

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Reha Ctr

Address: 8540 S Harlem Avenue Bridgeview 60455
Number City Zip Code

County: Cook

Telephone Number: 708-449-1900 Fax # 708-449-1500

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 1/1/16 to 12/31/16 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)
(Type or Print Name) Flora Reznik
(Title) CFO

Paid
Preparer

(Signed)
(Print Name and Title) Daniel S. Gaafar Partner
(Firm Name & Address) Bradley Associates 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317-237-5500 Fax # 317-237-5502

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 Reha Ctr

0047175 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)	404	147,864	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	TOTALS	404	147,864	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	116,685	563	8,059	125,307	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	116,685	563	8,059	125,307	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.74%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/1/2005

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

YES ☒ Date 47/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 404 and days of care provided 2,935

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number		Midway Neurological Reha Ctr				#	0047175	Report Period Beginning:		1/1/16	Ending: 12/31/16	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)												
	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	598,524		83,879	682,403		682,403	(1,122)	681,281			1
2	Food Purchase		594,801		594,801		594,801	651	595,452			2
3	Housekeeping	425,353	83,627		508,980		508,980	412	509,392			3
4	Laundry	80,070	32,157		112,227		112,227		112,227			4
5	Heat and Other Utilities			389,817	389,817		389,817	556	390,373			5
6	Maintenance	157,734	92,980	182,638	433,352		433,352	999	434,351			6
7	Other (specify):*											7
8	TOTAL General Services	1,261,681	803,565	656,334	2,721,580		2,721,580	1,496	2,723,076			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	5,005,215	377,808	50,154	5,433,177		5,433,177	(26,901)	5,406,276			10
10a	Therapy			1,470,478	1,470,478		1,470,478		1,470,478			10a
11	Activities	440,455	123,901		564,356		564,356	2,618	566,974			11
12	Social Services	356,624			356,624		356,624		356,624			12
13	CNA Training			872	872		872		872			13
14	Program Transportation											14
15	Other (specify):* pharmacy consultant			37,026	37,026		37,026		37,026			15
16	TOTAL Health Care and Programs	5,802,294	501,709	1,583,530	7,887,533		7,887,533	(24,283)	7,863,250			16
	C. General Administration											
17	Administrative	243,193			243,193		243,193		243,193			17
18	Directors Fees											18
19	Professional Services			562,701	562,701		562,701	(198,899)	363,802			19
20	Dues, Fees, Subscriptions & Promotions			18,777	18,777		18,777	(562)	18,215			20
21	Clerical & General Office Expenses	290,448	89,744	139,632	519,824		519,824	178,339	698,163			21
22	Employee Benefits & Payroll Taxes			1,318,858	1,318,858		1,318,858	51,726	1,370,584			22
23	Inservice Training & Education											23
24	Travel and Seminar			38,367	38,367		38,367	1,095	39,462			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			794,466	794,466		794,466	203,362	997,828			26
27	Other (specify):*											27
28	TOTAL General Administration	533,641	89,744	2,872,801	3,496,186		3,496,186	235,061	3,731,247			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,597,616	1,395,018	5,112,665	14,105,299		14,105,299	212,274	14,317,573			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			62,521	62,521		62,521	1,143,269	1,205,790			30
31	Amortization of Pre-Op. & Org.			2,127	2,127		2,127	457,401	459,528			31
32	Interest			3,199	3,199		3,199	733,446	736,645			32
33	Real Estate Taxes			810,000	810,000		810,000	323,417	1,133,417			33
34	Rent-Facility & Grounds			1,285,490	1,285,490		1,285,490	(1,279,804)	5,686			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			30,040	30,040		30,040		30,040			36
37	TOTAL Ownership			2,193,377	2,193,377		2,193,377	1,377,729	3,571,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,301	1,301		1,301		1,301			38
39	Ancillary Service Centers		204,229		204,229		204,229		204,229			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			959,555	959,555		959,555		959,555			42
43	Other (specify):* bad debt expense			220,736	220,736		220,736	(220,736)				43
44	TOTAL Special Cost Centers		204,229	1,181,592	1,385,821		1,385,821	(220,736)	1,165,085			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,597,616	1,599,247	8,487,634	17,684,497		17,684,497	1,369,267	19,053,764			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	948,155	30		9
10	Interest and Other Investment Income	(58,891)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,002)	21		18
19	Entertainment				19
20	Contributions	(145)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,736)	43		24
25	Fund Raising, Advertising and Promotional	(5,716)	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	(4,733)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 656,931		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 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)	712,336	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 712,336		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,369,267		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (3,882)	21	1
2	Lobbying expense	(851)	20	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
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	(4,733)		49

Summary A

12/31/16

[illegible]

Summary B

Facility Name & ID Number

0047175

1/1/16

12/31/16

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	33.393	Ambassador Nursing and Rehab Center	Chicago	Infinity Healthcare	Hillsdale	Mgmt company
GELP	33.392	Belhaven Nursing and Rehab	Chicago			
A&F Realty	23.965	West Suburban Nursing and Rehab Center	Bloomingtondale			
Joseph Blisko	5	City View Multicare Center	Cicero			
Joseph Meisels	4.25	Continental Nursing and Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Chicago			
		Lakeview Nursing & Rehab Center	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	1	Dietary	\$ 12,458	Infinity Healthcare Management		\$ 11,337	\$ (1,121)	1
2	V	2	Food Purchases		Infinity Healthcare Management		651	651	2
3	V	3	Housekeeping		Infinity Healthcare Management		412	412	3
4	V	5	Utilities		Infinity Healthcare Management		556	556	4
5	V	6	Maintenance		Infinity Healthcare Management		999	999	5
6	V	10	Nursing	42,595	Infinity Healthcare Management		15,694	(26,901)	6
7	V	11	Activities		Infinity Healthcare Management		2,618	2,618	7
8	V	19	Professional Fees	330,778	Infinity Healthcare Management		122,256	(208,522)	8
9	V	20	Dues, Fees, Subs, & Promotions		Infinity Healthcare Management		289	289	9
10	V	21	Office Expense	26,105	Infinity Healthcare Management		214,970	188,865	10
11	V	22	Employee Benefits	(3,452)	Infinity Healthcare Management		48,274	51,726	11
12	V	24	Travel & Seminar	356	Infinity Healthcare Management		1,451	1,095	12
13	V	26	Insurance		Infinity Healthcare Management		340	340	13
14	Total			\$ 408,840			\$ 419,847	\$ * 11,007	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Infinity Healthcare Mangement		\$ 242	\$ 242	15
16	V	32	Interest		Infinity Healthcare Mangement		3,127	3,127	16
17	V	34	Rent		Infinity Healthcare Mangement		5,686	5,686	17
18	V								18
19	V	33	Property Tax		Midway Nuerological and Rehabilitation Realty		323,417	323,417	19
20	V	26	Insurance		Midway Nuerological and Rehabilitation Realty		203,022	203,022	20
21	V	31	Amortization		Midway Nuerological and Rehabilitation Realty		457,401	457,401	21
22	V	19	Professional Services		Midway Nuerological and Rehabilitation Realty		9,623	9,623	22
23	V	21	Office Expense		Midway Nuerological and Rehabilitation Realty		219	219	23
24	V	30	Depreciation		Midway Nuerological and Rehabilitation Realty		194,872	194,872	24
25	V	32	Interest		Midway Nuerological and Rehabilitation Realty		789,210	789,210	25
26	V	34	Rent	1,285,490	Midway Nuerological and Rehabilitation Realty			(1,285,490)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,285,490			\$ 1,986,819	\$ * 701,329	39

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

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			Momence Meadows Nursing & Rehab Ctr	Momence				2
3			Niles Nursing & Rehab Center	Niles				3
4			Oak Lawn Respiratory & Rehab Center	Oak Lawn				4
5			Parker Nursing & Rehab Center	Streator				5
6			Parkshore Estates Nursing & Rehab Ctr	Chicago				6
7			Southpoint Nursing & Rehab Center	Chicago				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Midway Neurological Reha Ctr # 0047175 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD Loan		X	Mortgage	Interest only	5/25/15	\$ 23,416,884	\$ 23,036,759	7/1/49	3.4000	\$ 795,536	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 23,416,884	\$ 23,036,759			\$ 795,536	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 23,416,884	\$ 23,036,759			\$ 795,536	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 194,114 Line # 26

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

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

B. Real Estate Taxes

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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Midway Neurological Reha Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047175

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE 317-237-5500 FAX #: 317-237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	18-36-403-013-0000	Nursing Home	\$ 953,008.00	\$ 953,008.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 953,008.00	\$ 953,008.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:112,340

B. General Construction Type:ExteriorBrickFrameConcrete / SteelNumber of Stories5

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment☐ (b) Rent equipment from a Related Organization.☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$950,000	1
2					2
3	TOTALS			\$950,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	404		2009	7600000	\$ 7,600,000	\$	39	\$ 194,872	\$ 194,872	\$ 1,575,203
5										
6										
7										
8										
	Improvement Type**									
9	Combined 2005 Building Improvements			2005	323,803	8,303	15	8,303		245,756
10	2005 Assets not allowed for increased capital reimbursement			2005	6,291	161	15	161		4,774
11										
12	Combined 2006 Building Improvements			2006	195,836	13,056	15	13,056		144,234
13	2006 Assets not allowed for increased capital reimbursement			2006	15,508	1,034	15	1,034		11,422
14										
15	Air Conditioner			2007	10,330	265	39	265		2,649
16	Fire Sprinkler			2007	4,775	122	39	122		1,224
17	Fire System			2007	1,290	33	39	33		331
18	Auto Transfer Switch			2007	838	21	39	21		214
19	Video SecurityCameras			2007	3,900	100	39	100		1,000
20	Shower Room Tile			2007	9,010	231	39	231		2,310
21	Shower Room Tile			2007	3,543	91	39	91		909
22	Cubicle curtains			2007	4,059	104	39	104		1,041
23	Shower Room Tile			2007	5,497	141	39	141		1,410
24	Air Conditioner			2007	500	13	39	13		129
25	Air Conditioner			2007	500	13	39	13		129
26	Signage			2007	1,692	43	39	43		433
27	Fire Sprinkler			2007	1,373	35	39	35		352
28	Electrical work in reception area			2007	490	13	39	13		127
29	Painting - Shower Room			2007	1,000	26	39	26		257
30	Painting - Shower Room			2007	2,000	51	39	51		512
31	Painting - Shower Room			2007	3,000	77	39	77		769
32	Painting - Shower Room			2007	3,000	77	39	77		769
33	Toner			2007	13		39			3
34	Freezer maint			2007	3,188	82	39	82		818
35	Doors			2007	1,595	41	39	41		409
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 Reha Ctr

0047175

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Doors	2007	\$ 1,595	\$ 41	39	\$ 41	\$	\$ 409	37
38	Air Conditioner	2007	500	13	39	13		129	38
39	Locks on Gate	2007	3,509	90	39	90		900	39
40	Parking Lot Paving	2007	20,000	513	39	513		5,129	40
41	Parking Lot Paving	2007	21,410	549	39	549		5,490	41
42	Fencing	2007	1,550	40	39	40		398	42
43	Fencing	2007	1,500	38	39	38		384	43
44	Asbestos removal	2007	2,370	61	39	61		608	44
45									45
46	Pump	2008	1,498	38	39	38		345	46
47	Sprinkler Systems	2008	12,457	319	39	319		2,874	47
48	Sprinkler Systems	2008	1,625	42	39	42		376	48
49	Smoke Detector	2008	1,342	34	39	34		309	49
50	Refrigeration	2008	4,250	109	39	109		981	50
51	Refrigeration	2008	5,291	136	39	136		1,222	51
52	Refrigeration	2008	3,735	96	39	96		862	52
53	Refrigeration	2008	6,950	178	39	178		1,603	53
54	Refrigeration	2008	2,455	63	39	63		567	54
55	Refrigeration	2008	971	25	39	25		224	55
56	Refrigeration	2008	1,678	43	39	43		387	56
57	Refrigeration	2008	2,865	73	39	73		660	57
58	Tiling for Shower room	2008	276	7	39	7		64	58
59	Elevator	2008	1,270	33	39	33		294	59
60	Roof	2008	4,094	105	39	105		945	60
61	Fire Doors	2008	2,670	68	39	68		615	61
62	Fire Doors	2008	907	23	39	23		209	62
63	Hot Water Heater	2008	8,875	228	39	228		2,049	63
64	Elevator	2008	3,008	77	39	77		694	64
65	Roof	2008	35,700	915	39	915		8,238	65
66	Brick work on Bldg	2008	17,850	458	39	458		4,120	66
67	Windows	2008	135,000	3,462	39	3,462		31,155	67
68	2nd & 3rd floor tiling & nurses station	2008	80,000	2,051	39	2,051		18,461	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,590,229	\$ 34,061		\$ 228,933	\$ 194,872	\$ 2,087,885	70

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

Facility Name & ID Number Midway Neurological Reha Ctr

0047175

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,590,229	\$ 34,061		\$ 228,933	\$ 194,872	\$ 2,087,885	1
2	Renovation	2008	41,403	1,062	39	1,062		9,555	2
3	CATV wiring	2008	8,000	205	39	205		1,846	3
4	CATV wiring	2008	8,000	205	39	205		1,846	4
5	CATV wiring	2008	16,000	411	39	410	(1)	3,694	5
6									6
7	Alarm System	2009	629	16	39	16		129	7
8	Wiring	2009	6,300	162	39	162		1,293	8
9	Room Signs	2009	5,405	138	39	139	1	1,107	9
10	Brickwork	2009	39,000	1,000	39	1,000		8,000	10
11									11
12	Hardware, Paint, tiles, fixtures for entire construction project	2010	236,400	6,062	39	6,062		12,136	12
13	Labor-replace tiles, drywall, covebase & floor tiles	2010	195,524	5,013	39	5,013		10,038	13
14	2nd floor drywall, tiles, paint, baseboard & plumbing	2010	57,229	1,467	39	1,467		2,946	14
15	Cubicle curtain tracks & new room signs	2010	15,357	394	39	394		800	15
16	Sewer maintenance and upgrade	2010	3,379	87	39	87		186	16
17	Re-key entire building	2010	12,388	318	39	318		648	17
18	New fire doors	2010	30,801	790	39	790		1,592	18
19	Patch & re-roof overhang	2010	3,450	88	39	88		188	19
20	Cabling for nurse call system	2010	2,763	71	39	71		154	20
21	Labor for painting and paint supplies for entire building	2010	259,159	6,645	39	6,645		13,302	21
22	Outside concrete & brickwork	2010	48,642	1,247	39	1,247		2,506	22
23	Bathroom sink lens	2010	2,741	70	39	70		152	23
24	Insulation of boilers	2010	3,700	95	39	95		202	24
25	Light fixtures, circuits, electric box upgrades	2010	32,441	832	39	832		1,676	25
26	Painting & murals on Alzheimers unit	2010	15,245	391	39	391		794	26
27	Drywall & ceiling tile work throughout facility	2010	202,079	5,182	39	5,182		10,376	27
28	New front doors	2010	15,099	387	39	387		786	28
29	New A/C units, exhaust fans & duct work	2010	54,199	1,390	39	1,390		2,792	29
30	Wall plaster & change electrical outlets	2010	53,650	1,376	39	1,376		2,761	30
31	Air conditioning panels	2010	5,657	145	39	145		302	31
32	Post construction clean up	2010	15,889	407	39	407		826	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,980,758	\$ 69,717		\$ 264,589	\$ 194,872	\$ 2,180,518	34

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

Facility Name & ID Number Midway Neurological Reha Ctr

0047175

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,980,758	\$ 69,717		\$ 264,589	\$ 194,872	\$ 2,180,518	1
2	Repair asphalt	2010	2,867	74	39	74		160	2
3	Replace, water supply lines & valves	2010	27,303	700	39	700		1,412	3
4	Drainage pipe	2010	3,056	78	39	78		168	4
5	Replace shower valves, water lines, repipe & rod out sewer	2010	21,183	543	39	543		1,098	5
6	Repair water heaters	2010	2,830	73	39	73		158	6
7	2010 Assets not allowed for increased capital reimbursement	2010	72,793	1,865	39	1,866	1	3,742	7
8									8
9	Fix Hand Rails and Water Pumps	2011	16,413	421	39	421		2,525	9
10	Put Up Signs, Repair Stairs, Install New Cabinets	2011	1,035	27	39	27		160	10
11	Replace Waste Drain and Break	2011	2,950	76	39	76		455	11
12	Install Fire Dampers	2011	6,500	167	39	167		1,001	12
13	Update and Refit Lighting and Fixtures	2011	33,557	860	39	860		5,162	13
14	Replace Stairs	2011	2,990	77	39	77		461	14
15	Install and Updated Cabinets	2011	6,050	154	39	155	1	929	15
16	2011 Assets not allowed for increased capital reimbursement	2011	15,706	403	39	403		2,417	16
17									17
18	Replaced IFC-320 and TM-4 controls	2012	9,460	243	39	243		1,214	18
19	Relocate generator panels	2012	1,883	48	39	48		241	19
20	install sprinkler head in elevator shafts	2012	5,973	153	39	153		766	20
21	Fire Panel Call, contols, pull & trim outside west stand pipe	2012	5,439	140	39	139	(1)	698	21
22	7.5T Dry AC	2012	2,734	70	39	70		350	22
23	Advantage Carpet Ware	2012	3,290	84	39	84		421	23
24									24
25	Flooring / Tiles / Toilets in 5th floor resident rooms	2013	3,030	78	39	78		956	25
26	Wall repair, preparation and cove base in 5th floor res. Rooms	2013	2,811	72	39	72		886	26
27	Flooring - for 5th floor resident rooms	2013	5,494	141	39	141		1,732	27
28	Replace roof Exhaust	2013	4,805	123	39	123		1,514	28
29	Elevator	2013	28,000	718	39	718		8,826	29
30	Repair Elevator	2013	3,850	99	39	99		1,214	30
31	Wall repair - 5th floor	2013	3,000	77	39	77		946	31
32	Condenser - Kitchen / Barber Shop	2013	1,325	34	39	34		418	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,277,085	\$ 77,315		\$ 272,188	\$ 194,873	\$ 2,220,548	34

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

Facility Name & ID Number Midway Neurological Reha Ctr

0047175

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,277,085	\$ 77,315		\$ 272,188	\$ 194,873	\$ 2,220,548	1
2	<u>Sprinklers</u>	2013	2,825	72	39	72		890	2
3	<u>Emergency Generator</u>	2013	4,442	114	39	114		1,400	3
4									4
5	<u>Remove wallpaper, paint wall, cove base 4th floor dining room</u>	2014	2,469	63	39	63		778	5
6	<u>Install door restrictors and door detectors on elevators</u>	2014	3,520	90	39	90		1,109	6
7	<u>Condenser in main boiler room and service roof top units</u>	2014	25,362	650	39	650		7,994	7
8	<u>Install new hydrant and valve in pump room</u>	2014	11,604	298	39	298		3,659	8
9	<u>Rod out kitchen waste line & main branch from nrsg station</u>	2014	3,085	79	39	79		972	9
10	<u>Replace 205 linear feet of fence on patio including gate</u>	2014	16,000	410	39	410		5,043	10
11	<u>5 BTU wall units for MDS, Bookkeeping, Rms 206, 318, & 323</u>	2014	7,335	188	39	188		2,312	11
12	<u>Golden teak flooring for hallway and dining room on 1st floor</u>	2014	18,184	466	39	466		5,731	12
13	<u>2 rolls of wall covering for hallway and dining room on 1st flr</u>	2014	2,139	55	39	55		674	13
14	<u>2700 sq ft of plank flooring for hallway and dining 1st floor</u>	2014	2,993	77	39	77		944	14
15	<u>Painted seven patient rooms (201, 202, 404, 408, 416, 303, 322)</u>	2014	3,435	88	39	88		1,083	15
16	<u>Install insulation on roof air handler panels and seal roof units</u>	2014	1,975	51	39	51		623	16
17	<u>Tuck pointing and window caulking on entire exterior facility</u>	2014	13,469	345	39	345		4,245	17
18	<u>3rd flr door lock on elevator 2, new infared door detector also</u>	2014	1,650	42	39	42		519	18
19	<u>Paint walls in 536 - 544, 503, & 504; remove therapy closet</u>	2014	29,709	762	39	762		9,365	19
20	<u>Non-Allowable Assets</u>	2014	15,196	390	39	390		4,791	20
21									21
22	<u>Hallway and dining renovation - Paint, flooring, hand rails, and ot</u>	1/2/2015	112,702	2,890	39	2,890		5,780	22
23	<u>Flooring for new dining room on 4th floor</u>	1/21/2015	3,175	81	39	81		162	23
24	<u>Furnish & Install New Flooring on 1st Floor</u>	1/2/2015	2,993	77	39	77		154	24
25	<u>Remove old flooring, toilets, and countertops and install new blind</u>	1/25/2015	6,391	164	39	164		328	25
26	<u>Remove wall for dining room and install light fixtures</u>	1/25/2015	5,585	143	39	143		286	26
27	<u>Handrails, wall coverings, signage, and blinds</u>	2/18/2015	35,470	909	39	909		1,818	27
28	<u>Elevator panel, elevator hand railing</u>	2/20/2015	11,000	282	39	282		564	28
29	<u>Replace 4th floor electrical wiring</u>	2/13/2015	7,900	203	39	203		406	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,627,692	\$ 86,304		\$ 281,177	\$ 194,873	\$ 2,282,178	34

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

Facility Name & ID Number Midway Neurological Reha Ctr

0047175

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	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 12D, Carried Forward		\$ 10,627,692	\$ 86,304		\$ 281,177	\$ 194,873	\$ 2,282,178	1
2	Replace U-bends on boiler	3/9/2015	2,800	72	39	72		144	2
3	Plumbing - Sink faucet handles	4/27/2015	6,965	179	39	179		358	3
4	Install flooring and corner guards on 1st floor	4/9/2015	3,660	94	39	94		188	4
5	Replace U-bends on boiler	2/28/2015	3,268	84	39	84		168	5
6	Remove flooring and install new floor on 5th floor	5/3/2015	2,857	73	39	73		146	6
7	Steel door	5/3/2015	4,423	113	39	113		226	7
8	Replace Tiles, Cove Base, Cabinets & Floor in Therapy Rm	5/18/2015	7,872	202	39	202		404	8
9	New lock systems	5/16/2015	21,204	544	39	544		1,088	9
10	Smoking shelter	6/8/2015	4,875	125	39	125		250	10
11	Parking lot paving	7/9/2015	38,634	991	39	991		1,982	11
12	New lock systems	7/10/2015	4,575	117	39	117		234	12
13	Patient room doors	6/28/2015	2,900	74	39	74		148	13
14	Granite tops for dining room	6/28/2015	3,400	87	39	87		174	14
15	New door	8/20/2015	2,000	51	39	51		102	15
16	Replace laundry outside doors	7/23/2015	1,400	36	39	36		72	16
17	Replace laundry outside doors	9/29/2015	2,147	55	39	55		110	17
18	Air conditioning unit	7/29/2015	2,975	76	39	76		152	18
19	Pit ladders for elevator	12/28/2015	3,400	87	39	87		174	19
20									20
21	Light Pole Brackets	2/26/2016	3,600	92	39	92		92	21
22	Replace Laundry MLB Panel	2/16/2016	4,700	121	39	121		121	22
23	Flooring & Painting, double doors on 2nd and 3rd floors,	7/21/2016	17,480	238	39	448	210	448	23
24	2nd floor stairwell door, 4th floor dining room walls and								24
25	cove base								25
26	Replace HVAC	10/9/2016	2,950	86	39	76	(10)	76	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,775,777	\$ 89,901		\$ 284,974	\$ 195,073	\$ 2,289,035	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$4,541,896	\$106,350	\$908,379	\$802,029	5	\$4,541,896	71
72	Current Year Purchases	61,184	61,184	12,237	(48,947)	5	61,184	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$4,603,080	\$167,534	\$920,616	\$753,082		\$4,603,080	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$16,328,857	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$257,435	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,205,590	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$948,155	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,892,115	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost			(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$	5,712	\$ 388,912	\$	5,712	\$	388,912
2	Licensed Speech and Language Development Therapist		hrs		2,834	150,737		2,834		150,737
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist		hrs		6,151	368,329		6,151		368,329
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy		# of prescrpts				187,051			187,051
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify): XRAY						3,799			3,799
13	Other (specify): Lab						13,379			13,379
14	TOTAL			\$	14,697	\$ 907,978	\$ 204,229	14,697	\$	1,112,207

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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (186,720)	\$ 595,257	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,597,768	3,199,496	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	533,647	533,647	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)	\$ 2,944,695	\$ 4,328,400	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,175,776	3,175,776	15
16	Equipment, at Historical Cost	1,014,090	3,027,877	16
17	Accumulated Depreciation (book methods)	(1,817,782)	5,782,218	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170	43,170	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	17,480	6,878,496	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Goodwill / Org costs</u>)	1,031,036	(2,557,954)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,463,770	\$ 16,349,583	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,408,465	\$ 20,677,983	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,909,789	\$ 18,873,522	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(59,697)	(59,697)	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	495,973	263,957	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,397	(538,940)	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Settlement Reserves / LOC</u>	(16,886,420)	(16,356,170)	36
37	<u>RP Loan / Working Capital</u>	(4,198,294)	(4,198,294)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (6,626,252)	\$ (2,015,622)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		458,524	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 458,524	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (6,626,252)	\$ (1,557,098)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,034,717	\$ 22,235,081	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,408,465	\$ 20,677,983	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,363,282	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,363,282	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,661,426	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,989,991)	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)	\$ 2,671,435	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)	\$ 13,034,717	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Midway Neurological Reha Ctr

0047175

Report Period Beginning: 1/1/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 21,374,383	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,374,383	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	802,701	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 802,701	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	81,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,022	19
20	Radiology and X-Ray	1,371	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58,057	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58,057	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain on sale / misc income</u>	23,985	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,985	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,345,926	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,721,582	31
32	Health Care	7,887,533	32
33	General Administration	3,496,187	33
	B. Capital Expense		
34	Ownership	2,193,377	34
	C. Ancillary Expense		
35	Special Cost Centers	205,530	35
36	Provider Participation Fee	959,555	36
	D. Other Expenses (specify):		
37	<u>Bad debt</u>	220,736	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,684,500	40
41	Income before Income Taxes (line 30 minus line 40)**	4,661,426	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,661,426	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 18,445,290	44
45	Private Pay - Net Inpatient Revenue	104,155	45
46	Medicare - Net Inpatient Revenue	1,061,663	46
47	Other-(specify) <u>commercial</u>	176,327	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,787,435	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,272	2,511	\$ 133,130	\$ 53.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,593	28,393	932,729	32.85	3
4	Licensed Practical Nurses	63,727	69,979	2,019,850	28.86	4
5	CNAs & Orderlies	127,098	138,497	1,706,156	12.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	28,091	30,978	440,455	14.22	9
10	Activity Assistants					10
11	Social Service Workers	18,942	20,954	356,624	17.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,762	47,165	598,524	12.69	15
16	Dishwashers					16
17	Maintenance Workers	7,751	8,551	157,734	18.45	17
18	Housekeepers	33,352	36,791	425,352	11.56	18
19	Laundry	6,348	6,894	80,070	11.61	19
20	Administrator	4,012	4,341	243,193	56.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,983	27,287	428,199	15.69	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	3,816	4,326	75,600	17.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	387,747	426,667	\$ 7,597,616 *	\$ 17.81	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	356	\$ 12,458	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,433	50,154	10-3	38
39	Pharmacist Consultant	741	37,026	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	11,250	562,500	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	25	872	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13,805	\$ 663,010		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
La Quanta Jordan	Administrator		\$ 40,314
Carrie Dipaolo	Administrator		117,707
Brandin Stephenson	Administrator		28,520
Jeffrey Kalkowski	Administrator		56,652
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 243,193
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	\$	5,534
Johnson & Golburg	Accounting		2,900
Capital One	Accounting		13,509
Lewis Brsibois Bisgaard & Smith	Legal		58,300
Infinity Funding/ sedgwick	Legal		38,611
Jerome Schachter & Associates	Legal		18,212
Johnsen and Bell	legal		49,838
Various	legal		1,493
MTS Consulting	Prof.		11,825
Professional Search Net. Recruiters	Prf		22,516
Various	Prof.		1,027
Mgmt. Fees	Mgmt		338,936
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	562,701
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	223,658
Unemployment Compensation Insurance			81,956
FICA Taxes			566,209
Employee Health Insurance			378,959
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
			14,082
Uniforms			29,715
Pension Exp.			74,618
Employee Exp			750
Patient Background Checks			637
Emploee Background checks			
TOTAL (agree to Schedule V, line 22, col.8)		\$	1,370,584
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		\$	3,980
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed _____)			
Village of Bridgeview			100
Cook Co. Dept of Revenue			218
Employee Exp.			699
IHCA			13,218
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	18,215
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
mileage			34,080
Mgmt Co Mileage			1,040
Seminar Expense			4,287
Mgmt Co Seminar			55
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	39,462

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Midway Neurological Reha Ctr		STATE OF ILLINOIS			Page 22
		#	0047175	Report Period Beginning:	1/1/16	Ending:	12/31/16

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?
If YES, give association name and amount.

IHCA - \$13,218

Yes

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

5 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$96,568

Line10-2

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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
IDPH license number of this related party and the date the present owners took over.

X

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$959,555

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$0

N/A

Indicate the amount.

\$N/A

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A

0

N/A

N/A

N/A

N/A

No

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

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)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes