015	4,423	113	39	113		113	7
8	Remodeling of therapy room	5/18/2015	7,872	202	39	202		202	8
9	New lock systems	5/16/2015	21,204	544	39	544		544	9
10	Smoking shelter	6/8/2015	4,875	125	39	125		125	10
11	Parking lot paving	7/9/2015	38,634	991	39	991		991	11
12	New lock systems	7/10/2015	4,575	117	39	117		117	12
13	Patient room doors	6/28/2015	2,900	74	39	74		74	13
14	Granite tops for dining room	6/28/2015	3,400	87	39	87		87	14
15	New door	8/20/2015	2,000	51	39	51		51	15
16	Replace laundry outside doors	7/23/2015	1,400	36	39	36		36	16
17	Replace laundry outside doors	9/29/2015	2,147	55	39	55		55	17
18	Air conditioning unit	7/29/2015	2,975	76	39	76		76	18
19	Pit ladders for elevator	12/28/2015	3,400	87	39	87		87	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,747,047	\$ 297,778		\$ 297,778	\$	\$ 2,377,558	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	\$ 4,464,488	\$ 362,801	\$ 181,150	\$ (181,651)	5	\$ 4,269,616	71
72	Current Year Purchases	77,408	77,408	13,054	(64,354)	5-7	77,408	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,541,896	\$ 440,209	\$ 194,204	\$ (246,005)		\$ 4,347,024	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)	\$ 16,238,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 737,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 491,982	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (246,005)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,724,582	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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Midway Neurological Reh Ctr # 0047175 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	4,715	\$ 308,753	\$	4,715	\$ 308,753	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,254	156,557		2,254	156,557	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		7,528	440,159		7,528	440,159	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				255,785		255,785	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology</u>	39-2					5,890		5,890	12
13	Other (specify): <u>Lab</u>	39-2					13,071		13,071	13
14	TOTAL			\$	14,497	\$ 905,469	\$ 274,746	14,497	\$ 1,180,215	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# 0047175Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (383,596)	\$ (182,079)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,172,547	3,208,800	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	327,994	327,994	6
7	Other Prepaid Expenses		2,316	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		403,734	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,116,945	\$ 3,760,765	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	3,147,045	3,147,045	15
16	Equipment, at Historical Cost	952,905	4,541,895	16
17	Accumulated Depreciation (book methods)	(1,755,261)	(6,724,582)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,136,202	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(41,043)	(5,497,375)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	21,367	549,688	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,368,183	\$ 11,702,873	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,485,128	\$ 15,463,638	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,794,464	\$ 2,066,171	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(63,031)	(63,031)	28
29	Short-Term Notes Payable		380,126	29
30	Accrued Salaries Payable	419,803	419,803	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		66,348	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Working Capital/Reserves</u>	2,304,283	2,304,283	36
37	<u>Working Capital</u>	(9,333,673)	(9,333,673)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (4,878,154)	\$ (4,159,973)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,036,758	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)	\$	\$ 23,036,758	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (4,878,154)	\$ 18,876,785	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,363,282	\$ (3,413,147)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,485,128	\$ 15,463,638	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,811,647	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,811,647	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,685,436	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	(327,564)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Related party property co net loss</u>	(806,237)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,551,635	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)	\$ 10,363,282	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,205,200	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,205,200	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	828,657	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 828,657	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	140,986	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,042	19
20	Radiology and X-Ray	2,440	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,468	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	95,765	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 95,765	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous income</u>	35,242	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,242	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,318,332	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,822,830	31
32	Health Care	7,550,799	32
33	General Administration	3,360,076	33
B. Capital Expense			
34	Ownership	2,598,088	34
C. Ancillary Expense			
35	Special Cost Centers	312,564	35
36	Provider Participation Fee	965,549	36
D. Other Expenses (specify):			
37	<u>Medically Necessary transportation</u>	2,490	37
38	<u>Bad Debts</u>	20,500	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,632,896	40
41	Income before Income Taxes (line 30 minus line 40)**	4,685,436	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,685,436	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 17,726,865	44
45	Private Pay - Net Inpatient Revenue	(13,320)	45
46	Medicare - Net Inpatient Revenue	1,688,985	46
47	Other-(specify) <u>Commercial</u>	1,802,670	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 21,205,200	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: 01/01/2015

Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,007	2,126	\$ 112,639	\$ 52.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,909	14,529	445,920	30.69	3
4	Licensed Practical Nurses	64,254	75,306	2,143,494	28.46	4
5	CNAs & Orderlies	135,731	174,024	2,138,972	12.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,402	9,672	149,371	15.44	8
9	Activity Director	21,440	25,994	329,330	12.67	9
10	Activity Assistants					10
11	Social Service Workers	17,161	19,055	340,064	17.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,960	54,864	605,484	11.04	15
16	Dishwashers					16
17	Maintenance Workers	8,194	8,984	164,949	18.36	17
18	Housekeepers	38,354	48,341	465,665	9.63	18
19	Laundry	6,116	7,820	75,070	9.60	19
20	Administrator	4,244	4,429	206,375	46.60	20
21	Assistant Administrator					21
22	Other Administrative	4,172	4,919	118,761	24.14	22
23	Office Manager					23
24	Clerical	28,348	34,690	414,190	11.94	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	4,067	4,658	69,341	14.89	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	398,359	489,411	\$ 7,779,625 *	\$ 15.90	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	556	\$ 19,954	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	3,253	113,853	10-3	38
39	Pharmacist Consultant	756	37,818	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1,270	63,500	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,835	\$ 235,125		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

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Midway Neurological Reh Ctr

0047175

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. \$ 61,559 Line 10-2
- (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. \$ 965,549
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) 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.