FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0047175

Facility Name: MIDWAY NEUROLOGICAL/REHABILITATION CENTER

Address: 8540 SOUTH HARLEM AVENUE (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (708) 598-2605 **Fax #** (708) 595-5671

HFS ID Number:

Date of Initial License for Current Owners: 4/1/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANT'S COMPILATION REPORT (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	103,953	2,095	11,019	117,067	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	103,953	2,095	11,019	117,067	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.39%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 404 and days of care provided 8,939

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITA # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	500,284	51,773	15,000	567,057		567,057	(4,638)	562,419			1
2	Food Purchase		515,242		515,242		515,242	(940)	514,302			2
3	Housekeeping	480,611	64,029		544,640		544,640		544,640			3
4	Laundry	60,793	25,683		86,476		86,476		86,476			4
5	Heat and Other Utilities			389,614	389,614		389,614	485	390,099			5
6	Maintenance	142,149	11,669	169,474	323,292		323,292	(2,389)	320,903			6
7	Other (specify):*											7
8	TOTAL General Services	1,183,837	668,396	574,088	2,426,321		2,426,321	(7,482)	2,418,839			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	4,191,086	527,707	40,050	4,758,843		4,758,843	(9,015)	4,749,828			10
10a	Therapy			651,051	651,051		651,051		651,051			10a
11	Activities	276,455	60,627		337,082		337,082		337,082			11
12	Social Services	306,110		4,530	310,640		310,640		310,640			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* PHARMACY CONS.			17,670	17,670		17,670		17,670			15
16	TOTAL Health Care and Programs	4,773,651	588,334	743,301	6,105,286		6,105,286	(9,015)	6,096,271			16
	C. General Administration											
17	Administrative	189,877			189,877		189,877	(80,034)	109,843			17
18	Directors Fees											18
19	Professional Services			320,991	320,991		320,991	(287,479)	33,512			19
20	Dues, Fees, Subscriptions & Promotions			3,973	3,973		3,973	25	3,998			20
21	Clerical & General Office Expenses	251,079	100,673	26,190	377,942		377,942	108,808	486,750			21
22	Employee Benefits & Payroll Taxes			1,090,504	1,090,504		1,090,504	8,177	1,098,681			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,744	13,744		13,744	(10,044)	3,700			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			347,293	347,293		347,293	97,706	444,999			26
27	Other (specify):*											27
28	TOTAL General Administration	440,956	100,673	1,802,695	2,344,324		2,344,324	(162,841)	2,181,483			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,398,444	1,357,403	3,120,084	10,875,931		10,875,931	(179,338)	10,696,593			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTE #0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			199,778	199,778		199,778	614,205	813,983			30
31	Amortization of Pre-Op. & Org.			2,878	2,878		2,878	522,132	525,010			31
32	Interest			91,433	91,433		91,433	1,101,809	1,193,242			32
33	Real Estate Taxes							706,288	706,288			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,386,099)	13,901			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			4,778	4,778		4,778		4,778			36
37	TOTAL Ownership			2,698,867	2,698,867		2,698,867	558,335	3,257,202			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		436,186		436,186		436,186		436,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,190	221,190		221,190		221,190			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		436,186	221,190	657,376		657,376		657,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,398,444	1,793,589	6,040,141	14,232,174		14,232,174	378,997	14,611,171			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CEN' # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	12,194	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,473)	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	(39,205)	ARIOUS		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,575)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	430,572	VARIOUS	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 430,572		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 378,997		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
MIDWAY NEUROLOGICAL/REHABILITATION CENTER
ID# 0047175
Report Period Beginning: 1/1/2011
Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COMMUTING	$ (10,562)	24	1
2	VENDING INCOME	(2,057)	6	2
3	DIETARY MISC.	(128)	1	3
4	PROF. SERVICES MISC.	(1,260)	19	4
5	WORK COMP MISC.	(490)	22	5
6	MEDICAL RECORDS MISC.	(2,006)	10	6
7	ADMIN MISC.	(34)	17	7
8	OFFICE MISC.	(22,668)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(39,205)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTE # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	(219)	(4,419)	0	0	0	0	0	0	0	0	0	(4,638)	1
2	Food Purchase	0	(940)	0	0	0	0	0	0	0	0	0	(940)	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	485	0	0	0	0	0	0	0	0	0	485	5
6	Maintenance	(2,057)	(332)	0	0	0	0	0	0	0	0	0	(2,389)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,276)	(5,206)	0	0	0	0	0	0	0	0	0	(7,482)	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	(2,006)	(7,009)	0	0	0	0	0	0	0	0	0	(9,015)	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**	(2,006)	(7,009)	0	0	0	0	0	0	0	0	0	(9,015)	16
	C. General Administration													
17	Administrative	(34)	(80,000)	0	0	0	0	0	0	0	0	0	(80,034)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,260)	(297,719)	11,500	0	0	0	0	0	0	0	0	(287,479)	19
20	Fees, Subscriptions & Promotions	0	0	25	0	0	0	0	0	0	0	0	25	20
21	Clerical & General Office Expenses	(47,141)	155,929	20	0	0	0	0	0	0	0	0	108,808	21
22	Employee Benefits & Payroll Taxes	(490)	8,667	0	0	0	0	0	0	0	0	0	8,177	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,562)	518	0	0	0	0	0	0	0	0	0	(10,044)	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	476	97,230	0	0	0	0	0	0	0	0	97,706	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(59,487)	(212,129)	108,775	0	0	0	0	0	0	0	0	(162,841)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,769)	(224,344)	108,775	0	0	0	0	0	0	0	0	(179,338)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTI # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	12,194	0	602,011	0	0	0	0	0	0	0	0	614,205	30
31	Amortization of Pre-Op. & Org.	0	0	522,132	0	0	0	0	0	0	0	0	522,132	31
32	Interest	0	0	1,101,809	0	0	0	0	0	0	0	0	1,101,809	32
33	Real Estate Taxes	0	0	706,288	0	0	0	0	0	0	0	0	706,288	33
34	Rent-Facility & Grounds	0	(2,386,099)	0	0	0	0	0	0	0	0	0	(2,386,099)	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	12,194	(2,386,099)	2,932,240	0	0	0	0	0	0	0	0	558,335	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,575)	(2,610,443)	3,041,015	0	0	0	0	0	0	0	0	378,997	45

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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
SEE ATTACHMENT #1						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 15,000	INFINITY MANAGEMENT		$ 10,581	$ (4,419)	1
2	V	2	FOOD	940	INFINITY MANAGEMENT			(940)	2
3	V	5	UTILITIES	73	INFINITY MANAGEMENT		558	485	3
4	V	6	MAINTENANCE	1,200	INFINITY MANAGEMENT		868	(332)	4
5	V	10	NURSING	53,200	INFINITY MANAGEMENT		46,191	(7,009)	5
6	V	17	ADMINISTRATOR	80,000	INFINITY MANAGEMENT			(80,000)	6
7	V	19	PROFESSIONAL FEES	298,000	INFINITY MANAGEMENT		281	(297,719)	7
8	V	21	OFFICE	67,650	INFINITY MANAGEMENT		223,579	155,929	8
9	V	22	BENEFITS	1,917	INFINITY MANAGEMENT		10,584	8,667	9
10	V	24	TRAVEL	29	INFINITY MANAGEMENT		547	518	10
11	V	26	INSURANCE		INFINITY MANAGEMENT		476	476	11
12	V	34	RENT		INFINITY MANAGEMENT		13,901	13,901	12
13	V	34	RENT	2,400,000	MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC			(2,400,000)	13
14	Total			$ 2,918,009			$ 307,566	$ * (2,610,443)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OTHER ADMIN EXP	$	MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		$ 20	$ 20	15
16	V	30	DEPRECIATION		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		602,011	602,011	16
17	V	20	LICENSES & FEES		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		25	25	17
18	V	33	REAL ESTATE TAXES		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		706,288	706,288	18
19	V	26	LIABILITY INSURANCE		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		97,230	97,230	19
20	V	32	INTEREST		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		1,101,809	1,101,809	20
21	V	19	PROFESSIONAL FEES		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		11,500	11,500	21
22	V	31	AMORTIZATION		MIDWAY NEUROLOGICAL AND REHAB REALTY, LLC		522,132	522,132	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			$			$ 3,041,015	$ * 3,041,015	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	27.823%
MOISHE GUBIN	27.822%
JOSEPH & RIKA MEISELS	4.250%
MARTY LOEB	5.000%
JOSEPH BLISKO	5.000%
TEVI MINDICK	5.000%
HOWARD N. SUSS	3.925%
A&F GENERAL PARTNERSHIP	21.180%
	100.000%

OTHER RELATED BUSINESS ENTITIES

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

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILIT # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CEN # 0047175 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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 [X]

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITA # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PRUDENTIAL FINANCIAL		X	MORTGAGE OF FACILITY	$95,507.00	11/30/07	$ 17,255,000	$ 16,564,629	10/31/37	5.7500	$ 958,364	1
2	3G		X	FINANCING	INTEREST ON	11/30/07	2,400,000	1,600,000	10/31/17	9.0000	144,000	2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL	NONE	4/24/09	3,000,000	2,970,000	7/16/12	VARIOUS	91,433	6
7												7
8												8
9	TOTAL Facility Related				$95,507.00		$ 22,655,000	$ 21,134,629			$ 1,193,797	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 22,655,000	$ 21,134,629			$ 1,193,797	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	492,208	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.)	$	636,451	2
3. Under or (over) accrual (line 2 minus line 1).	$	144,243	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$	562,045	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.	$	706,288	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	456,275	8
2007	462,092	9
2008	504,542	10
2009	592,327	11
2010	636,451	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MIDWAY NEUROLOGICAL/REHABILITATION CENTE 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-403-013-0000	NURSING FACILITY	$ 636,451.28	$ 636,451.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 636,451.28	$ 636,451.28

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 1/1/2011 Ending: 12/31/2011

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 43,170
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 2,878
4. Dates Incurred: 4/5/09 - 12/09

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		2007	$ 950,000	1
2					2
3	TOTALS			$ 950,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	404		2009		$ 7,600,000	$ 194,868	39	$ 194,872	$ 4	$ 795,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Combined 2005 Building Improvements			2005	323,803	21,587	15	21,587		151,108	9
10											10
11	Combined 2006 Building Improvements			2006	195,836	13,056	15	13,056		78,334	11
12											12
13	Air Conditioner			2007	10,330	265	39	265		1,324	13
14	Fire Sprinkler			2007	4,775	122	39	122		612	14
15	Fire System			2007	1,290	33	39	33		165	15
16	Auto Transfer Switch			2007	838	21	39	21		107	16
17	Video SecurityCameras			2007	3,900	100	39	100		500	17
18	Shower Room Tile			2007	9,010	231	39	231		1,155	18
19	Shower Room Tile			2007	3,543	91	39	91		454	19
20	Cubicle curtains			2007	4,059	104	39	104		520	20
21	Shower Room Tile			2007	5,497	141	39	141		705	21
22	Air Conditioner			2007	500	13	39	13		64	22
23	Air Conditioner			2007	500	13	39	13		64	23
24	Signage			2007	1,692	43	39	43		217	24
25	Fire Sprinkler			2007	1,373	35	39	35		176	25
26	Electrical work in reception area			2007	490	13	39	13		63	26
27	Painting - Shower Room			2007	1,000	26	39	26		128	27
28	Painting - Shower Room			2007	2,000	51	39	51		256	28
29	Painting - Shower Room			2007	3,000	77	39	77		385	29
30	Painting - Shower Room			2007	3,000	77	39	77		385	30
31	Toner			2007	13		39				31
32	Freezer maint			2007	3,188	82	39	82		409	32
33	Doors			2007	1,595	41	39	41		204	33
34	Doors			2007	1,595	41	39	41		204	34
35	Air Conditioner			2007	500	13	39	13		64	35
36	Locks on Gate			2007	3,509	90	39	90		450	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	
37	Parking Lot Paving	2007	$ 20,000	$ 513	39	$ 513	$	$ 2,565	37
38	Parking Lot Paving	2007	21,410	549	39	549		2,745	38
39	Fencing	2007	1,550	40	39	40		200	39
40	Fencing	2007	1,500	38	39	38		190	40
41	Asbestos removal	2007	2,370	61	39	61		305	41
42					39				42
43	Pump	2008	1,498	38	39	38		152	43
44	Sprinkler Systems	2008	12,457	319	39	319		1,276	44
45	Sprinkler Systems	2008	1,625	42	39	42		168	45
46	Smoke Detector	2008	1,342	34	39	34		136	46
47	Refrigeration	2008	4,250	109	39	109		436	47
48	Refrigeration	2008	5,291	136	39	136		544	48
49	Refrigeration	2008	3,735	96	39	96		384	49
50	Refrigeration	2008	6,950	178	39	178		712	50
51	Refrigeration	2008	2,455	63	39	63		252	51
52	Refrigeration	2008	971	25	39	25		100	52
53	Refrigeration	2008	1,678	43	39	43		172	53
54	Refrigeration	2008	2,865	73	39	73		292	54
55	Tiling for Shower room	2008	276	7	39	7		28	55
56	Elevator	2008	1,270	33	39	33		132	56
57	Roof	2008	4,094	105	39	105		420	57
58	Fire Doors	2008	2,670	68	39	68		272	58
59	Fire Doors	2008	907	23	39	23		92	59
60	Hot Water Heater	2008	8,875	228	39	228		912	60
61	Elevator	2008	3,008	77	39	77		308	61
62	Roof	2008	35,700	915	39	915		3,660	62
63	Brick work on Bldg	2008	17,850	458	39	458		1,832	63
64	Windows	2008	135,000	3,462	39	3,462		13,848	64
65	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		8,204	65
66	Renovation	2008	41,403	1,062	39	1,062		4,248	66
67	CATV wiring	2008	8,000	205	39	205		820	67
68	CATV wiring	2008	8,000	205	39	205		820	68
69	CATV wiring	2008	16,000	410	39	410		1,640	69
70	TOTAL (lines 4 thru 69)		$ 8,641,833	$ 242,899		$ 242,903	$ 4	$ 1,081,648	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 12A, Carried Forward		$ 8,641,833	$ 242,899		$ 242,903	$ 4	$ 1,081,648	1
2	Alarm System	2009	629	16	39	16	(0)	48	2
3	Wiring	2009	6,300	162	39	162	0	486	3
4	Room Signs	2009	5,405	139	39	139	0	417	4
5	Nurse Call Light System	2009	8,721	224	39	224	0	672	5
6	Brickwork	2009	39,000	1,000	39	1,000		3,000	6
7									7
8	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,062	39	6,062		12,123	8
9	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		10,027	9
10	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		2,935	10
11	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		788	11
12									12
13	Sewer maintenance and upgrade	2010	3,379	87	39	87		173	13
14	Re-key entire building	2010	12,388	318	39	318		635	14
15	New fire doors	2010	30,801	790	39	790		1,580	15
16									16
17	Patch & re-roof overhang	2010	3,450	88	39	88		177	17
18	Cabling for nurse call system	2010	2,763	71	39	71		142	18
19	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		13,290	19
20	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		2,494	20
21	Bathroom sink lens	2010	2,741	70	39	70		141	21
22									22
23	Insulation of boilers	2010	3,700	95	39	95		190	23
24	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		1,664	24
25	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		782	25
26	Drywall & ceiling tile work throughout facility	2010	202,079	5,182	39	5,182		10,363	26
27									27
28	New front doors	2010	15,099	387	39	387		774	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		2,779	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		2,751	30
31					39				31
32					39				32
33					39				33
34	TOTAL (lines 1 thru 33)		$ 9,946,134	$ 276,343		$ 276,348	$ 5	$ 1,150,078	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 12B, Carried Forward		$ 9,946,134	$ 276,343		$ 276,348	$ 5	$ 1,150,078	1
2	Air conditioning panels	2010	5,657	145	39	60	(85)	120	2
3	Post construction clean up	2010	15,889	407	39	12	(395)	24	3
4									4
5	Repair asphalt	2010	2,867	74	39	48	(26)	96	5
6	Replace, water supply lines & valves	2010	27,303	700	39	15	(685)	30	6
7	Drainage pipe	2010	3,056	78	39	50	(28)	100	7
8	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	41	(502)	82	8
9	Repair water heaters	2010	2,830	73	39	21	(52)	42	9
10									10
11									11
12	Fix Hand Rails and Water Pumps	2011	19,243	493	39	435	(58)	870	12
13	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	233	206	466	13
14	Replace Waste Drain and Break	2011	2,950	76	39	69	(7)	138	14
15	Install Fire Dampers	2011	6,500	167	39	139	(28)	278	15
16	Update and Refit Lighting and Fixtures	2011	33,557	860	39	645	(215)	1,290	16
17	Replace Stairs	2011	2,990	77	39	77	0	154	17
18	Install and Updated Cabinets	2011	6,050	155	39	139	(16)	278	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)		$ 10,097,244	$ 280,217		$ 278,332	$ (1,885)	$ 1,154,046	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,284,332	$ 412,422	$ 522,367	$ 109,945	5	$ 1,878,466	71
72	Current Year Purchases	105,722	105,722	13,284	(92,438)	5	105,722	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,390,054	$ 518,144	$ 535,651	$ 17,507		$ 1,984,188	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)	$ 14,437,298	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 798,361	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 813,983	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,622	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,138,234	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTI # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	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	$		$ 267,424	$		$ 267,424	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			160,845			160,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			222,788			222,788	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 prescrpts				422,787		422,787	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology & Lab	39-2					13,399		13,399	13
14	TOTAL			$		$ 651,057	$ 436,186		$ 1,087,243	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTI # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (112,620)	$ 79,805	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,634,264	6,746,547	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145,351	145,351	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,666,995	$ 6,971,703	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		950,000	13
14	Buildings, at Historical Cost		7,600,000	14
15	Leasehold Improvements, at Historical Cost	2,593,690	2,593,690	15
16	Equipment, at Historical Cost	521,257	3,371,257	16
17	Accumulated Depreciation (book methods)	(891,919)	(3,153,356)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,875,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,531)	(2,161,579)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Security Deposit**	21,367	21,367	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,258,034	$ 17,096,565	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,925,029	$ 24,068,268	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 816,802	$ 1,116,802	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	404,673	404,672	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	574,381	574,381	36
37	Working Capital	2,970,000	2,970,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,765,856	$ 5,065,855	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,164,629	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)**	$	$ 18,164,629	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,765,856	$ 23,230,484	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,159,173	$ 837,784	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,925,029	$ 24,068,268	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,813,469	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,813,469	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,945,706	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	(600,002)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,345,704	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)**	$ 4,159,173	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,351,644	1
2	Discounts and Allowances for all Levels	(847,947)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,503,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,204,684	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,204,684	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	424,941	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,632	19
20	Radiology and X-Ray	3,969	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 452,542	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	2,057	28
28a	Miscellaneous Revenue	14,900	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,957	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,177,880	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,456,321	31
32	Health Care	6,075,286	32
33	General Administration	2,344,324	33
	B. Capital Expense		
34	Ownership	2,698,867	34
	C. Ancillary Expense		
35	Special Cost Centers	436,186	35
36	Provider Participation Fee	221,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,232,174	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,945,706	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,945,706	43

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

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

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

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTE # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,817	1,982	$ 90,899	$ 45.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,107	20,592	652,578	31.69	3
4	Licensed Practical Nurses	65,246	70,315	1,936,294	27.54	4
5	CNAs & Orderlies	114,548	124,348	1,366,457	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,968	3,221	35,129	10.91	8
9	Activity Director	20,021	22,367	276,455	12.36	9
10	Activity Assistants					10
11	Social Service Workers	16,466	17,578	306,110	17.41	11
12	Dietician	40,997	45,254	500,283	11.06	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,153	8,683	142,149	16.37	17
18	Housekeepers	43,507	47,791	480,611	10.06	18
19	Laundry	4,724	5,935	60,793	10.24	19
20	Administrator	2,792	3,012	189,877	63.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,929	16,118	251,079	15.58	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	7,187	7,849	109,730	13.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	361,462	395,045	$ 6,398,444 *	$ 16.20	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	801	40,050	10-3	38
39	Pharmacist Consultant	353	17,670	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	129	4,530	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,712	$ 77,250		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomeka Brown	Admin	0	$ 12,790
Rick Eugene	Admin	0	24,966
Karla Ismay	Admin	0	7,875
Konstantine Stavropoulos	Admin	0	144,246
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 189,877

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bradley & Associates	Accounting	$ 16,241
Johnson, Goldber, & Brown	Accounting	5,000
Swanson, Martin, Bell	legal	116
Infinity Healthcare Management	Mgmt. Co.	299,634
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 320,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,632
Unemployment Compensation Insurance	
FICA Taxes	471,080
Employee Health Insurance	204,659
Employee Meals	73,878
Illinois Municipal Retirement Fund (IMRF)*	
SUTA	173,890
FUTA	20,865
UNIFORM EXPENS	10,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,088,644

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,015
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Village of Bridgeview	1,290
Cook County	218
CLIA Laboratory	150
State Fire Marshall	300
Filing Fees	25
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,998

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,199
Seminar Expense	1,954
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,153

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CEN # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHABILITATION CENTER # 0047175 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **90,754** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **221,190**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees