

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	122,265	363	7,258	129,886	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	122,265	363	7,258	129,886	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.08%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 3,292

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center # 0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	665,005	94,797	19,476	779,278		779,278	(4,243)	775,035		1
2	Food Purchase		753,557		753,557		753,557	2,842	756,399		2
3	Housekeeping	347,092	68,507		415,599		415,599	30	415,629		3
4	Laundry	72,893	33,907		106,800		106,800		106,800		4
5	Heat and Other Utilities			440,016	440,016		440,016	(14,093)	425,923		5
6	Maintenance	277,861	93,169	247,869	618,899		618,899	2,574	621,473		6
7	Other (specify):*										7
8	TOTAL General Services	1,362,851	1,043,937	707,361	3,114,149		3,114,149	(12,890)	3,101,259		8
	B. Health Care and Programs										
9	Medical Director			35,675	35,675		35,675		35,675		9
10	Nursing and Medical Records	4,909,228	344,130	47,169	5,300,527		5,300,527	38,277	5,338,804		10
10a	Therapy			1,034,327	1,034,327		1,034,327		1,034,327		10a
11	Activities	462,690	112,528		575,218		575,218		575,218		11
12	Social Services	493,398		5,440	498,838		498,838		498,838		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			38,331	38,331		38,331	(820)	37,511		15
16	TOTAL Health Care and Programs	5,865,316	456,658	1,160,942	7,482,916		7,482,916	37,457	7,520,373		16
	C. General Administration										
17	Administrative	234,248			234,248		234,248		234,248		17
18	Directors Fees										18
19	Professional Services			1,037,103	1,037,103		1,037,103	(789,304)	247,799		19
20	Dues, Fees, Subscriptions & Promotions			9,368	9,368		9,368	(56)	9,312		20
21	Clerical & General Office Expenses	199,450	92,700	(25,436)	266,714		266,714	366,021	632,735		21
22	Employee Benefits & Payroll Taxes			1,361,871	1,361,871		1,361,871	72,592	1,434,463		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,066	21,066		21,066	5,960	27,026		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			798,772	798,772		798,772	151,926	950,698		26
27	Other (specify):*										27
28	TOTAL General Administration	433,698	92,700	3,202,744	3,729,142		3,729,142	(192,861)	3,536,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,661,865	1,593,295	5,071,047	14,326,207		14,326,207	(168,294)	14,157,913		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			157,667	157,667		157,667	155,822	313,489		30
31	Amortization of Pre-Op. & Org.							457,401	457,401		31
32	Interest			(2,709,126)	(2,709,126)		(2,709,126)	3,334,572	625,446		32
33	Real Estate Taxes			1,071,662	1,071,662		1,071,662		1,071,662		33
34	Rent-Facility & Grounds			1,186,353	1,186,353		1,186,353	(1,177,059)	9,294		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Replacement Tax			31,275	31,275		31,275		31,275		36
37	TOTAL Ownership			(262,169)	(262,169)		(262,169)	2,770,736	2,508,567		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		151,853		151,853		151,853	(3,131)	148,722		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			987,493	987,493		987,493		987,493		42
43	Other (specify):* Bad Debt Expense			325,396	325,396		325,396	(325,396)			43
44	TOTAL Special Cost Centers		151,853	1,312,889	1,464,742		1,464,742	(328,527)	1,136,215		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,661,865	1,745,148	6,121,767	15,528,780		15,528,780	2,273,915	17,802,695		45

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

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	(39,050)	30		9
10	Interest and Other Investment Income	(145,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(285)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(325,396)	43		24
25	Fund Raising, Advertising and Promotional	(26,872)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	2,680,237	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 2,143,523		\$	30

BHF USE ONLY							
48		49		50		51	

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)	130,392	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 130,392		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,273,915		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

Midway Neurological & Rehabilitation Center

ID# 0047175

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (213)	21	1
2	Vending Income	(4,232)	1	2
3	PAC Expenses	(243)	20	3
4	RP Profit	(96)	10	4
5	RP Profit	(820)	15	5
6	RP Profit	(3,131)	39	6
7	Miscellaneous Income	(18,788)	5	7
8	Miscellaneous Income	(1,366)	10	8
9	Interest Expense	2,709,126	32	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
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,680,237		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(4,243)	0	0	0	0	0	0	0	0	0	0	(4,243)	1
2	Food Purchase	0	2,842	0	0	0	0	0	0	0	0	0	2,842	2
3	Housekeeping	0	30	0	0	0	0	0	0	0	0	0	30	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(18,788)	4,695	0	0	0	0	0	0	0	0	0	(14,093)	5
6	Maintenance	0	2,574	0	0	0	0	0	0	0	0	0	2,574	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,031)	10,141	0	0	0	0	0	0	0	0	0	(12,890)	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	(1,462)	39,739	0	0	0	0	0	0	0	0	0	38,277	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):*	(820)	0	0	0	0	0	0	0	0	0	0	(820)	15
16	TOTAL Health Care and Programs	(2,282)	39,739	0	0	0	0	0	0	0	0	0	37,457	16
	C. General Administration													
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	(793,204)	3,900	0	0	0	0	0	0	0	0	(789,304)	19
20	Fees, Subscriptions & Promotions	(243)	187	0	0	0	0	0	0	0	0	0	(56)	20
21	Clerical & General Office Expenses	(27,370)	393,391	0	0	0	0	0	0	0	0	0	366,021	21
22	Employee Benefits & Payroll Taxes	0	72,592	0	0	0	0	0	0	0	0	0	72,592	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,960	0	0	0	0	0	0	0	0	0	5,960	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	2,505	149,421	0	0	0	0	0	0	0	0	151,926	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,613)	(318,569)	153,321	0	(192,861)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,926)	(268,689)	153,321	0	(168,294)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Midway Neurological & Rehabilitation Center # 0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(39,050)	0	194,872	0	0	0	0	0	0	0	0	155,822	30
31	Amortization of Pre-Op. & Org.	0	0	457,401	0	0	0	0	0	0	0	0	457,401	31
32	Interest	2,564,026	0	770,546	0	0	0	0	0	0	0	0	3,334,572	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,177,059)	0	0	0	0	0	0	0	0	(1,177,059)	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	2,524,976	0	245,760	0	2,770,736	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	(3,131)	0	0	0	0	0	0	0	0	0	0	(3,131)	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):*	(325,396)	0	0	0	0	0	0	0	0	0	0	(325,396)	43
44	TOTAL Special Cost Centers	(328,527)	0	0	0	0	0	0	0	0	0	0	(328,527)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,143,523	(268,689)	399,081	0	2,273,915	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 and Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt Co
GELP	33.392%	Belhaven Nursing and Rehab	Chicago	Midway Realty Company		Property Co
A&F Realty	23.965%	West Suburban Nursing and Rehab Center	Bloomington	United RX	Hillside	Pharmacy Co
Joseph Blisko	5%	City View Multicare Center	Cicero			
Joseph Meisels	4.25%	Continental Nursing and Rehab Center	Chicago			
		Forest View Rehab and Nursing Center	Chicago			
		Lakeview Nursing and 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Infinity Healthcare Management of Illinois		\$	\$	1
2	V	2 Food Purchase		Infinity Healthcare Management of Illinois		2,842	2,842	2
3	V	3 Housekeeping		Infinity Healthcare Management of Illinois		30	30	3
4	V	5 Utilities		Infinity Healthcare Management of Illinois		4,695	4,695	4
5	V	6 Maintenance		Infinity Healthcare Management of Illinois		2,574	2,574	5
6	V	10 Nursing	47,482	Infinity Healthcare Management of Illinois		87,221	39,739	6
7	V	17 Administrative		Infinity Healthcare Management of Illinois				7
8	V	19 Professional Fees	797,183	Infinity Healthcare Management of Illinois		3,979	(793,204)	8
9	V	20 Dues & Fees	88	Infinity Healthcare Management of Illinois		275	187	9
10	V	21 Office Expense	93,237	Infinity Healthcare Management of Illinois		486,628	393,391	10
11	V	22 Employee Benefits	1,485	Infinity Healthcare Management of Illinois		74,077	72,592	11
12	V	24 Travel Expenses	2,851	Infinity Healthcare Management of Illinois		8,811	5,960	12
13	V	26 Insurance		Infinity Healthcare Management of Illinois		2,505	2,505	13
14	Total		\$ 942,326			\$ 673,637	\$ * (268,689)	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	30 Depreciation	\$	Infinity Healthcare Management of Illinois		\$		15
16	V	32 Interest		Infinity Healthcare Management of Illinois		8,120	8,120	16
17	V	34 Rent		Infinity Healthcare Management of Illinois		9,294	9,294	17
18	V							18
19	V							19
20	V							20
21	V	19 Professional Fees		Midway Neurological and Rehabilitation Realty		3,900	3,900	21
22	V	26 Insurance		Midway Neurological and Rehabilitation Realty		149,421	149,421	22
23	V	30 Depreciation		Midway Neurological and Rehabilitation Realty		194,872	194,872	23
24	V	31 Amortization		Midway Neurological and Rehabilitation Realty		457,401	457,401	24
25	V	32 Interest		Midway Neurological and Rehabilitation Realty		762,426	762,426	25
26	V	34 Rent	1,186,353	Midway Neurological and Rehabilitation Realty			(1,186,353)	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		\$ 1,186,353			\$ 1,585,434	\$ * 399,081	39

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

Facility Name & ID Number

Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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			Momence Meadows Nursing and Rehab Ctr	Momence				1
2			Niles Nursing and Rehab Center	Niles				2
3			Oak Lawn Respiratory and Rehab Center	Oak Lawn				3
4			Parker Nursing and Rehab Center	Streator				4
5			Parkshore Estates Nursing and Rehab Ctr	Chicago				5
6			Southpoint Nursing and Rehab Center	Chicago				6
7			Landmark of Des Plaines Rehab Center	Des Plaines				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
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26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Midway Neurological & Rehabilitation Cent # 0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 & Rehabilitation Center # 0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Midway Neurological & Rehabilitation Cente # 0047175 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		7	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	\$97,534.00	5/25/15	\$ 23,416,884	\$ 22,236,371	7/1/49	3.4000	\$ 770,546	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$97,534.00		\$ 23,416,884	\$ 22,236,371			\$ 770,546	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 23,416,884	\$ 22,236,371			\$ 770,546	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 149,421 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	726,291	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.)		\$	1,232,766	2
3. Under or (over) accrual (line 2 minus line 1).		\$	506,475	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	565,187	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	1,071,662	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	799,313	8	
	2014	921,323	9	
	2015	953,008	10	
	2016	1,006,349	11	
	2017	1,232,766	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Midway Neurological & Rehabilitation Center 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 2017 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 2017.

(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 Facility</u>	\$ <u>1,232,765.85</u>	\$ <u>1,232,765.85</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,232,765.85</u></u>	\$ <u><u>1,232,765.85</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175 Report Period Beginning:

1/1/18 Ending:

12/31/18

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Land, 950,000. Row 3: TOTALS, 950,000.

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	\$	\$ 1,964,947	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Combined 2005 Building Improvements		2005	323,803	21,587	15	21,587		288,930	9
10	2005 Assets not allowed for increased capital reimbursement		2005	6,291	419	15	419		5,612	10
11										11
12	Combined 2006 Building Improvements		2006	195,836	13,056	15	13,056		170,346	12
13	2006 Assets not allowed for increased capital reimbursement		2006	15,508	1,034	15	1,034		13,490	13
14										14
15	Air Conditioner		2007	10,330	265	39	265		3,179	15
16	Fire Sprinkler		2007	4,775	122	39	122		1,468	16
17	Fire System		2007	1,290	33	39	33		397	17
18	Auto Transfer Switch		2007	838	21	39	21		256	18
19	Video SecurityCameras		2007	3,900	100	39	100		1,200	19
20	Shower Room Tile		2007	9,010	231	39	231		2,772	20
21	Shower Room Tile		2007	3,543	91	39	91		1,091	21
22	Cubicle curtains		2007	4,059	104	39	104		1,249	22
23	Shower Room Tile		2007	5,497	141	39	141		1,692	23
24	Air Conditioner		2007	500	13	39	13		155	24
25	Air Conditioner		2007	500	13	39	13		155	25
26	Signage		2007	1,692	43	39	43		519	26
27	Fire Sprinkler		2007	1,373	35	39	35		422	27
28	Electrical work in reception area		2007	490	13	39	13		153	28
29	Painting - Shower Room		2007	1,000	26	39	26		309	29
30	Painting - Shower Room		2007	2,000	51	39	51		614	30
31	Painting - Shower Room		2007	3,000	77	39	77		923	31
32	Painting - Shower Room		2007	3,000	77	39	77		923	32
33	Toner		2007	13		39			3	33
34	Freezer maint		2007	3,188	82	39	82		982	34
35	Doors		2007	1,595	41	39	41		491	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 & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	\$	\$ 491	37
38	Air Conditioner	2007	500	13	39	13		155	38
39	Locks on Gate	2007	3,509	90	39	90		1,080	39
40	Parking Lot Paving	2007	20,000	513	39	513		6,154	40
41	Parking Lot Paving	2007	21,410	549	39	549		6,587	41
42	Fencing	2007	1,550	40	39	40		478	42
43	Fencing	2007	1,500	38	39	38		460	43
44	Asbestos removal	2007	2,370	61	39	61		730	44
45									45
46	Pump	2008	1,498	38	39	38		421	46
47	Sprinkler Systems	2008	12,457	319	39	319		3,512	47
48	Sprinkler Systems	2008	1,625	42	39	42		460	48
49	Smoke Detector	2008	1,342	34	39	34		377	49
50	Refrigeration	2008	4,250	109	39	109		1,199	50
51	Refrigeration	2008	5,291	136	39	136		1,494	51
52	Refrigeration	2008	3,735	96	39	96		1,054	52
53	Refrigeration	2008	6,950	178	39	178		1,959	53
54	Refrigeration	2008	2,455	63	39	63		693	54
55	Refrigeration	2008	971	25	39	25		274	55
56	Refrigeration	2008	1,678	43	39	43		473	56
57	Refrigeration	2008	2,865	73	39	73		806	57
58	Tiling for Shower room	2008	276	7	39	7		78	58
59	Elevator	2008	1,270	33	39	33		360	59
60	Roof	2008	4,094	105	39	105		1,155	60
61	Fire Doors	2008	2,670	68	39	68		751	61
62	Fire Doors	2008	907	23	39	23		255	62
63	Hot Water Heater	2008	8,875	228	39	228		2,505	63
64	Elevator	2008	3,008	77	39	77		848	64
65	Roof	2008	35,700	915	39	915		10,068	65
66	Brick work on Bldg	2008	17,850	458	39	458		5,036	66
67	Windows	2008	135,000	3,462	39	3,462		38,081	67
68	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		22,563	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,590,229	\$ 242,475		\$ 242,475	\$	\$ 2,572,835	70

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center# 0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18**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	\$	\$ 2,572,835	1
2	Renovation	2008	41,403	1,062	39	1,062		11,679	2
3	CATV wiring	2008	8,000	205	39	205		2,256	3
4	CATV wiring	2008	8,000	205	39	205		2,256	4
5	CATV wiring	2008	16,000	411	39	410	(1)	4,513	5
6									6
7	Alarm System	2009	629	16	39	16		161	7
8	Wiring	2009	6,300	162	39	162		1,616	8
9	Room Signs	2009	5,405	138	39	139	1	1,385	9
10	Brickwork	2009	39,000	1,000	39	1,000		9,998	10
11									11
12	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,062	39	6,062		39,522	12
13	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		32,685	13
14	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		9,566	14
15	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		2,568	15
16	Sewer maintenance and upgrade	2010	3,379	87	39	87		566	16
17	Re-key entire building	2010	12,388	318	39	318		2,072	17
18	New fire doors	2010	30,801	790	39	790		5,150	18
19	Patch & re-roof overhang	2010	3,450	88	39	88		575	19
20	Cabling for nurse call system	2010	2,763	71	39	71		462	20
21	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		43,324	21
22	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		8,131	22
23	Bathroom sink lens	2010	2,741	70	39	70		457	23
24	Insulation of boilers	2010	3,700	95	39	95		619	24
25	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		5,424	25
26	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		2,549	26
27	Drywall & ceiling tile work throughout facility	2010	202,079	5,182	39	5,182		33,783	27
28	New front doors	2010	15,099	387	39	387		2,524	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		9,062	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		8,970	30
31	Air conditioning panels	2010	5,657	145	39	145		945	31
32	Post construction clean up	2010	15,889	407	39	407		2,655	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,980,758	\$ 278,131		\$ 278,131	\$	\$ 2,818,308	34

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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 12B, Carried Forward		\$ 9,980,758	\$ 278,131		\$ 278,131	\$	\$ 2,818,308	1
2	Repair asphalt	2010	2,867	74	39	74		481	2
3	Replace, water supply lines & valves	2010	27,303	700	39	700		4,564	3
4	Drainage pipe	2010	3,056	78	39	78		510	4
5	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	543		3,541	5
6	Repair water heaters	2010	2,830	73	39	73		475	6
7	2010 Assets not allowed for increased capital reimbursement	2010	72,793	1,865	39	1,866	1	12,165	7
8									8
9	Fix Hand Rails and Water Pumps	2011	16,413	421	39	421		3,367	9
10	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	27		214	10
11	Replace Waste Drain and Break	2011	2,950	76	39	76		607	11
12	Install Fire Dampers	2011	6,500	167	39	167		1,335	12
13	Update and Refit Lighting and Fixtures	2011	33,557	860	39	860		6,882	13
14	Replace Stairs	2011	2,990	77	39	77		615	14
15	Install and Updated Cabinets	2011	6,050	154	39	155	1	1,240	15
16	2011 Assets not allowed for increased capital reimbursement	2011	15,706	403	39	403		3,220	16
17									17
18	Replaced IFC-320 and TM-4 controls	2012	9,460	243	39	243		1,703	18
19	Relocate generator panels	2012	1,883	48	39	48		337	19
20	install sprinkler head in elevator shafts	2012	5,973	153	39	153		1,072	20
21	Fire Panel Call, contols, pull & trim outside west stand pipe	2012	5,439	140	39	139	(1)	975	21
22	7.5T Dry AC	2012	2,734	70	39	70		490	22
23	Advantage Carpet Ware	2012	3,290	84	39	84		589	23
24									24
25	Flooring / Tiles / Toilets in 5th floor resident rooms	2013	3,030	78	39	78		1,112	25
26	Wall repair, preparation and cove base in 5th floor res. Rooms	2013	2,811	72	39	72		1,030	26
27	Flooring - for 5th floor resident rooms	2013	5,494	141	39	141		2,014	27
28	Replace roof Exhaust	2013	4,805	123	39	123		1,760	28
29	Elevator	2013	28,000	718	39	718		10,262	29
30	Repair Elevator	2013	3,850	99	39	99		1,412	30
31	Wall repair - 5th floor	2013	3,000	77	39	77		1,100	31
32	Condenser - Kitchen / Barber Shop	2013	1,325	34	39	34		486	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,277,085	\$ 285,729		\$ 285,730	\$ 1	\$ 2,881,866	34

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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 12C, Carried Forward		\$ 10,277,085	\$ 285,729		\$ 285,730	\$ 1	\$ 2,881,866	1
2	Sprinklers	2013	2,825	72	39	72		1,034	2
3	Emergency Generator	2013	4,442	114	39	114		1,628	3
4									4
5	Remove wallpaper, paint wall, cove base 4th floor dining room	2014	2,469	63	39	63		904	5
6	Install door restrictors and door detectors on elevators	2014	3,520	90	39	90		1,289	6
7	Condenser in main boiler room and service roof top units	2014	25,362	650	39	650		9,294	7
8	Install new hydrant and valve in pump room	2014	11,604	298	39	298		4,255	8
9	Rod out kitchen waste line & main branch from nrsg station	2014	3,085	79	39	79		1,130	9
10	Replace 205 linear feet of fence on patio including gate	2014	16,000	410	39	410		5,863	10
11	5 BTU wall units for MDS, Bookkeeping, Rms 206, 318, & 323	2014	7,335	188	39	188		2,688	11
12	Golden teak flooring for hallway and dining room on 1st floor	2014	18,184	466	39	466		6,663	12
13	2 rolls of wall covering for hallway and dining room on 1st flr	2014	2,139	55	39	55		784	13
14	2700 sq ft of plank flooring for hallway and dining 1st floor	2014	2,993	77	39	77		1,098	14
15	Painted seven patient rooms (201, 202, 404, 408, 416, 303, 322)	2014	3,435	88	39	88		1,259	15
16	Install insulation on roof air handler panels and seal roof units	2014	1,975	51	39	51		725	16
17	Tuck pointing and window caulking on entire exterior facility	2014	13,469	345	39	345		4,935	17
18	3rd flr door lock on elevator 2, new infared door detector also	2014	1,650	42	39	42		603	18
19	Paint walls in 536 - 544, 503, & 504; remove therapy closet	2014	29,709	762	39	762		10,889	19
20	Non-Allowable Assets	2014	15,196	390	39	390		5,571	20
21									21
22	Hallway and dining renovation - Paint, flooring, hand rails, and ot	2015	112,702	2,890	39	2,890		11,560	22
23	Flooring for new dining room on 4th floor	2015	3,175	81	39	81		324	23
24	Furnish & Install New Flooring on 1st Floor	2015	2,993	77	39	77		308	24
25	Remove old flooring, toilets, and countertops and install new blind	2015	6,391	164	39	164		656	25
26	Remove wall for dining room and install light fixtures	2015	5,585	143	39	143		572	26
27	Handrails, wall coverings, signage, and blinds	2015	35,470	909	39	909		3,636	27
28	Elevator panel, elevator hand railing	2015	11,000	282	39	282		1,128	28
29	Replace 4th floor electrical wiring	2015	7,900	203	39	203		812	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,627,692	\$ 294,718		\$ 294,719	\$ 1	\$ 2,961,474	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		\$ 294,719	\$ 1	\$ 2,961,474	1
2	Replace U-bends on boiler	2015	2,800	72	39	72		288	2
3	Plumbing - Sink faucet handles	2015	6,965	179	39	179		716	3
4	Install flooring and corner guards on 1st floor	2015	3,660	94	39	94		376	4
5	Replace U-bends on boiler	2015	3,268	84	39	84		336	5
6	Remove flooring and install new floor on 5th floor	2015	2,857	73	39	73		292	6
7	Steel door	2015	4,423	113	39	113		452	7
8	Replace Tiles, Cove Base, Cabinets & Floor in Therapy Rm	2015	7,872	202	39	202		808	8
9	New lock systems	2015	21,204	544	39	544		2,176	9
10	Smoking shelter	2015	4,875	125	39	125		500	10
11	Parking lot paving	2015	38,634	991	39	991		3,964	11
12	New lock systems	2015	4,575	117	39	117		468	12
13	Patient room doors	2015	2,900	74	39	74		296	13
14	Granite tops for dining room	2015	3,400	87	39	87		348	14
15	New door	2015	2,000	51	39	51		204	15
16	Replace laundry outside doors	2015	1,400	36	39	36		144	16
17	Replace laundry outside doors	2015	2,147	55	39	55		220	17
18	Air conditioning unit	2015	2,975	76	39	76		304	18
19	Pit ladders for elevator	2015	3,400	87	39	87		348	19
20									20
21	Light Pole Brackets	2016	3,600	92	39	92		276	21
22	Replace Laundry MLB Panel	2016	4,700	121	39	121		363	22
23	Flooring & Painting, double doors on 2nd and 3rd floors,	2016	17,480	448	39	448		1,344	23
24	2nd floor stairwell door, 4th floor dining room walls and								24
25	cove base								25
26	Replace HVAC	2016	2,950	76	39	76		228	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,775,777	\$ 298,515		\$ 298,516	\$ 1	\$ 2,975,925	34

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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 12E, Carried Forward		\$ 10,775,777	\$ 298,515		\$ 298,516	\$ 1	\$ 2,975,925	1
2	Mural for 4th Floor Alzheimer Unit	2017	3,600	92	39	92		138	2
3	Air Conditioners	2017	2,950	76	39	76		114	3
4	New Roof for Upper Main Roof	2017	23,350	599	39	599		898	4
5	Air Conditioners	2017	2,950	76	39	76		114	5
6	New Condensor for AC Unit in Beauty Supply Room	2017	29,950	768	39	768		1,152	6
7	Replace Car Sills for Four Elevators	2017	3,120	80	39	80		120	7
8	New Air Conditioners	2017	2,950	76	39	76		114	8
9	New Heating Boilers for Mezzanine Area	2017	34,260	878	39	878		1,317	9
10	New Domestic Hot Water System	2017	48,520	1,244	39	1,244		1,866	10
11									11
12	Replace light fixtures & repair heater room 435	2018	4,055	52	39	52		52	12
13	Main control circuit board for generator	2018	3,045	39	39	39		39	13
14	Air Conditioners in patient rooms	2018	2,950	38	39	38		38	14
15	Restoration of nurse call station on 3rd floor	2018	3,161	41	39	41	(1)	41	15
16	Custom modify louver windows in kitchen	2018	2,500	32	39	32		32	16
17	new shelving for freezers	2018	4,183	54	39	54	(1)	54	17
18	Paint 4th floor corridor & dining room	2018	3,995	51	39	51		51	18
19	Paint 3rd floor corridor & doors	2018	3,995	51	39	51		51	19
20	New Air Conditioners in patient rooms	2018	3,020	39	39	39	(1)	39	20
21	1st 4th 5th floor smoke compartments into compliance	2018	8,287	106	39	106		106	21
22	Replace jockey pump for sprinkler system	2018	8,900	114	39	114		114	22
23	Replace fire sprinkler heads in laundry chute	2018	2,820	36	39	36		36	23
24	New Air Conditioners in patient rooms	2018	3,720	48	39	48	(1)	48	24
25	New flooring for administrator office	2018	2,639	34	39	34		34	25
26	New Air Conditioners in patient rooms	2018	3,020	39	39	39	(1)	39	26
27	New motor for 1st floor exhaust fan	2018	3,999	51	39	52	1	51	27
28	Cubicle curtains in patient rooms	2018	15,516	199	39	199		199	28
29	New doors for linen chute & rubbish chute doors	2018	6,937	89	39	89		89	29
30	New hopper door for linen chute	2018	3,788	49	39	49	(1)	49	30
31	New LVT flooring for admin office and conference room	2018	4,527	58	39	58		58	31
32	New Air Conditioners in patient rooms	2018	3,020	39	39	39	(1)	39	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,025,504	\$ 303,663		\$ 303,661	\$ (2)	\$ 2,983,017	34

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

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 11,025,504	\$ 303,663		\$ 303,661	\$ (2)	\$ 2,983,017	1
2	New computer wiring for building	2018	8,880	114	39	114		114	2
3	New emergency shutoff valve for boilers on 5th floor	2018	2,610	33	39	34	1	33	3
4	Patch for field or wall flashings for the roof	2018	6,900	88	39	89	1	88	4
5	Labor to install new lvt flooring in admin office and conference room	2018	1,777	23	39	23		23	5
6	New LVT flooring in admin office and conference room	2018	1,378	18	39	18	(1)	18	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	TOTAL (lines 1 thru 33)		\$ 11,047,049	\$ 303,939		\$ 303,938	\$ (2)	\$ 2,983,293	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	\$	\$	\$	\$	5	\$	71
72	Current Year Purchases	48,602	48,602	9,720	(38,882)	5	48,602	72
73	Fully Depreciated Assets	4,629,102				5	4,629,102	73
74								74
75	TOTALS	\$ 4,677,704	\$ 48,602	\$ 9,720	\$ (38,882)		\$ 4,677,704	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)	\$ 16,674,753	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 352,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,658	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,883)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,660,997	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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	\$	8,396	\$ 535,916	\$	8,396	\$ 535,916	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,359	25,612		1,359	25,612	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		9,387	472,799		9,387	472,799	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				146,298		146,298	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Ray & Lab</u>	39-2					5,555		5,555	12
13	Other (specify):									13
14	TOTAL			\$	19,142	\$ 1,034,327	\$ 151,853	19,142	\$ 1,186,180	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 & Rehabilitation Center

0047175

Report Period Beginning: 1/1/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(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	\$ (94,519)	\$ 119,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,117,526	2,117,526	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	528,952	528,952	6
7	Other Prepaid Expenses	230,835	230,835	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow Accounts</u>	2,521,213	2,746,207	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,304,007	\$ 5,743,500	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	3,447,047	3,447,047	15
16	Equipment, at Historical Cost	1,088,715	4,677,705	16
17	Accumulated Depreciation (book methods)	(2,107,059)	(7,660,996)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	103,820	7,196,852	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(43,170)	(6,826,589)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Replacement reserves</u>	626,200	626,200	22
23	Other(specify): <u>LT Escrows</u>		1,107,112	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,115,553	\$ 11,117,331	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,419,560	\$ 16,860,831	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,573,864	\$ 12,879,922	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(63,031)	(63,031)	28
29	Short-Term Notes Payable		420,884	29
30	Accrued Salaries Payable	483,808	483,808	30
31	Accrued Taxes Payable (excluding real estate taxes)	109,257	109,257	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		63,004	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Settlement Reserves / LOC</u>	(21,446,679)	(21,446,679)	36
37	<u>RP Loan / Working Capital</u>	(3,236,971)	(2,550,171)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (11,579,752)	\$ (10,103,006)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		21,815,787	39
40	Mortgage Payable			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)	\$	\$ 21,815,787	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (11,579,752)	\$ 11,712,781	46
47	TOTAL EQUITY(page 18, line 24)	\$ 19,999,312	\$ 5,148,050	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,419,560	\$ 16,860,831	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,996,368	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,996,368	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,003,404	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	(3,000,462)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 5,002,944	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)	\$ 19,999,312	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Midway Neurological & Rehabilitation Center

0047175

Report Period Beginning: 1/1/18

Ending: 12/31/18

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,474,780	1
2	Discounts and Allowances for all Levels	1,162,239	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 22,637,019	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	645,586	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 645,586	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	69,952	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,152	19
20	Radiology and X-Ray	2,670	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75,774	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	143,736	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 143,736	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Revenue	30,069	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,069	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,532,184	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,114,149	31
32	Health Care	7,482,916	32
33	General Administration	3,729,142	33
B. Capital Expense			
34	Ownership	(262,169)	34
C. Ancillary Expense			
35	Special Cost Centers	151,853	35
36	Provider Participation Fee	987,493	36
D. Other Expenses (specify):			
37	Bad Debt Expense	325,396	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,528,780	40
41	Income before Income Taxes (line 30 minus line 40)**	8,003,404	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,003,404	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 20,133,035	44
45	Private Pay - Net Inpatient Revenue	67,155	45
46	Medicare - Net Inpatient Revenue	1,743,067	46
47	Other-(specify)	693,762	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 22,637,019	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 & Rehabilitation Center

0047175

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	2,317	2,482	\$ 138,644	\$ 55.86	1
2	Assistant Director of Nursing	11,079	12,156	448,462	36.89	2
3	Registered Nurses	11,235	12,113	405,609	33.49	3
4	Licensed Practical Nurses	58,917	64,316	2,241,652	34.85	4
5	CNAs & Orderlies	80,154	88,953	1,522,378	17.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	21,409	23,589	462,690	19.61	9
10	Activity Assistants					10
11	Social Service Workers	25,871	27,372	493,398	18.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,189	46,430	665,005	14.32	15
16	Dishwashers					16
17	Maintenance Workers	15,424	16,793	277,861	16.55	17
18	Housekeepers	24,733	26,654	347,092	13.02	18
19	Laundry	4,393	4,691	72,893	15.54	19
20	Administrator	4,249	4,424	234,248	52.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,679	13,104	199,450	15.22	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	2,852	3,077	56,022	18.21	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	3,853	4,239	96,461	22.76	33
34	TOTAL (lines 1 - 33)	320,354	350,393	\$ 7,661,865 *	\$ 21.87	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	\$ 19,476	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,348	47,169	10-3	38
39	Pharmacist Consultant	767	38,331	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	(851)	(42,572)	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	100	3,510	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,920	\$ 65,914		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. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Angie Ramirez</u>	<u>Administrator</u>		\$ <u>50,457</u>	<u>Workers' Compensation Insurance</u>	\$ <u>333,623</u>	<u>IDPH License Fee</u>	\$ _____	
<u>Michael Brown</u>	<u>Administrator</u>		<u>161,370</u>	<u>Unemployment Compensation Insurance</u>	<u>17,507</u>	<u>Advertising: Employee Recruitment</u>	_____	
<u>Hamed Ishola</u>	<u>Administrator</u>		<u>22,421</u>	<u>FICA Taxes</u>	<u>598,380</u>	<u>Health Care Worker Background Check</u>	_____	
				<u>Employee Health Insurance</u>	<u>429,772</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>IHCA</u>	<u>3,587</u>	
				<u>Uniform Expense</u>	<u>7,624</u>	<u>IDPH</u>	<u>1,990</u>	
				<u>Employee Background Checks</u>	<u>1,565</u>	<u>Village of Bridgeview</u>	<u>988</u>	
				<u>Pension</u>	<u>32,234</u>	<u>CMS</u>	<u>569</u>	
				<u>Employee Expense</u>	<u>13,758</u>	<u>Various</u>	<u>2,178</u>	
						<u>Less: Public Relations Expense</u>	(_____)	
						<u>Non-allowable advertising</u>	(_____)	
						<u>Yellow page advertising</u>	(_____)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>234,248</u>	TOTAL (agree to Schedule V, line 22, col.8)		\$ <u>9,312</u>		
(List each licensed administrator separately.)								
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			\$ _____	Description	Line #	Amount	Description	Amount
						\$ _____	<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	
							<u>Mileage</u>	<u>20,412</u>
							<u>Auto Allowance</u>	<u>5,960</u>
							<u>Seminar Expense</u>	
							<u>Education & Seminars</u>	<u>654</u>
							<u>Entertainment Expense</u>	(_____)
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services			Amount					
Vendor/Payee	Type		\$ _____					
<u>Bradley Associates</u>	<u>Accounting</u>		<u>12,220</u>					
<u>US Department of Education</u>	<u>Legal</u>		<u>34,544</u>					
<u>Abbey Road Tax Consultants</u>	<u>Legal</u>		<u>16,383</u>					
<u>Various</u>	<u>Legal</u>		<u>217</u>					
<u>Infinity Funding/Sedgwick</u>	<u>Legal</u>		<u>169,770</u>					
<u>MTS Consulting</u>	<u>Professional</u>		<u>(5,615)</u>					
<u>Abbey Road Tax Consultants</u>	<u>Professional</u>		<u>16,383</u>					
<u>Various</u>	<u>Professional</u>		<u>5,836</u>					
<u>Infinity Healthcare Mgmt</u>	<u>Professional/Mgmt</u>		<u>774,440</u>					
<u>Empire Risk Management</u>	<u>Mgmt</u>		<u>12,925</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>1,037,103</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

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. IHCA - \$3,587
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 78,830 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. \$ 987,493
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - 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