

		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

<p>I. IDPH License ID Number: <u>0049973</u></p> <p>Facility Name: <u>Neighbors Rehabilitation Center</u></p> <p>Address: <u>811 West 2nd Street</u> <u>Byron</u> <u>61010</u> <small>Number City Zip Code</small></p> <p>County: <u>Ogle</u></p> <p>Telephone Number: <u>(815) 234-2511</u> Fax # <u>(815) 234-3114</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/10/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/10</u> to <u>12/31/10</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary N. Drazner, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary N. Drazner, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input checked="" type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary N. Drazner, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																												

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,865</u>	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	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF			<u>2,891</u>	<u>2,891</u>	8
9	SNF/PED					9
10	ICF	<u>24,191</u>	<u>4,520</u>	<u>2,163</u>	<u>30,874</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,191</u>	<u>4,520</u>	<u>5,054</u>	<u>33,765</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.59%

D. How many bed-hold days during this year were paid by the Department? None (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 6/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/1/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 101 and days of care provided 2,891

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	244,445	15,517	20,244	280,206		280,206	(7,178)	273,028		1
2	Food Purchase		142,411		142,411	(7,282)	135,129	(190)	134,940		2
3	Housekeeping	123,188	18,696		141,884		141,884	(710)	141,174		3
4	Laundry	80,962	24,062		105,024		105,024	(102)	104,922		4
5	Heat and Other Utilities			94,357	94,357		94,357	645	95,002		5
6	Maintenance	50,902	23,059	101,483	175,444		175,444	(19,203)	156,241		6
7	Other (specify):*							1,886	1,886		7
8	TOTAL General Services	499,497	223,745	216,084	939,326	(7,282)	932,044	(24,852)	907,193		8
	B. Health Care and Programs										
9	Medical Director			9,900	9,900		9,900		9,900		9
10	Nursing and Medical Records	1,567,552	74,523	98,153	1,740,228		1,740,228	(13,318)	1,726,910		10
10a	Therapy	98,760	5,259	13,557	117,576		117,576	(7,393)	110,183		10a
11	Activities	107,530	10,809	1,700	120,039		120,039		120,039		11
12	Social Services	49,803		1,700	51,503		51,503		51,503		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,377	2,377		15
16	TOTAL Health Care and Programs	1,823,645	90,591	125,010	2,039,246		2,039,246	(18,334)	2,020,912		16
	C. General Administration										
17	Administrative	75,145		289,808	364,953		364,953	(235,666)	129,287		17
18	Directors Fees										18
19	Professional Services			143,930	143,930	(178)	143,752	(84,809)	58,943		19
20	Dues, Fees, Subscriptions & Promotions			45,206	45,206		45,206	(28,998)	16,208		20
21	Clerical & General Office Expenses	100,601	22,056	149,267	271,924		271,924	(55,699)	216,225		21
22	Employee Benefits & Payroll Taxes			408,342	408,342	7,282	415,624		415,624		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,895	4,895		4,895	3,320	8,215		24
25	Other Admin. Staff Transportation			7,151	7,151		7,151	4,114	11,265		25
26	Insurance-Prop.Liab.Malpractice			67,092	67,092		67,092	313	67,405		26
27	Other (specify):*							21,216	21,216		27
28	TOTAL General Administration	175,746	22,056	1,115,691	1,313,493	7,104	1,320,597	(376,209)	944,388		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,498,888	336,392	1,456,785	4,292,065	(178)	4,291,887	(419,395)	3,872,492		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Neighbors Rehabilitation Center

#0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			16,524	16,524		16,524	95,126	111,650			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,965	9,965		9,965	144,429	154,394			32
33	Real Estate Taxes			61,800	61,800	178	61,978	(187)	61,791			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles			10,254	10,254		10,254	4,740	14,994			35
36	Other (specify):*											36
37	TOTAL Ownership			326,543	326,543	178	326,721	16,108	342,829			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,552	279,484	365,036		365,036		365,036			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298		55,298		55,298			42
43	Other (specify):*			333	333		333	(333)				43
44	TOTAL Special Cost Centers		85,552	335,115	420,667		420,667	(333)	420,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,498,888	421,944	2,118,443	5,039,275		5,039,275	(403,620)	4,635,655			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,197)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(47,371)	30		9
10	Interest and Other Investment Income	(394)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(190)	02		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	(2,438)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,968)	21		24
25	Fund Raising, Advertising and Promotional	(23,158)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,521)	20		28
29	Other-Attach Schedule	(32,679)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (223,116)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(180,504)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (180,504)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (403,620)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (8,115)	21	1
2	Bldg. Co - Amortization	(16,750)	36	2
3				3
4	PT Area Adjustments:			4
5	Utilities	(610)	05	5
6	Maintenance	(1,133)	06	6
7	Insurance	(434)	26	7
8	Depreciation	(107)	30	8
9	Interest	(64)	32	9
10	Real Estate Taxes	(399)	33	10
11				11
12	Capitalized R&M	(3,242)	06	12
13	2010 Seminar Cost	2,817	24	13
14	Non-Allowable Legal	(3,136)	19	14
15	Marketing Expense	(333)	43	15
16	Collection Fee	(1,173)	19	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	(32,679)		49

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(7,178)								(7,178)	1
2	Food Purchase	(190)											(190)	2
3	Housekeeping					(710)							(710)	3
4	Laundry					(102)							(102)	4
5	Heat and Other Utilities	(610)			1,255								645	5
6	Maintenance	(14,572)		(4,227)	(404)								(19,203)	6
7	Other (specify):*			498	1,388								1,886	7
8	TOTAL General Services	(15,372)		(3,729)	(4,939)	(812)							(24,852)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(14,043)	3,853	(3,128)							(13,318)	10
10a	Therapy				(7,393)								(7,393)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,215	1,162								2,377	15
16	TOTAL Health Care and Programs			(12,828)	(2,378)	(3,128)							(18,334)	16
	C. General Administration													
17	Administrative			(270,523)	34,857								(235,666)	17
18	Directors Fees													18
19	Professional Services	(4,309)		(88,266)	7,766								(84,809)	19
20	Fees, Subscriptions & Promotions	(29,117)		119									(28,998)	20
21	Clerical & General Office Expenses	(111,283)		55,547	37								(55,699)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	2,817		503									3,320	24
25	Other Admin. Staff Transportation			4,114									4,114	25
26	Insurance-Prop.Liab.Malpractice	(434)		684	63								313	26
27	Other (specify):*			13,900	7,316								21,216	27
28	TOTAL General Administration	(142,326)		(283,922)	50,039								(376,209)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(157,698)		(300,479)	42,722	(3,940)							(419,395)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(47,478)	138,103		4,501								95,126	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(458)	158,766	(17,629)	3,750								144,429	32
33	Real Estate Taxes	(399)	(1,779)		1,991								(187)	33
34	Rent-Facility & Grounds		(228,000)										(228,000)	34
35	Rent-Equipment & Vehicles			4,740									4,740	35
36	Other (specify):*	(16,750)	16,750											36
37	TOTAL Ownership	(65,085)	83,840	(12,889)	10,242								16,108	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(333)											(333)	43
44	TOTAL Special Cost Centers	(333)											(333)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(223,116)	83,840	(313,368)	52,964	(3,940)							(403,620)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		See Attached
				Neighbors Property, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 228,000	Neighbors Porperty, LLC	100.00%	\$	\$ (228,000)	1
2	V	33 Rental Income - Taxes	61,800	Neighbors Porperty, LLC	100.00%		(61,800)	2
3	V	36 Amortization of Loan Fess		Neighbors Porperty, LLC	100.00%	16,750	16,750	3
4	V	32 Interest Mortgage		Neighbors Porperty, LLC	100.00%	158,766	158,766	4
5	V	33 Real Estate Taxes		Neighbors Porperty, LLC	100.00%	60,021	60,021	5
6	V	30 Depreciation Expense		Neighbors Porperty, LLC	100.00%	138,103	138,103	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 289,800			\$ 373,640	\$ * 83,840	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	6 REPAIRS AND MAINT.	\$ 10,908	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,681	\$ (4,227)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	498	498
17	V	10 NURSING	21,816	S.I.R. MANAGEMENT, INC.	100.00%	7,773	(14,043)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,215	1,215
19	V	19 PROFESSIONAL FEES	89,316	S.I.R. MANAGEMENT, INC.	100.00%	1,050	(88,266)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	119	119
21	V	21 CLERICAL & GENERAL	21,816	S.I.R. MANAGEMENT, INC.	100.00%	29,535	7,719
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	503	503
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,114	4,114
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	684	684
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,139	4,139
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,629)	(17,629)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,740	4,740
28	V						
29	V	17 ADMINISTRATIVE	284,348	S.I.R. MANAGEMENT, INC.	100.00%	13,825	(270,523)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	523	
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	47,828	47,828
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,761	9,761
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 428,204			\$ 115,359	\$ * (313,368)

* 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	1	DIETARY SALARIES	\$ 10,908	S.I.R. MANAGEMENT, INC.	100.00%	\$ 3,730	\$ (7,178)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	589	589	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,853	3,853	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	606	606	18
19	V	17	ADMIN./LEGAL SALARIES	5,460	S.I.R. MANAGEMENT, INC.	100.00%	40,317	34,857	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,736	7,736	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,316	7,316	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	10,908	S.I.R. MANAGEMENT, INC.	100.00%	3,515	(7,393)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	556	556	25
26	V								26
27	V	6	MAINTENANCE SALARIES	5,037	S.I.R. MANAGEMENT, INC.	100.00%	4,223	(814)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	799	799	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,255	1,255	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	410	410	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	30	30	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	37	37	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	63	63	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,501	4,501	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,750	3,750	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,991	1,991	37
38	V								38
39	Total		\$ 32,313				\$ 85,277	\$ * 52,964	39

* 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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	10,661	Xcel Supply, LLC	100.00%	9,951	(710)	16
17	V	4 Laundry	1,529	Xcel Supply, LLC	100.00%	1,427	(102)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	46,929	Xcel Supply, LLC	100.00%	43,801	(3,128)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 59,119			\$ 55,179	\$ * (3,940)	39

* 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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 105,520	\$ 105,520	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	105,520	CCS Employee Benefits Group	100.00%		(105,520)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 105,520			\$ 105,520	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Bryan Barrish	Member	Administrative	11.62%	See Attached	1.68	3.73%	Alloc. Salary	\$ 8,393	17-7	1
2	Michael Giannini	Member	Administrative	9.83%	See Attached	1.47	3.68%	Alloc. Salary	7,000	17-7	2
3	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	0.71	4.18%	Alloc. Salary	1,560	21-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.1	4.20%	Alloc. Salary	4,472	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	2.1	4.20%	Alloc. Salary	3,730	1-7	5
6	Tom Winter	Owner	Administrative	1.77%	See Attached	2.52	4.20%	Alloc. Salary	8,393	17-7	6
7	Adam Vales	Relative	Clerical	0.00%	See Attached	0.55	1.38%	Alloc. Salary	969	22-7	7
8	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.1	0.45%	Alloc. Salary	352	17-7	8
9	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.25	0.54%	Alloc. Salary	4,197	17-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable										11
12	by the IL Dept. of HFS.										12
13								TOTAL	\$ 39,066		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

S.I.R. MANAGEMENT, INC.

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 675 -7979

Fax Number

(847) 675 -0555

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.

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	6	REPAIRS AND MAINT.	PATIENT DAYS	804,585	12	\$ 159,205	\$ 76,299	33,765	\$ 6,681	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		33,765	498	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	33,765	7,773	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		33,765	1,215	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	33,765	1,050	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		33,765	119	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	33,765	29,535	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		33,765	503	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		33,765	4,114	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		33,765	684	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		33,765	4,139	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		33,765	(17,629)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		33,765	4,740	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	33,765	13,825	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		33,765	523	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	33,765	47,828	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		33,765	9,761	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,748,883	\$ 2,300,573		\$ 115,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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	DIETARY SALARIES	PATIENT DAYS	804,585	12	\$ 88,890	\$ 88,890	33,765	\$ 3,730	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		33,765	589	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	33,765	3,853	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		33,765	606	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	33,765	40,317	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		33,765	7,736	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		33,765	7,316	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	10,908	3,515	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,888	12	13,949		10,908	556	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018	5,037	4,223	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079		5,037	799	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		540	1,255	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		540	410	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		540	30	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		540	37	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		540	63	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		540	4,501	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		540	3,750	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		540	1,991	23
24										24
25	TOTALS					\$ 2,238,902	\$ 1,499,668		\$ 85,277	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					9,951	2
3	4	Laundry	Direct Allocation					1,427	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					43,801	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$ 55,179	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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.

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 105,520	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				\$	\$		\$ 105,520	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	The Private Bank		X	Mortgage			\$	\$ 2,503,656			\$ 158,702	1										
2												2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	The Private Bank		X	Line of Credit				450,000			9,965	6										
7	Alloc. - SIR Management	X									3,750	7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related						\$	\$ 2,953,656			\$ 172,417	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(394)	10										
11	Alloc. - SIR Management	X									(17,629)	11										
12												12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			\$ (18,023)	14										
15	TOTALS (line 9+line14)						\$	\$ 2,953,656			\$ 154,394	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related										20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	60,399	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.)		\$	60,211	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(188)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	61,800	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.)		\$	178	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.		\$	61,790	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<u>49,354</u>	<u>8</u>	
	2006	<u>50,172</u>	<u>9</u>	
	2007	<u>49,908</u>	<u>10</u>	
	2008	<u>58,382</u>	<u>11</u>	
	2009	<u>58,220</u>	<u>12</u>	

2010 Accrual = \$58220 x 1.03 = \$61,800				
Alloc. - SIR Management =1,991				
Beginning accrual adjusted as the result of the page 5A adjustment				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Center COUNTY Ogle
 FACILITY IDPH LICENSE NUMBER 0049973
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-31-201-004</u>	<u>Long Term Care Property</u>	\$ <u>58,220.46</u>	\$ <u>58,220.46</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>80,891.59</u>	\$ <u>2,656.22</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>139,112.05</u>	\$ <u>60,876.68</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Center COUNTY Ogle
 FACILITY IDPH LICENSE NUMBER 0049973
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 NO

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,195 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

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).
Physical Therapy Room for non-residents. Applicable costs have been adjusted out on page 5

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,175,000	82,052		55,769	(26,283)	144,070	67
68		62,771	2,068		2,769	701	24,852	68
69			16,417			(16,417)		69
70		\$ 2,237,771	\$ 100,537		\$ 58,538	\$ (41,999)	\$ 168,922	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 2,237,771	\$ 100,537		\$ 58,538	\$ (41,999)	\$ 168,922	1
2	Tile Flooring	2009	30,221		20	1,511	1,511	3,022	2
3	Sign	2009	3,451		20	345	345	575	3
4	Nurse Station	2009	16,260		20	813	813	1,491	4
5	Water Heater	2009	5,560		20	278	278	510	5
6	Boiler Work	2009	6,695		20	335	335	558	6
7	Electrical Work	2010	9,400		20	392	392	392	7
8	Flooring	2010	12,484		20	364	364	364	8
9	Furnace - 300 Wing	2010	4,796		20	40	40	40	9
10	Furnace	2010	2,850		20	24	24	24	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,329,488	\$ 100,537		\$ 62,640	\$ (37,897)	\$ 175,897	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information								1
2	Buildings:								2
3		1971	2,175,000	82,052	39	55,769	(26,283)	144,070	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,175,000	\$ 82,052		\$ 55,769	\$ (26,283)	\$ 144,070	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1993	18,980	603	35	542	(61)	9,490	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	2010	1,145		20	19	19	19	9
10	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	2009	1,140	140	20	57	(83)	103	10
11	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	2007	332	36	20	17	(19)	66	11
12	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	2002	75		20	4	4	32	12
13	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1999	2,405		20	120	120	1,383	13
14	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1998	1,149		20	57	57	718	14
15	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1997	72		20	4	4	52	15
16	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1994	181	5	20	9	4	149	16
17	<u>Alloc.-S.I.R. Properties - S.I.R. Management</u>	1993	308	2	20	15	13	270	17
18									18
19	<u>Alloc.-S.I.R. Management</u>	1993	4,812	134	20	239	105	4,294	19
20	<u>Alloc.-S.I.R. Management</u>	1994	15		20			15	20
21	<u>Alloc.-S.I.R. Management</u>	1995	110		20	5	5	85	21
22	<u>Alloc.-S.I.R. Management</u>	1997	7,394	166	20	370	204	5,105	22
23	<u>Alloc.-S.I.R. Management</u>	1999	581		20	29	29	327	23
24	<u>Alloc.-S.I.R. Management</u>	2000	686		20	34	34	362	24
25	<u>Alloc.-S.I.R. Management</u>	2007	2,205	236	20	110	(126)	352	25
26	<u>Alloc.-S.I.R. Management</u>	2008	6,078	608	20	383	(225)	1,090	26
27	<u>Alloc.-S.I.R. Management</u>	2009	15,103	138	20	755	617	940	27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 62,771	\$ 2,068		\$ 2,769	\$ 701	\$ 24,852	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 448,226	\$ 58,334	\$ 48,428	\$ (9,906)	10	\$ 121,572	71
72	Current Year Purchases	7,868	68	468	400	10	468	72
73	Fully Depreciated Assets	16,462		33	33	10	16,462	73
74								74
75	TOTALS	\$ 472,556	\$ 58,402	\$ 48,928	\$ (9,474)		\$ 138,502	75

D. Vehicle Depreciation (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		Allocated from SIR Management	2010	\$ 1,111	\$ 83	\$ 83	\$	5	\$ 83	76
77										77
78										78
79										79
80	TOTALS			\$ 1,111	\$ 83	\$ 83	\$		\$ 83	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)	\$ 2,803,155	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,022	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 111,651	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,371)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 314,482	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? YES NO

If NO, see instructions.

		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? YES NO

16. Rental Amount for movable equipment: \$ 14,994 Description: See Attached Schedule

(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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 123,274				\$ 123,274	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				13,515				13,515	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				142,695				142,695	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					72,987			72,987	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>							12,565			12,565	13
14	TOTAL				\$		\$ 279,484	\$ 85,552		\$	365,036	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973Report Period Beginning: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 151,715	\$ 153,798	1
2	Cash-Patient Deposits	16,543	16,543	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	744,495	744,495	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,300	44,300	6
7	Other Prepaid Expenses	10,983	10,983	7
8	Accounts Receivable (owners or related parties)	260,000	260,000	8
9	Other(specify): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,228,036	\$ 1,230,119	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		70,000	13
14	Buildings, at Historical Cost		1,358,976	14
15	Leasehold Improvements, at Historical Cost	68,891	325,316	15
16	Equipment, at Historical Cost	94,928	694,178	16
17	Accumulated Depreciation (book methods)	(32,168)	(341,783)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		83,852	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(43,271)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		857,500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 131,651	\$ 3,004,768	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,359,687	\$ 4,234,887	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 123,631	\$ 123,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,806	16,806	28
29	Short-Term Notes Payable	450,000	450,000	29
30	Accrued Salaries Payable	216,138	216,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,219	12,219	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,800	61,800	32
33	Accrued Interest Payable		13,947	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,500	7,500	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		260,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 888,094	\$ 1,162,041	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,503,656	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,503,656	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 888,094	\$ 3,665,697	46
47	TOTAL EQUITY(page 18, line 24)	\$ 471,593	\$ 569,190	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,359,687	\$ 4,234,887	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 695,992	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 695,992	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	208,201	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	(432,600)	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)	\$ (224,399)	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)	\$ 471,593	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Neighbors Rehabilitation Center**# **0049973**Report Period Beginning: **01/01/10**Ending: **12/31/10****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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,783,008	1
2	Discounts and Allowances for all Levels	(436,833)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,346,175	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	717,450	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 717,450	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	96,247	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,794	19
20	Radiology and X-Ray	2,535	20
21	Other Medical Services	14,179	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,755	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	394	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 394	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	64,702	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 64,702	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,247,476	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	939,326	31
32	Health Care	2,039,246	32
33	General Administration	1,313,493	33
B. Capital Expense			
34	Ownership	326,543	34
C. Ancillary Expense			
35	Special Cost Centers	365,369	35
36	Provider Participation Fee	55,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,039,275	40
41	Income before Income Taxes (line 30 minus line 40)**	208,201	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 208,201	43

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

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

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

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

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	1,947	2,103	\$ 70,730	\$ 33.63	1
2	Assistant Director of Nursing	1,843	2,099	51,211	24.40	2
3	Registered Nurses	8,802	9,246	225,694	24.41	3
4	Licensed Practical Nurses	15,135	16,473	352,939	21.43	4
5	CNAs & Orderlies	60,104	65,958	789,438	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,255	5,899	98,760	16.74	8
9	Activity Director	3,783	4,185	55,255	13.20	9
10	Activity Assistants	4,381	4,692	52,275	11.14	10
11	Social Service Workers	4,104	4,405	49,803	11.31	11
12	Dietician					12
13	Food Service Supervisor	2,025	2,396	39,023	16.29	13
14	Head Cook	8,581	9,272	109,712	11.83	14
15	Cook Helpers/Assistants	8,934	9,516	95,710	10.06	15
16	Dishwashers					16
17	Maintenance Workers	3,440	3,806	50,902	13.37	17
18	Housekeepers	10,262	11,224	123,188	10.98	18
19	Laundry	6,948	7,576	80,962	10.69	19
20	Administrator	1,893	2,086	75,145	36.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,781	6,316	100,601	15.93	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	3,584	4,046	77,540	19.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	156,802	171,298	\$ 2,498,888 *	\$ 14.59	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 20,244	01-03	35
36	Medical Director	Monthly	9,900	09-03	36
37	Medical Records Consultant	Monthly	720	10-03	37
38	Nurse Consultant	Monthly	21,816	10-03	38
39	Pharmacist Consultant	Monthly	5,830	10-03	39
40	Physical Therapy Consultant	Monthly	1,344	10a-03	40
41	Occupational Therapy Consultant	Monthly	1,118	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	187	10a-03	43
44	Activity Consultant	Monthly	1,700	11-03	44
45	Social Service Consultant	Monthly	1,700	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	10,908	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 75,467		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	282	\$ 11,095	10-03	50
51	Licensed Practical Nurses	611	20,239	10-03	51
52	Certified Nurse Assistants/Aides	2,009	38,453	10-03	52
53	TOTAL (lines 50 - 52)	2,902	\$ 69,787		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Pawn Thammarath</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 75,145</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 73,753</u>	<u>IDPH License Fee</u>	<u>\$ 1,323</u>	
				<u>Unemployment Compensation Insurance</u>	<u>20,456</u>	<u>Advertising: Employee Recruitment</u>	<u>2,875</u>	
				<u>FICA Taxes</u>	<u>187,315</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>102,415</u>	<u>(Indicate # of checks performed <u>212</u>)</u>	<u>2,120</u>	
				<u>Employee Meals</u>	<u>7,282</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>9,371</u>	
				<u>401k Contribution</u>	<u>10,000</u>	<u>Licenses & Permits</u>	<u>400</u>	
				<u>Employee Benefits- Other</u>	<u>14,403</u>	<u>Advertising and Promotion</u>	<u>23,158</u>	
						<u>Yellow Pages Advertising</u>	<u>3,521</u>	
						<u>See Supplemental Schedule</u>	<u>119</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>(23,158)</u>	
						<u>Yellow page advertising</u>	<u>(3,521)</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 75,145					
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
					\$ 415,624		\$ 16,208	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
<u>S.I.R. Management- Dir Of Admin Services</u>			<u>\$ 21,816</u>	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
<u>S.I.R. Management- Ancillary Admin Charges</u>			<u>22,428</u>				Description	Amount
<u>S.I.R. Management- Owners Concil Dues</u>			<u>5,460</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>See Supplemental Schedule</u>			<u>240,104</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 289,808				<u>In-State Travel</u>	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount			\$	()
<u>Frost, Ruttenberg, & Rothblatt</u>	<u>Accounting</u>		<u>\$ 19,275</u>				<u>(agree to Sch. V,</u>	
<u>S.I.R. Management</u>	<u>Accounting</u>		<u>36,000</u>				<u>line 24, col. 8)</u>	
<u>S.I.R. Management</u>	<u>Bookkeeping</u>		<u>42,408</u>				TOTAL	\$ 8,215
<u>Personnel Planners</u>	<u>Unemployment Tax Consltg</u>		<u>2,064</u>					
<u>eHealth Data Solutions</u>	<u>Computer Services</u>		<u>3,600</u>					
<u>Pinnacle Consulting</u>	<u>Customer Satisfaction</u>		<u>1,534</u>					
<u>Accumed Services</u>	<u>MDS Software</u>		<u>3,465</u>					
<u>Pension Specialists</u>	<u>401k Services</u>		<u>3,316</u>					
<u>Olympic Engineering</u>	<u>Engineering</u>		<u>10,000</u>					
<u>Grabowski</u>	<u>Collection Fee</u>		<u>1,173</u>					
<u>Honkamp Krueger</u>	<u>Fed. Tax Credit Program</u>		<u>360</u>					
<u>See Supplemental Schedule</u>			<u>20,734</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 143,929					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973Report Period Beginning: 01/01/10Ending: 12/31/10**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. ICLTC - \$7830
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,425 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,298
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. \$ 7,282 Has any meal income been offset against related costs? No 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? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.