FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0049973

Facility Name: Neighbors Rehabilitation Center

Address: 811 West Second (Number) Byron (City) 61010 (Zip Code)

County: Ogle

Telephone Number: (815) 234-2511 **Fax #** (815) 234-3114

HFS ID Number:

Date of Initial License for Current Owners: 07/10/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	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	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,562	3,562	8
9	SNF/PED					9
10	ICF	23,291	4,375	2,582	30,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,291	4,375	6,144	33,810	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.71%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 6/1/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 3,562

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,799	17,251	23,282	281,332		281,332	(8,430)	272,902			1
2	Food Purchase		145,219		145,219	(7,391)	137,828	(1,167)	136,660			2
3	Housekeeping	125,364	18,853		144,217		144,217	(472)	143,745			3
4	Laundry	77,415	23,789		101,204		101,204		101,204			4
5	Heat and Other Utilities			114,183	114,183		114,183	(11,355)	102,828			5
6	Maintenance	42,146	49,278	110,876	202,300		202,300	(12,624)	189,676			6
7	Other (specify):*							5,846	5,846			7
8	TOTAL General Services	485,724	254,390	248,341	988,455	(7,391)	981,064	(28,202)	952,861			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900		9,900			9
10	Nursing and Medical Records	1,578,091	77,150	68,154	1,723,395		1,723,395	(15,567)	1,707,828			10
10a	Therapy	99,749	1,192	14,508	115,449		115,449	(7,394)	108,055			10a
11	Activities	108,636	11,380	1,774	121,790		121,790		121,790			11
12	Social Services	58,616		1,774	60,390		60,390		60,390			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,813	2,813			15
16	TOTAL Health Care and Programs	1,845,092	89,722	96,110	2,030,924		2,030,924	(20,148)	2,010,776			16
	C. General Administration											
17	Administrative	85,043		316,370	401,413		401,413	(263,693)	137,720			17
18	Directors Fees											18
19	Professional Services			143,267	143,267	(474)	142,793	(85,288)	57,505			19
20	Dues, Fees, Subscriptions & Promotions			45,327	45,327		45,327	(28,477)	16,850			20
21	Clerical & General Office Expenses	101,285	18,801	74,649	194,735		194,735	19,828	214,563			21
22	Employee Benefits & Payroll Taxes			420,081	420,081	7,391	427,472		427,472			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,030	5,030		5,030	351	5,381			24
25	Other Admin. Staff Transportation			5,300	5,300		5,300	4,835	10,135			25
26	Insurance-Prop.Liab.Malpractice			71,945	71,945		71,945	327	72,272			26
27	Other (specify):*							21,541	21,541			27
28	TOTAL General Administration	186,328	18,801	1,081,969	1,287,098	6,917	1,294,015	(330,576)	963,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,517,144	362,913	1,426,420	4,306,477	(474)	4,306,003	(378,926)	3,927,077			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: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,199	22,199		22,199	98,757	120,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,443	13,443		13,443	145,440	158,883			32
33	Real Estate Taxes			61,800	61,800	474	62,274	(1,046)	61,228			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles			7,177	7,177		7,177	3,518	10,695			35
36	Other (specify):*											36
37	**TOTAL Ownership**			332,619	332,619	474	333,093	18,669	351,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,920	305,354	425,274		425,274	(18,301)	406,973			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,298	177,298		177,298		177,298			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		119,920	482,652	602,572		602,572	(18,301)	584,271			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,517,144	482,833	2,241,691	5,241,668		5,241,668	(378,558)	4,863,110			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,924)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(42,542)	30		9
10	Interest and Other Investment Income	(5,445)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(187)	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	(750)	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	(20,659)	21		24
25	Fund Raising, Advertising and Promotional	(23,884)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,430)	20		28
29	Other-Attach Schedule	(62,884)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (175,205)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(203,353)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,353)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (378,558)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (7,808)	21	1
2	Shareholder Interest	(1,675)	32	2
3	Miscellaneous Income	(145)	21	3
4	Guest Meals	(980)	2	4
5	Non-Allowable Legal	(6,888)	19	5
6	Bldg. Co. Amortization	(16,750)	36	6
7	Bldg. Co. Office Expense	(1,200)	21	7
8	Capitalized R&M	(5,697)	6	8
9	Additional R&M	2,125	6	9
10	State Replacement Tax	(1,000)	21	10
11	Prior Period Pharmacy	(18,301)	39	11
12				12
13	Physical Therapy Allocations:			13
14	Utilities	(738)	5	14
15	Maintenance	(1,207)	6	15
16	Insurance	(465)	26	16
17	Depreciation	(742)	30	17
18	Interest	(1,039)	32	18
19	Real Estate Taxes	(374)	33	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**	(62,884)		49

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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:** 01/01/11 **Ending:** 12/31/11

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				(8,430)								(8,430)	1
2	Food Purchase	(1,167)											(1,167)	2
3	Housekeeping					(472)							(472)	3
4	Laundry													4
5	Heat and Other Utilities	(12,662)			1,307								(11,355)	5
6	Maintenance	(4,779)		(6,751)	(1,068)	(26)							(12,624)	6
7	Other (specify):*			426	5,420								5,846	7
8	**TOTAL General Services**	(18,608)		(6,325)	(2,771)	(498)							(28,202)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(16,379)	3,838	(3,026)							(15,567)	10
10a	Therapy				(7,394)								(7,394)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,351	1,462								2,813	15
16	**TOTAL Health Care and Programs**			(15,028)	(2,094)	(3,026)							(20,148)	16
	C. General Administration													
17	Administrative			(302,914)	39,221								(263,693)	17
18	Directors Fees													18
19	Professional Services	(6,888)		(86,531)	8,131								(85,288)	19
20	Fees, Subscriptions & Promotions	(29,064)		587									(28,477)	20
21	Clerical & General Office Expenses	(33,312)	1,200	51,904	36								19,828	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			351									351	24
25	Other Admin. Staff Transportation			4,835									4,835	25
26	Insurance-Prop.Liab.Malpractice	(465)		730	62								327	26
27	Other (specify):*			12,685	8,856								21,541	27
28	**TOTAL General Administration**	(69,729)	1,200	(318,353)	56,306								(330,576)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,337)	1,200	(339,706)	51,441	(3,525)							(378,926)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Neighbors Rehabilitation Center **#** 0049973 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	(43,284)	138,103		4,174	(237)							98,757	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,159)	154,418	(4,418)	3,599								145,440	32
33	Real Estate Taxes	(374)	(3,956)		3,284								(1,046)	33
34	Rent-Facility & Grounds		(228,000)										(228,000)	34
35	Rent-Equipment & Vehicles			3,518									3,518	35
36	Other (specify):*	(16,750)	16,750											36
37	**TOTAL Ownership**	(68,567)	77,315	(900)	11,057	(237)							18,669	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(18,301)											(18,301)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(18,301)											(18,301)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(175,205)	78,515	(340,606)	62,498	(3,761)							(378,558)	45

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 228,000	Neighbors Property, LLC	100.00%	$	$ (228,000)	1
2	V	33	Rental Income - Taxes	61,800	Neighbors Property, LLC	100.00%		(61,800)	2
3	V	36	Amortization of Loan Fees		Neighbors Property, LLC	100.00%	16,750	16,750	3
4	V	30	Depreciation Expense		Neighbors Property, LLC	100.00%	138,103	138,103	4
5	V	32	Interest Mortgage		Neighbors Property, LLC	100.00%	154,418	154,418	5
6	V	21	Office Expense		Neighbors Property, LLC	100.00%	1,200	1,200	6
7	V	33	Real Estate Taxes		Neighbors Property, LLC	100.00%	57,844	57,844	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 289,800			$ 368,315	$ * 78,515	14

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 12,120	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,369	$ (6,751)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	426	426	16
17	V	10	NURSING	24,240	S.I.R. MANAGEMENT, INC.	100.00%	7,861	(16,379)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,351	1,351	18
19	V	19	PROFESSIONAL FEES	92,964	S.I.R. MANAGEMENT, INC.	100.00%	6,433	(86,531)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	587	587	20
21	V	21	CLERICAL & GENERAL	24,240	S.I.R. MANAGEMENT, INC.	100.00%	26,449	2,209	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	351	351	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,835	4,835	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	730	730	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,319	2,319	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(4,418)	(4,418)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,518	3,518	27
28	V								28
29	V	17	ADMINISTRATIVE	316,370	S.I.R. MANAGEMENT, INC.	100.00%	13,456	(302,914)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	966		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	49,695	49,695	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,366	10,366	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 469,934			$ 130,294	$ * (340,606)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 12,120	S.I.R. MANAGEMENT, INC.	100.00%	$ 3,690	$ (8,430)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	642	642	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,838	3,838	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	664	664	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	39,221	39,221	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,629	7,629	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,856	8,856	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	12,120	S.I.R. MANAGEMENT, INC.	100.00%	4,726	(7,394)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	798	798	25
26	V								26
27	V	6	MAINTENANCE SALARIES	25,438	S.I.R. MANAGEMENT, INC.	100.00%	23,835	(1,603)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,778	4,778	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,307	1,307	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	535	535	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	28	28	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	36	36	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	62	62	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,174	4,174	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,599	3,599	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,284	3,284	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	474	474	38
39	Total			$ 49,678			$ 112,176	$ * 62,498	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	7,789	Xcel Supply, LLC	100.00%	7,317	(472)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance	430	Xcel Supply, LLC	100.00%	404	(26)	18
19	V	10	Nursing	49,919	Xcel Supply, LLC	100.00%	46,893	(3,026)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation	3,905	Xcel Supply, LLC	100.00%	3,668	(237)	23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 62,044			$ 58,282	$ * (3,761)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 127,511	$ 127,511	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	127,511	CCS Employee Benefits Group	100.00%		(127,511)	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			$ 127,511			$ 127,511	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES, LLC	36.282%	ALBANY CARE INC	EVANSTON	NEIGHBORS PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED PARTNERSHIP	12.748%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST D/T/D 9/1/04	12.748%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	MICHAEL GIANNINI TRUST	10.786%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	EXTENDED CARE-OWNER'S CO	LINCOLNWOOD	MANAGEMENT CO.	4
5	RALPH GESUALDO	12.748%	ELMWOOD CARE, INC.	ELMWOOD PARK	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	5
6	RALPH GESUALDO CHILDRENS TRUST	12.748%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD	CCS VEBA	EVANSTON	HEALTH INSURANCE	6
7	THOMAS WINTER	1.942%	GREENWOOD CARE, INC.	EVANSTON				7
8			MAPLEWOOD CARE, INC.	ELGIN				8
9			REGENCY REHABILITATION CENTER,LLC	NILES				9
10			ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11			WILSON CARE, INC.	CHICAGO				11
12			APPLEWOOD REHABILITATION CENTER	MATTESON				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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Member	Administrative	12.75%	See Attached	1.61	3.58%	Alloc. Salary	$ 8,073	17-7	1
2	Michael Giannini	Member	Administrative	10.79%	See Attached	1.41	3.53%	Alloc. Salary	6,741	17-7	2
3	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	1.61	3.58%	Alloc. Salary	1,818	21-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.02	4.04%	Alloc. Salary	4,834	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	2.02	4.04%	Alloc. Salary	3,690	1-7	5
6	Tom Winter	Owner	Administrative	1.95%	See Attached	2.42	4.03%	Alloc. Salary	8,073	17-7	6
7	Adam Vales	Relative	Clerical	0.00%	See Attached	0.76	1.90%	Alloc. Salary	1,348	22-7	7
8	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.2	0.50%	Alloc. Salary	778	17-7	8
9	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.24	0.52%	Alloc. Salary	5,502	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	$ 40,857		13

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

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	$ 133,007	$ 59,965	33,810	$ 5,369	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		33,810	426	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	33,810	7,861	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		33,810	1,351	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	33,810	6,433	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		33,810	587	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	33,810	26,449	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		33,810	351	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		33,810	4,835	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		33,810	730	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		33,810	2,319	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		33,810	(4,418)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		33,810	3,518	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	33,810	13,456	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		33,810	966	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	33,810	49,695	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		33,810	10,366	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,227,764	$ 2,435,627		$ 130,294	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	$ 91,408	$ 91,408	33,810	$ 3,690	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		33,810	642	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	33,810	3,838	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		33,810	664	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	33,810	39,221	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		33,810	7,629	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		33,810	8,856	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	12,120	4,726	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		12,120	798	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	25,438	23,835	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		25,438	4,778	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		520	1,307	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		520	535	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		520	28	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		520	36	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		520	62	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		520	4,174	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		520	3,599	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		520	3,284	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		520	474	24
25	TOTALS					$ 2,490,426	$ 1,625,498		$ 112,176	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						7,317	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation						404	4
5	10	Nursing	Direct Allocation						46,893	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation						3,668	9
10	39	Ancillary	Direct Allocation							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					$	$		$ 58,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 127,511	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					$	$		$ 127,511	25

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X	Mortgage			$	$ 2,449,408			$ 153,379	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	The Private Bank		X	Line of Credit				1,100,000			11,767	6
7	Shareholder Loan	X						150,000			1,675	7
8	See Supplemental Schedule										3,599	8
9	TOTAL Facility Related						$	$ 3,699,408			$ 170,420	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,445)	10
11	Shareholder Loan	X									(1,675)	11
12	Alloc. - SIR Management	X									(4,418)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (11,538)	14
15	TOTALS (line 9+line14)						$	$ 3,699,408			$ 158,882	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: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. - SIR Management						$	$			$ 3,599	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,599	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.)

Facility Name & ID Number Neighbors Rehabilitation Center **#** 0049973 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 62,173	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.)		$ 61,127	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,046)	3
4. Real Estate Tax accrual used for 2011 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.**		$ 474	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.		$ 61,228	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	50,172	8
2007	49,908	9
2008	58,382	10
2009	58,220	11
2010	57,843	12

2011 Accrual = $57,843 x 1.07 = $61,800 (Rounded)
Allocated from SIR Management = $3,758
Beginning accrual adjusted as the result of the page 5A adjustment

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

NOTES:

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

2010 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-31-201-004	Long-Term Care Property	$ 57,843.70	$ 57,843.70
2.	See Attached	See Attached	$ 76,900.85	$ 3,104.69
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134,744.55	$ 60,948.39

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0049973

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 5A

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		2008	1971	$ 2,175,000	$ 92,017	39	$ 55,769	$ (36,248)	$ 199,839	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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		60,802	1,899		2,704	805	26,109	68
69	Financial Statement Depreciation			21,457			(21,457)		69
70	TOTAL (lines 4 thru 69)		$ 2,235,802	$ 115,373		$ 58,473	$ (56,900)	$ 225,948	70

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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,235,802	$ 115,373		$ 58,473	$ (56,900)	$ 225,948	1
2	Tile Flooring	2008	30,221		20	1,511	1,511	4,533	2
3	Sign	2009	3,451		20	345	345	920	3
4	Nurse Station	2009	16,260		20	813	813	2,304	4
5	Water Heater	2009	5,560		20	278	278	788	5
6	Boiler Work	2009	6,695		20	335	335	893	6
7	Electrical Work	2010	9,400		20	470	470	862	7
8	Flooring - Carpet	2010	12,484		20	1,783	1,783	2,824	8
9	Furnace - 300 Wing	2010	4,796		20	240	240	280	9
10	Furnace	2010	2,850		20	143	143	166	10
11	Water Heater	2011	6,381		20	239	239	239	11
12	Closet Units (100 Built-In)	2011	57,000		20	2,375	2,375	2,375	12
13	Sprinkler System	2011	152,422		20	4,446	4,446	4,446	13
14	Sprinkler System	2011	26,898		20	448	448	448	14
15	Steel Fencing	2011	9,893		20	371	371	371	15
16	Sprinkler Monitoring System	2011	5,697		20				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)		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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
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22									22
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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)		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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
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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)		$ 2,585,810	$ 115,373		$ 72,270	$ (43,103)	$ 247,396	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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.

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$	$		$	$	$	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Alloc.-S.I.R. Properties - S.I.R. Management	1993	18,275	580	35	522	(58)	9,137	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc.-S.I.R. Properties - S.I.R. Management	2010	1,103		20	55	55	74	9
10	Alloc.-S.I.R. Properties - S.I.R. Management	2009	1,097	96	20	55	(41)	154	10
11	Alloc.-S.I.R. Properties - S.I.R. Management	2007	320	26	20	16	(10)	80	11
12	Alloc.-S.I.R. Properties - S.I.R. Management	2002	72		20	4	4	35	12
13	Alloc.-S.I.R. Properties - S.I.R. Management	1999	2,316		20	116	116	1,447	13
14	Alloc.-S.I.R. Properties - S.I.R. Management	1998	1,107		20	55	55	747	14
15	Alloc.-S.I.R. Properties - S.I.R. Management	1997	69		20	3	3	53	15
16	Alloc.-S.I.R. Properties - S.I.R. Management	1994	174	4	20	9	5	152	16
17	Alloc.-S.I.R. Properties - S.I.R. Management	1993	296	2	20	15	13	274	17
18									18
19	Alloc.-S.I.R. Management	1993	4,633	129	20	230	101	4,364	19
20	Alloc.-S.I.R. Management	1994	14		20			14	20
21	Alloc.-S.I.R. Management	1995	106		20	5	5	87	21
22	Alloc.-S.I.R. Management	1997	7,120	159	20	349	190	5,265	22
23	Alloc.-S.I.R. Management	1999	560		20	28	28	343	23
24	Alloc.-S.I.R. Management	2000	661		20	33	33	381	24
25	Alloc.-S.I.R. Management	2007	2,124	196	20	106	(90)	445	25
26	Alloc.-S.I.R. Management	2008	5,852	559	20	369	(190)	1,418	26
27	Alloc.-S.I.R. Management	2009	14,543	133	20	727	594	1,632	27
28	Alloc.-S.I.R. Management	2011	360	15	20	7	(8)	7	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.

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								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
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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)		$ 60,802	$ 1,899		$ 2,704	$ 805	$ 26,109	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 454,653	$ 47,944	$ 45,897	$ (2,047)	10	$ 167,628	71
72	Current Year Purchases	43,079	5	2,579	2,574	10	2,596	72
73	Fully Depreciated Assets	16,018		9	9	10	16,018	73
74								74
75	TOTALS	$ 513,750	$ 47,949	$ 48,484	$ 535		$ 186,242	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from SIR	2011	$ 1,419	$ 175	$ 201	$ 26	5	$ 281	76
77										77
78										78
79										79
80	TOTALS			$ 1,419	$ 175	$ 201	$ 26		$ 281	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)	$ 3,100,979	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 163,497	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,955	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (42,542)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 433,918	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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 ☒ X NO
16. Rental Amount for movable equipment: $ 10,695 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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

STATE OF ILLINOIS
0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 139,624	$		$ 139,624	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,988			9,988	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			151,233			151,233	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 prescrpts				95,963		95,963	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					4,509	23,957		28,466	13
14	TOTAL			$		$ 305,354	$ 119,920		$ 425,274	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

STATE OF ILLINOIS

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 73,801	$ 76,857	1
2	Cash-Patient Deposits	23,190	23,190	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,844,841	1,844,841	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,212	44,212	6
7	Other Prepaid Expenses	1,660	1,660	7
8	Accounts Receivable (owners or related parties)	130,000	130,000	8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,117,704	$ 2,120,760	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	321,485	843,259	15
16	Equipment, at Historical Cost	139,933	739,183	16
17	Accumulated Depreciation (book methods)	(54,367)	(547,784)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		83,752	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(60,021)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	47,098	904,598	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 454,149	$ 3,391,963	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,571,853	$ 5,512,723	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 284,481	$ 284,481	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,200	23,200	28
29	Short-Term Notes Payable	1,250,000	1,250,000	29
30	Accrued Salaries Payable	212,467	212,467	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,871	12,871	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,800	61,800	32
33	Accrued Interest Payable		13,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,000	11,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	35,625	165,625	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,891,444	$ 2,034,873	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,449,408	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,449,408	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,891,444	$ 4,484,281	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 680,409	$ 1,028,442	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,571,853	$ 5,512,723	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 471,593	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 471,590	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	565,419	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	(226,600)	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)**	$ 338,819	17
	B. Transfers (Itemize):		
18	Capital Transfer to Building Co.	(130,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (130,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 680,409	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,905,966	1
2	Discounts and Allowances for all Levels	(1,168,116)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,737,850	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	939,720	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 939,720	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	980	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,836	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,770	19
20	Radiology and X-Ray	3,518	20
21	Other Medical Services	21,167	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 110,271	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,445	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,445	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,801	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,801	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,807,087	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	988,455	31
32	Health Care	2,030,924	32
33	General Administration	1,287,098	33
	B. Capital Expense		
34	Ownership	332,619	34
	C. Ancillary Expense		
35	Special Cost Centers	425,274	35
36	Provider Participation Fee	177,298	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,241,668	40
41	**Income before Income Taxes (line 30 minus line 40)****	565,419	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 565,419	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: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,996	2,101	$ 76,206	$ 36.27	1
2	Assistant Director of Nursing	2,356	2,480	57,605	23.23	2
3	Registered Nurses	11,281	11,875	293,907	24.75	3
4	Licensed Practical Nurses	12,104	12,741	268,881	21.10	4
5	CNAs & Orderlies	63,641	66,991	805,903	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,616	5,912	99,749	16.87	8
9	Activity Director	3,995	4,206	56,397	13.41	9
10	Activity Assistants	4,272	4,575	52,239	11.42	10
11	Social Service Workers	5,066	5,333	58,616	10.99	11
12	Dietician					12
13	Food Service Supervisor	5,026	4,238	62,887	14.84	13
14	Head Cook	6,780	7,451	83,971	11.27	14
15	Cook Helpers/Assistants	9,042	9,518	93,941	9.87	15
16	Dishwashers					16
17	Maintenance Workers	4,136	4,357	42,146	9.67	17
18	Housekeepers	10,184	11,139	125,364	11.25	18
19	Laundry	6,480	7,065	77,415	10.96	19
20	Administrator	2,041	2,148	85,043	39.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,831	6,138	101,285	16.50	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	3,943	4,151	75,589	18.21	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	163,790	172,419	$ 2,517,144 *	$ 14.60	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 23,282	01-03	35
36	Medical Director	Monthly	9,900	09-03	36
37	Medical Records Consultant	Monthly	960	10-03	37
38	Nurse Consultant	Monthly	24,240	10-03	38
39	Pharmacist Consultant	Monthly	6,056	10-03	39
40	Physical Therapy Consultant	Monthly	1,227	10a-03	40
41	Occupational Therapy Consultant	Monthly	1,086	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	75	10a-03	43
44	Activity Consultant	Monthly	1,774	11-03	44
45	Social Service Consultant	Monthly	1,774	12-03	45
46	Other(specify)				46
47	Special Rehab Consult.	Monthly	12,120	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 82,494		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	323	$ 12,690	10-03	50
51	Licensed Practical Nurses	692	23,149	10-03	51
52	Certified Nurse Assistants/Aides	63	1,059	10-03	52
53	TOTAL (lines 50 - 52)	1,078	$ 36,898		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0.00%	$ 85,043
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,043

B. Administrative - Other

Description	Amount
SIR Managemant- Dir. Of Admin Services	$ 24,240
SIR Managemant- Ancillary Admin Charges	24,240
SIR Management- Management Fees	267,890
TOTAL (agree to Schedule V, line 17, col. 3)	$ 316,370
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 8,721
SIR Management	Legal	12,120
SIR Management	Accounting	36,000
Frost, Ruttenberg, & Rothblatt	Accounting	21,013
SIR Management	Bookkeeping	44,844
Personel Planners	Unemployment Tax Counsltg	2,028
eHealth Data Solutions	Computer Services	3,600
Pinnacle Consulting	Customer Satisfaction	1,252
Accumed Services	MDS Software	4,095
Pension Specialist	401K Specialist	3,887
HDSI	Computer Services	288
See Supplemetal Schedule		5,419
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 143,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,194
Unemployment Compensation Insurance	28,360
FICA Taxes	188,892
Employee Health Insurance	108,669
Employee Meals	7,391
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching	12,782
Other Benefits	14,184
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,472

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	2,044
Health Care Worker Background Check	1,420
(Indicate # of checks performed 142)	
Patient Background Checks	
Advertising and Promotion	28,314
Dues & Subscriptions	9,984
Licences &Permits	823
Allocated from S.I.R. Management	587
Less: Public Relations Expense	( )
Non-allowable advertising	(23,884)
Yellow page advertising	(4,430)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,850

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,030
Allocated from S.I.R. Management	351
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,381

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 - $8,592**

(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. $ **33,810** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **177,298**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,391** 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.