FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0047175

Facility Name: MIDWAY NEUROLOGICAL/REHAB CTR

Address: 8540 S HARLEM AVE (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: Alan Sorscher **Telephone Number:** 708-449-1900
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 1/1/13 to 12/31/13 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) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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**

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	109,255	881	7,870	118,006	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	109,255	881	7,870	118,006	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.03%

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 6,452

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	576,105	54,730	17,945	648,780		648,780	(7,002)	641,778			1
2	Food Purchase		502,302		502,302		502,302	455	502,757			2
3	Housekeeping	532,554	68,568		601,122		601,122		601,122			3
4	Laundry	57,874	41,717		99,591		99,591		99,591			4
5	Heat and Other Utilities			330,400	330,400		330,400	1,707	332,107			5
6	Maintenance	145,799	8,286	200,622	354,707		354,707	2,100	356,807			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,312,332	675,603	548,967	2,536,902		2,536,902	(2,740)	2,534,162			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,769,459	530,178	54,211	5,353,848		5,353,848	(3,704)	5,350,144			10
10a	Therapy			799,780	799,780		799,780		799,780			10a
11	Activities	389,405	97,275		486,680		486,680		486,680			11
12	Social Services	328,033		7,445	335,478		335,478		335,478			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Pharmacy Consultant**			32,972	32,972		32,972		32,972			15
16	**TOTAL Health Care and Programs**	5,486,897	627,453	930,408	7,044,758		7,044,758	(3,704)	7,041,054			16
	C. General Administration											
17	Administrative	161,990			161,990		161,990	(20,000)	141,990			17
18	Directors Fees											18
19	Professional Services			503,681	503,681		503,681	(198,639)	305,042			19
20	Dues, Fees, Subscriptions & Promotions			29,175	29,175		29,175		29,175			20
21	Clerical & General Office Expenses	315,315	161,279	41,197	517,791		517,791	(79,401)	438,390			21
22	Employee Benefits & Payroll Taxes			1,300,994	1,300,994		1,300,994	28,734	1,329,728			22
23	Inservice Training & Education											23
24	Travel and Seminar			46,342	46,342		46,342	3,530	49,872			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			371,066	371,066		371,066	562	371,628			26
27	Other (specify):*											27
28	**TOTAL General Administration**	477,305	161,279	2,292,455	2,931,039		2,931,039	(265,214)	2,665,825			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,276,534	1,464,335	3,771,830	12,512,699		12,512,699	(271,658)	12,241,041			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.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR #0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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			1,028,962	1,028,962		1,028,962	(36,408)	992,554			30
31	Amortization of Pre-Op. & Org.			506,661	506,661		506,661	(506,661)				31
32	Interest			2,350,008	2,350,008		2,350,008	(164,948)	2,185,060			32
33	Real Estate Taxes			705,854	705,854		705,854		705,854			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,390,327)	9,673			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			6,991,485	6,991,485		6,991,485	(3,098,344)	3,893,141			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		284,680		284,680		284,680		284,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			898,133	898,133		898,133		898,133			42
43	Other (specify):* Bad Debt			440,070	440,070		440,070	(440,070)				43
44	TOTAL Special Cost Centers		284,680	1,338,203	1,622,883		1,622,883	(440,070)	1,182,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,276,534	1,749,015	12,101,518	21,127,067		21,127,067	(3,810,072)	17,316,995			45

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	(36,408)	30		9
10	Interest and Other Investment Income	(165,166)	32		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	(440,070)	43		24
25	Fund Raising, Advertising and Promotional	(24,723)	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	(2,966,744)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,633,202)		$	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)	(176,870)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (176,870)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,810,072)		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.		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

STATE OF ILLINOIS

MIDWAY NEUROLOGICAL/REHAB CTR

ID# 0047175

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	vending	$ (2,904)	6	1
2	misc	(57,179)	21	2
3	rent	(2,400,000)	34	3
4	amort of goodwill	(506,661)	31	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,966,744)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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	(91)	(6,911)	0	0	0	0	0	0	0	0	0	(7,002)	1
2	Food Purchase	0	455	0	0	0	0	0	0	0	0	0	455	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,707	0	0	0	0	0	0	0	0	0	1,707	5
6	Maintenance	(2,904)	5,004	0	0	0	0	0	0	0	0	0	2,100	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,995)	255	0	0	0	0	0	0	0	0	0	(2,740)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(3,704)	0	0	0	0	0	0	0	0	0	(3,704)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(3,704)	0	0	0	0	0	0	0	0	0	(3,704)	16
	C. General Administration													
17	Administrative	0	(20,000)	0	0	0	0	0	0	0	0	0	(20,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(198,639)	0	0	0	0	0	0	0	0	0	(198,639)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(81,902)	2,501	0	0	0	0	0	0	0	0	0	(79,401)	21
22	Employee Benefits & Payroll Taxes	0	28,734	0	0	0	0	0	0	0	0	0	28,734	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,530	0	0	0	0	0	0	0	0	0	3,530	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	562	0	0	0	0	0	0	0	0	0	562	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(81,902)	(183,312)	0	0	0	0	0	0	0	0	0	(265,214)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,897)	(186,761)	0	0	0	0	0	0	0	0	0	(271,658)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(36,408)	0	0	0	0	0	0	0	0	0	0	(36,408)	30
31	Amortization of Pre-Op. & Org.	(506,661)	0	0	0	0	0	0	0	0	0	0	(506,661)	31
32	Interest	(165,166)	218	0	0	0	0	0	0	0	0	0	(164,948)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,400,000)	9,673	0	0	0	0	0	0	0	0	0	(2,390,327)	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**	(3,108,235)	9,891	0	0	0	0	0	0	0	0	0	(3,098,344)	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):*	(440,070)	0	0	0	0	0	0	0	0	0	0	(440,070)	43
44	**TOTAL Special Cost Centers**	(440,070)	0	0	0	0	0	0	0	0	0	0	(440,070)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,633,202)	(176,870)	0	0	0	0	0	0	0	0	0	(3,810,072)	45

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Attached Listing						

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	$ 17,946	infinity management		$ 11,035	$ (6,911)	1
2	V	2	food	(455)	infinity management			455	2
3	V	5	utilities		infinity management		1,707	1,707	3
4	V	6	maint		infinity management		5,004	5,004	4
5	V	10	nursing	41,472	infinity management		37,768	(3,704)	5
6	V	17	administrative	20,000	infinity management			(20,000)	6
7	V	19	prof fees	199,848	infinity management		1,209	(198,639)	7
8	V	21	office	136,678	infinity management		139,179	2,501	8
9	V	22	benefits	862	infinity management		29,596	28,734	9
10	V	24	travel	68	infinity management		3,598	3,530	10
11	V	26	insurance		infinity management		562	562	11
12	V	32	interest		infinity management		218	218	12
13	V	34	rent		infinity management		9,673	9,673	13
14	Total			$ 416,419			$ 239,549	$ * (176,870)	14

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

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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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
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15								15
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17								17
18								18
19								19
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTI # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Private Bank		x	Mortgage	$55,495.00	1/1/13	$ 23,000,000	$ 22,452,757	1/30/18	6.7500	$ 2,268,591	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		x	working capital	none	01/31/13	3,471,000	850,000	01/31/14	4.2500	81,417	6
7												7
8												8
9	**TOTAL Facility Related**				$55,495.00		$ 26,471,000	$ 23,302,757			$ 2,350,008	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 26,471,000	$ 23,302,757			$ 2,350,008	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.)**

**** 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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 706,288	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.)		$ 776,295	2
3. Under or (over) accrual (line 2 minus line 1).		$ 70,007	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 635,847	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.		$ 705,854	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	504,542	8
	2009	592,327	9
	2010	636,451	10
	2011	832,041	11
	2012	776,295	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MIDWAY NEUROLOGICAL/REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047175

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-403-013-0000	nursing home	$ 776,294.61	$ 776,294.61
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 776,294.61	$ 776,294.61

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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		$ 194,868	$	$ 1,185,459	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Combined 2005 Building Improvements			2005	323,803	21,587	15	21,587		194,300	9
10											10
11	Combined 2006 Building Improvements			2006	195,836	13,056	15	13,056		101,835	11
12											12
13	Air Conditioner			2007	10,330	265	39	265		1,854	13
14	Fire Sprinkler			2007	4,775	122	39	122		857	14
15	Fire System			2007	1,290	33	39	33		231	15
16	Auto Transfer Switch			2007	838	21	39	21		150	16
17	Video SecurityCameras			2007	3,900	100	39	100		700	17
18	Shower Room Tile			2007	9,010	231	39	231		1,618	18
19	Shower Room Tile			2007	3,543	91	39	91		636	19
20	Cubicle curtains			2007	4,059	104	39	104		729	20
21	Shower Room Tile			2007	5,497	141	39	141		987	21
22	Air Conditioner			2007	500	13	39	13		90	22
23	Air Conditioner			2007	500	13	39	13		90	23
24	Signage			2007	1,692	43	39	43		304	24
25	Fire Sprinkler			2007	1,373	35	39	35		246	25
26	Electrical work in reception area			2007	490	13	39	13		88	26
27	Painting - Shower Room			2007	1,000	26	39	26		180	27
28	Painting - Shower Room			2007	2,000	51	39	51		359	28
29	Painting - Shower Room			2007	3,000	77	39	77		539	29
30	Painting - Shower Room			2007	3,000	77	39	77		539	30
31	Toner			2007	13		39			2	31
32	Freezer maint			2007	3,188	82	39	82		572	32
33	Doors			2007	1,595	41	39	41		286	33
34	Doors			2007	1,595	41	39	41		286	34
35	Air Conditioner			2007	500	13	39	13		90	35
36	Locks on Gate			2007	3,509	90	39	90		630	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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$	$ 3,590	37
38	Parking Lot Paving	2007	21,410	549	39	549		3,843	38
39	Fencing	2007	1,550	40	39	40		278	39
40	Fencing	2007	1,500	38	39	38		269	40
41	Asbestos removal	2007	2,370	61	39	61		425	41
42									42
43	Pump	2008	1,498	38	39	38		230	43
44	Sprinkler Systems	2008	12,457	319	39	319		1,917	44
45	Sprinkler Systems	2008	1,625	42	39	42		250	45
46	Smoke Detector	2008	1,342	34	39	34		206	46
47	Refrigeration	2008	4,250	109	39	109		654	47
48	Refrigeration	2008	5,291	136	39	136		814	48
49	Refrigeration	2008	3,735	96	39	96		575	49
50	Refrigeration	2008	6,950	178	39	178		1,069	50
51	Refrigeration	2008	2,455	63	39	63		378	51
52	Refrigeration	2008	971	25	39	25		149	52
53	Refrigeration	2008	1,678	43	39	43		258	53
54	Refrigeration	2008	2,865	73	39	73		441	54
55	Tiling for Shower room	2008	276	7	39	7		43	55
56	Elevator	2008	1,270	33	39	33		195	56
57	Roof	2008	4,094	105	39	105		630	57
58	Fire Doors	2008	2,670	68	39	68		411	58
59	Fire Doors	2008	907	23	39	23		140	59
60	Hot Water Heater	2008	8,875	228	39	228		1,365	60
61	Elevator	2008	3,008	77	39	77		463	61
62	Roof	2008	35,700	915	39	915		5,492	62
63	Brick work on Bldg	2008	17,850	458	39	458		2,746	63
64	Windows	2008	135,000	3,463	39	3,462	(1)	20,769	64
65	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		12,307	65
66	Renovation	2008	41,403	1,062	39	1,062		6,370	66
67	CATV wiring	2008	8,000	205	39	205		1,231	67
68	CATV wiring	2008	8,000	205	39	205		1,231	68
69	CATV wiring	2008	16,000	410	39	410		2,462	69
70	TOTAL (lines 4 thru 69)		$ 8,641,833	$ 242,901		$ 242,900	$ (1)	$ 1,564,858	70

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 242,901		$ 242,900	$ (1)	$ 1,564,858	1
2	Alarm System	2009	629	16	39	16		81	2
3	Wiring	2009	6,300	162	39	162		807	3
4	Room Signs	2009	5,405	138	39	139	1	692	4
5									5
6	Brickwork	2009	39,000	1,000	39	1,000		5,000	6
7									7
8	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,061	39	6,062	1	23,739	8
9	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		19,633	9
10	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		5,747	10
11	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		1,542	11
12									12
13	Sewer maintenance and upgrade	2010	3,379	87	39	87		339	13
14	Re-key entire building	2010	12,388	318	39	318		1,244	14
15	New fire doors	2010	30,801	790	39	790		3,093	15
16									16
17	Patch & re-roof overhang	2010	3,450	88	39	88		346	17
18	Cabling for nurse call system	2010	2,763	71	39	71		277	18
19	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		26,023	19
20	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		4,884	20
21	Bathroom sink lens	2010	2,741	70	39	70		275	21
22									22
23	Insulation of boilers	2010	3,700	95	39	95		372	23
24	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		3,258	24
25	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		1,531	25
26	Drywall & ceiling tile work throughout facility	2010	202,079	5,181	39	5,182	1	20,292	26
27									27
28	New front doors	2010	15,099	387	39	387		1,516	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		5,442	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		5,387	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,937,413	$ 276,120		$ 276,122	$ 2	$ 1,696,378	34

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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		$ 9,937,413	$ 276,120		$ 276,122	$ 2	$ 1,696,378	1
2	Air conditioning panels	2010	5,657	145	39	145		568	2
3	Post construction clean up	2010	15,889	407	39	407		1,595	3
4									4
5	Repair asphalt	2010	2,867	74	39	74		288	5
6	Replace, water supply lines & valves	2010	27,303	700	39	700		2,742	6
7	Drainage pipe	2010	3,056	78	39	78		307	7
8	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	543		2,127	8
9	Repair water heaters	2010	2,830	73	39	73		284	9
10									10
11									11
12	Fix Hand Rails and Water Pumps	2011	16,413	420	39	421	1	1,263	12
13	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	27		80	13
14	Replace Waste Drain and Break	2011	2,950	76	39	76		227	14
15	Install Fire Dampers	2011	6,500	167	39	167		500	15
16	Update and Refit Lighting and Fixtures	2011	33,557	860	39	860		2,582	16
17	Replace Stairs	2011	2,990	77	39	77		230	17
18	Install and Updated Cabinets	2011	6,050	155	39	155		465	18
19									19
20	Replaced IFC-320 and TM-4 controls	2012	9,460	244	39	243	(1)	485	20
21	Relocate generator panels	2012	1,883	48	39	48		97	21
22	install sprinkler head in elevator shafts	2012	5,973	153	39	153		306	22
23	Fire Panel Call, contols, pull & trim outside west stand pipe	2012	5,439	139	39	139		279	23
24	7.5T Dry AC	2012	2,734	70	39	70		140	24
25	Advantage Carpet Ware	2012	3,290	84	39	84		169	25
26									26
27	2005 Assets not allowed for increased capital reimbursement	2005	6,291	419	15	419		3,754	27
28									28
29	2006 Assets not allowed for increased capital reimbursement	2006	15,508	1,034	15	1,034		11,551	29
30									30
31	2010 Assets not allowed for increased capital reimbursement	2010	72,793	1,867	39	1,866	(1)	7,309	31
32									32
33	2010 Assets not allowed for increased capital reimbursement	2011	15,706	403	39	403		1,208	33
34	TOTAL (lines 1 thru 33)		$ 10,224,770	$ 284,383		$ 284,384	$ 1	$ 1,734,934	34

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 12C, Carried Forward		$ 10,224,770	$ 284,383		$ 284,384	$ 1	$ 1,734,934	1
2	Flooring / Tiles / Toilets	10/23/2013	3,030	2,638	39	78	(2,560)	2,638	2
3	Wall repair, preparation and cove base	10/7/2013	2,811	2,448	39	72	(2,376)	2,448	3
4	Flooring - 1st floor	9/25/2013	5,494	4,784	39	141	(4,643)	4,784	4
5	Replace roof Exhaust	12/3/2013	4,805	4,184	39	123	(4,061)	4,184	5
6	Elevator	12/4/2012	28,000	24,378	39	718	(23,660)	24,378	6
7	Repair Elevator	12/10/2013	3,850	3,352	39	99	(3,253)	3,352	7
8	Wall repair	11/20/2013	3,000	2,612	39	77	(2,535)	2,612	8
9	Condenser - Kitchen / Barber Shop	7/29/2013	1,325	1,154	39	34	(1,120)	1,154	9
10	Sprinklers	8/20/2013	2,825	2,460	39	72	(2,388)	2,460	10
11	Emergency Generator	9/9/2013	4,442	3,868	39	114	(3,754)	3,868	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)		$ 10,284,353	$ 336,261		$ 285,912	$ (50,349)	$ 1,786,812	34

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 3,468,071	$ 560,328	$ 693,614	$ 133,286	5	$ 3,037,591	71
72	Current Year Purchases	132,373	132,373	13,028	(119,345)	5	132,373	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,600,444	$ 692,701	$ 706,642	$ 13,941		$ 3,169,964	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)	$ 14,834,797	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,028,962	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 992,554	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,408)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,956,776	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 352,697	$		$ 352,697	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			89,656			89,656	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			357,427			357,427	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				271,519		271,519	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): lab & radiology	39-2					13,161		13,161	13
14	TOTAL			$		$ 799,780	$ 284,680		$ 1,084,460	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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ (42,167)	$ 81,614	1
2	Cash-Patient Deposits	13,457	13,457	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,448,777	7,448,777	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,166	133,166	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)**	$ 7,553,233	$ 7,677,014	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	2,684,352	2,684,352	15
16	Equipment, at Historical Cost	750,444	3,600,444	16
17	Accumulated Depreciation (book methods)	(1,478,851)	(4,959,790)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	7,875,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(35,287)	(3,349,518)	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)**	$ 1,985,195	$ 14,422,041	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,538,428	$ 22,099,055	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,059,720	$ 1,359,720	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,819,614	1,819,614	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,879,334	$ 3,179,334	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,452,728	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	working capital	850,000	850,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 850,000	$ 23,302,728	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,729,334	$ 26,482,062	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,809,094	$ (4,383,007)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,538,428	$ 22,099,055	48

***(See instructions.)**

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR **#** 0047175 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,165,026	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,165,026	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(522,713)	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	(500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Related Party Property Co net income**	1,666,781	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 644,068	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)**	$ 5,809,094	24 *

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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,729,672	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,729,672	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,433	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 252,433	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	165,166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 165,166	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Related Party Property Company Income	2,400,000	28
28a	Miscellaneous & Vending Revenue	57,083	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,457,083	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,604,354	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,536,902	31
32	Health Care	7,044,758	32
33	General Administration	2,931,039	33
	B. Capital Expense		
34	Ownership	6,991,485	34
	C. Ancillary Expense		
35	Special Cost Centers	284,680	35
36	Provider Participation Fee	898,133	36
	D. Other Expenses (specify):		
37	bad debt exp	440,070	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,127,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	(522,713)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (522,713)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 14,082,354	44
45	Private Pay - Net Inpatient Revenue	362,203	45
46	Medicare - Net Inpatient Revenue	3,113,614	46
47	Other-(specify) Commercian Net Inpatient Revenue	171,501	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,729,672	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/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	2,016	2,080	$ 105,414	$ 50.68	1
2	Assistant Director of Nursing	3,222	3,640	145,699	40.03	2
3	Registered Nurses	9,187	10,001	316,729	31.67	3
4	Licensed Practical Nurses	78,081	85,053	2,512,028	29.53	4
5	CNAs & Orderlies	136,621	150,765	1,689,589	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20,426	22,854	389,405	17.04	9
10	Activity Assistants					10
11	Social Service Workers	16,781	18,207	328,033	18.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,896	46,710	576,105	12.33	15
16	Dishwashers					16
17	Maintenance Workers	7,665	8,371	145,799	17.42	17
18	Housekeepers	43,724	48,971	532,554	10.87	18
19	Laundry	4,773	5,445	57,874	10.63	19
20	Administrator	2,895	3,210	161,990	50.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,899	10,996	216,464	19.69	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	6,273	6,844	98,851	14.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	383,459	423,147	$ 7,276,534 *	$ 17.20	34

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

** See instructions.

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	359	$ 17,945	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,084	54,211	10-3	38
39	Pharmacist Consultant	659	32,972	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	149	7,445	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,251	$ 112,573		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

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomeka Brown	admin		$ 29,864
blake wiley	admin		67,681
josh graber	admin		64,445
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 161,990

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
lewis brisbois	legal	$ 60,329
swanson martin bell	legal	11,320
bernice russel	legal	103,923
bradley & associates	accctg	7,620
johnson goldberg brown	accctg	2,500
infinity healthcare	consulting fees	244,500
stirs	prof fees	47,500
various	prof fees	1,646
mts consulting	prof fees	4,523
dna search	prof fees	16,500
polsinelli	legal	3,196
sklare	legal	124
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 503,681

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 229,834
Unemployment Compensation Insurance	310,148
FICA Taxes	559,807
Employee Health Insurance	173,442
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pemnsion	30,585
employee exp	25,912
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,329,728

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	23,992
clia	150
village of bridgeview	800
sec of state	500
various	1,743
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,175

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto allowance	23,530
mileage	1,069
Seminar Expense	
seminar	7,457
education	14,816
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 46,872

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CTR # 0047175 Report Period Beginning: 1/1/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Council**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **107,474** 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. $ **898,133**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.