FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0049973

Facility Name: Neighbors Rehabilitation Ctr

Address: 811 West 2nd Street (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: 7/10/2008

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	17,964	4,851	5,989	28,804	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,964	4,851	5,989	28,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.13%

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 06/12/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/2008 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 2,668

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	227,915	13,685	22,875	264,475		264,475	(9,296)	255,179			1
2	Food Purchase		165,974		165,974	(9,855)	156,119	(871)	155,248			2
3	Housekeeping	135,828	23,911		159,739		159,739		159,739			3
4	Laundry	80,492	27,897		108,389		108,389		108,389			4
5	Heat and Other Utilities			110,304	110,304		110,304	(15,169)	95,135			5
6	Maintenance	43,680	38,165	112,915	194,760		194,760	(390)	194,370			6
7	Other (specify):*							4,422	4,422			7
8	**TOTAL General Services**	487,915	269,632	246,094	1,003,641	(9,855)	993,786	(21,304)	972,482			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900		9,900			9
10	Nursing and Medical Records	1,352,068	103,915	366,570	1,822,553		1,822,553	(13,957)	1,808,596			10
10a	Therapy	96,254		9,745	105,999		105,999	(4,981)	101,018			10a
11	Activities	103,587	11,981	1,787	117,355		117,355		117,355			11
12	Social Services	67,345		1,789	69,134		69,134		69,134			12
13	CNA Training											13
14	Program Transportation			4,183	4,183		4,183		4,183			14
15	Other (specify):*							2,982	2,982			15
16	**TOTAL Health Care and Programs**	1,619,254	115,896	393,974	2,129,124		2,129,124	(15,956)	2,113,168			16
	C. General Administration											
17	Administrative	90,136		53,328	143,464		143,464	(822)	142,642			17
18	Directors Fees											18
19	Professional Services			157,684	157,684	(339)	157,345	(87,016)	70,329			19
20	Dues, Fees, Subscriptions & Promotions			59,146	59,146		59,146	(31,161)	27,985			20
21	Clerical & General Office Expenses	120,619	15,585	78,281	214,485		214,485	17,105	231,590			21
22	Employee Benefits & Payroll Taxes			363,242	363,242	9,855	373,097		373,097			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,554	3,554		3,554	397	3,951			24
25	Other Admin. Staff Transportation			11,224	11,224		11,224	(7,075)	4,149			25
26	Insurance-Prop.Liab.Malpractice			66,126	66,126		66,126	670	66,796			26
27	Other (specify):*							20,288	20,288			27
28	**TOTAL General Administration**	210,755	15,585	792,585	1,018,925	9,516	1,028,441	(87,614)	940,827			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,317,924	401,113	1,432,653	4,151,690	(339)	4,151,351	(124,874)	4,026,477			29

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

Facility Name & ID Number Neighbors Rehabilitation Ctr #0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			36,944	36,944		36,944	106,552	143,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,803	19,803		19,803	108,980	128,783			32
33	Real Estate Taxes			60,000	60,000	339	60,339	3,370	63,709			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles			13,992	13,992		13,992	3,140	17,132			35
36	Other (specify):*											36
37	**TOTAL Ownership**			358,739	358,739	339	359,078	(5,958)	353,120			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,737	419,639	533,376		533,376		533,376			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,950	222,950		222,950		222,950			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		113,737	642,589	756,326		756,326		756,326			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,317,924	514,850	2,433,981	5,266,755	(0)	5,266,755	(130,832)	5,135,923			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(592)	02		4
5	Telephone, TV & Radio in Resident Rooms	(15,422)	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	(35,429)	30		9
10	Interest and Other Investment Income	(1,259)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(279)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,049)	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	(17,068)	21		24
25	Fund Raising, Advertising and Promotional	(22,685)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,283)	20		28
29	Other-Attach Schedule	(50,454)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (149,520)		$	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)	18,688		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,688		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,832)		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

STATE OF ILLINOIS **Page 5A**

Neighbors Rehabilitation Ctr

ID# **0049973**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections	$ (3,260)	19	1
2	Bank Fees	(9,457)	21	2
3	Miscellaneous Income	(15)	21	3
4	State Replacement Tax	(1,105)	21	4
5	Additional R&M	1,763	06	5
6	Non Allowable Dues	(900)	20	6
7	Capitalized R&M	(2,549)	06	7
8	Bldg Co - Fees	(250)	20	8
9	Bldg Co. - Professional Fees	(16,450)	19	9
10	PAC Dues	(2,660)	20	10
11	Prior Year Adjustment	(946)	10	11
12	Non Allowable Travel	(12,000)	25	12
13				13
14				14
15				15
16				16
17	Physical Therapy Allocation :			17
18	Utilities	(713)	05	18
19	Maintenance	(730)	06	19
20	Insurance	(427)	26	20
21	Depreciation	(239)	30	21
22	Interest	(128)	32	22
23	Real Estate Taxes	(388)	33	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**	(50,454)		49

Neighbors Rehabilitation Ctr

ID# 0049973

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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				(9,296)								(9,296)	1
2	Food Purchase	(871)											(871)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,135)			966								(15,169)	5
6	Maintenance	(1,516)		(6,733)	7,859								(390)	6
7	Other (specify):*			338	4,084								4,422	7
8	**TOTAL General Services**	(18,522)		(6,395)	3,613								(21,304)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(946)		(16,918)	3,907								(13,957)	10
10a	Therapy				(4,981)								(4,981)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,721	1,261								2,982	15
16	**TOTAL Health Care and Programs**	(946)		(15,197)	187								(15,956)	16
	C. General Administration													
17	Administrative			(40,343)	39,521								(822)	17
18	Directors Fees													18
19	Professional Services	(19,710)	16,450	(91,680)	7,924								(87,016)	19
20	Fees, Subscriptions & Promotions	(32,827)	250	1,416									(31,161)	20
21	Clerical & General Office Expenses	(27,645)		44,715	35								17,105	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			397									397	24
25	Other Admin. Staff Transportation	(12,000)		4,925									(7,075)	25
26	Insurance-Prop.Liab.Malpractice	(427)		1,028	69								670	26
27	Other (specify):*			12,128	8,160								20,288	27
28	**TOTAL General Administration**	(92,609)	16,700	(67,414)	55,709								(87,614)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(112,077)	16,700	(89,006)	59,509								(124,874)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(35,668)	139,408		2,812								106,552	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,387)	117,103	(9,794)	3,058								108,980	32
33	Real Estate Taxes	(388)	72		3,686								3,370	33
34	Rent-Facility & Grounds		(228,000)										(228,000)	34
35	Rent-Equipment & Vehicles			3,140									3,140	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(37,443)	28,583	(6,654)	9,556								(5,958)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(149,520)	45,283	(95,660)	69,065								(130,832)	45

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	60,000	Neighbors Property, LLC	100.00%		(60,000)	2
3	V	19	Professional Fees		Neighbors Property, LLC	100.00%	16,450	16,450	3
4	V	30	Depreciation		Neighbors Property, LLC	100.00%	139,408	139,408	4
5	V	20	Fees		Neighbors Property, LLC	100.00%	250	250	5
6	V	32	Interest - Mortgage		Neighbors Property, LLC	100.00%	117,103	117,103	6
7	V	33	Real Estate Tax	928	Neighbors Property, LLC	100.00%	61,000	60,072	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 288,928			$ 334,211	$ * 45,283	14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 5,387	$ (6,733)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	338	338	16
17	V	10	NURSING	29,088	S.I.R. MANAGEMENT, INC.	100.00%	12,170	(16,918)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,721	1,721	18
19	V	19	PROFESSIONAL FEES	100,236	S.I.R. MANAGEMENT, INC.	100.00%	5,102	(95,134)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,416	1,416	20
21	V	21	CLERICAL & GENERAL	29,088	S.I.R. MANAGEMENT, INC.	100.00%	22,669	(6,419)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	397	397	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,925	4,925	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,028	1,028	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,575	3,575	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(9,794)	(9,794)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,612	2,612	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	528	528	28
29	V								29
30	V	17	ADMINISTRATIVE	53,328	S.I.R. MANAGEMENT, INC.	100.00%	12,985	(40,343)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	3,454	3,454	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	51,134	51,134	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,553	8,553	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 223,860			$ 128,200	$ * (95,660)	39

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 2,824	$ (9,296)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	416	416	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,907	3,907	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	557	557	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	39,521	39,521	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,549	7,549	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,160	8,160	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	9,696	S.I.R. MANAGEMENT, INC.	100.00%	4,715	(4,981)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	704	704	25
26	V								26
27	V	6	MAINTENANCE SALARIES	16,353	S.I.R. MANAGEMENT, INC.	100.00%	23,453	7,100	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,668	3,668	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	966	966	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	759	759	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	375	375	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	35	35	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	69	69	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,812	2,812	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,058	3,058	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,686	3,686	37
38	V								38
39	Total			$ 38,169			$ 107,234	$ * 69,065	39

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	Ancillary	$ 5,376	Long Term Care Laboratory, LLC	100.00%	$ 5,376	$	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			$ 5,376			$ 5,376	$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST D/T/D 9/1/04	12.748%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	MICHAEL GIANNINI TRUST	10.786%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	RALPH GESUALDO	12.748%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	RALPH GESUALDO CHILDRENS TRUST	12.748%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	THOMAS WINTER	1.942%	OAKTON PAVILLION	DESPLAINES				7
8			GREENWOOD CARE, INC.	EVANSTON				8
9			WESLEY HEALTHCARE & REHABILITATION CENTER	AUBURN				9
10			REGENCY REHABILITATION CENTER,LLC	NILES				10
11			ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Relative	Administrative	0	See Attached	1.53	3.40%	Alloc. Salary	$ 7,665	17-7	1
2	Kirsten Barrish	Relative	Clerical	0	See Attached	1.92	3.84%	Alloc. Salary	3,536	21-7	2
3	Sarah Barrish	Relative	Administrative	0	See Attached	1.72	3.82%	Alloc. Salary	4,663	17-7	3
4	Michael Giannini	Relative	Administrative	0	See Attached	1.34	3.35%	Alloc. Salary	6,398	17-7	4
5	Nenita Guzman	Relative	Dietary	0	See Attached	1.92	3.84%	Alloc. Salary	2,824	1-7	5
6	Tom Winter	Owner	Administrative	1.94	See Attached	2.3	3.83%	Alloc. Salary	7,665	17-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 32,751		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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	751,530	16	$ 140,542	$ 58,090	28,804	$ 5,387	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		28,804	338	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	28,804	12,170	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		28,804	1,721	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	28,804	5,102	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		28,804	1,416	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	28,804	22,669	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		28,804	397	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		28,804	4,925	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		28,804	1,028	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		28,804	3,575	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		28,804	(9,794)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		28,804	2,612	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		28,804	528	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	28,804	12,985	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		28,804	3,454	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	28,804	51,134	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		28,804	8,553	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 128,200	25

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	751,530	16	$ 73,669	$ 73,669	28,804	$ 2,824	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		28,804	416	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	28,804	3,907	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		28,804	557	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	28,804	39,521	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		28,804	7,549	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		28,804	8,160	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	9,696	4,715	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		9,696	704	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	16,353	23,453	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		16,353	3,668	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		494	966	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		494	759	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		494	375	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		494	35	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		494	69	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		494	2,812	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		494	3,058	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		494	3,686	23
24										24
25	TOTALS					$ 2,757,482	$ 1,907,027		$ 107,234	25

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Long Term Care Laboratory, LLC
Street Address: 2458 Elmhurst Road
City / State / Zip Code: Elk Grove Village, IL 60007
Phone Number: (630)422-7800
Fax Number: (847)422-1360

	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	39	Ancillary	Direct Allocation			$	$		$ 5,376	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					$	$		$ 5,376	25

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$ 2,283,500			$ 117,103	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				760,350			19,070	6
7	GMAC		X	Note Payable				9,506			605	7
8	See Supplemental Schedule							150,000			3,058	8
9	TOTAL Facility Related						$	$ 3,203,356			$ 139,836	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,259)	10
11	Alloc - SIR Management										(9,794)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,053)	14
15	TOTALS (line 9+line14)						$	$ 3,203,356			$ 128,783	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.)**

**** 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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Member Loans	X					$	$ 150,000			$	8
9	Alloc - SIR Management										3,058	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							150,000			3,058	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 Ctr **#** 0049973 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 60,388	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.)		$ 62,758	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,370	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,000	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.)**		$ 339	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.		$ 63,709	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	58,220	8
2010	57,843	9
2011	56,599	10
2012	58,482	11
2013	59,072	12

2014 Accrual = $59,072 x 1.0325 = $61000. (Rounded)

Allocated from SIR Management = $3,686

Beginning Accural is adjusted for the Real Estate tax expense allocated to the outpatient therapy.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Ctr 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 2013 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 2013.

	(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	$ 59,072.32	$ 59,072.32
2.	Home Office Allocation	See attached	$ 116,016.54	$ 3,484.81
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 175,088.86	$ 62,557.13

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Ctr 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 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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Facility		2008	$ 170,000	1
2					2
3	TOTALS			$ 170,000	3

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 78,179	39	$ 55,769	$ (22,410)	$ 367,146	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	30,221		20	1,511	1,511	9,192	9
10	Various			2009	31,966		20	1,771	1,771	10,217	10
11	Various			2010	29,530		20	2,636	2,636	12,039	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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)		44,751	1,305		2,238	933	2,238	67
68	Related Party Allocations (Pages 12H & 12I)		69,661	1,881		2,667	786	34,061	68
69	Financial Statement Depreciation			36,705			(36,705)		69
70	TOTAL (lines 4 thru 69)		$ 2,381,129	$ 118,070		$ 66,591	$ (51,479)	$ 434,893	70

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,381,129	$ 118,070		$ 66,591	$ (51,479)	$ 434,893	1
2	Water Heater	2011	6,381		20	319	319	1,196	2
3	Closet Units (100 Built-In)	2011	57,000		20	2,850	2,850	10,925	3
4	Sprinkler System	2011	152,422		20	7,621	7,621	27,309	4
5	Sprinkler System	2011	26,898		20	1,345	1,345	4,483	5
6	Steel Fencing	2011	9,893		20	495	495	1,855	6
7	Sprinkler Monitoring System	2011	5,697		20	285	285	1,068	7
8	Generator Transfer Switch	2012	4,720		20	236	236	708	8
9	Sprinkler System	2012	28,360		20	1,418	1,418	3,900	9
10	Wiring For Emergency Recepticles	2012	3,075		20	154	154	346	10
11	Generator	2012	72,600		20	3,630	3,630	8,470	11
12	Condensing Unit	2012	2,625		20	131	131	273	12
13	Anti Freeze Loop Sprinkler	2013	3,397		20	170	170	340	13
14	Hvac Roof-Top Units	2013	9,471		20	474	474	710	14
15	Door Holders And Alarm Devices	2013	2,653		20	133	133	188	15
16	Security System	2013	5,790		20	290	290	338	16
17	Seal Coating & Asphalt Repairs	2013	3,778		20	189	189	299	17
18	Plumbing Backflow Device	2013	2,716		20	136	136	272	18
19	10 Air Conditioners	2013	5,525		20	276	276	460	19
20	Drainage Tile Installation & Gutter Repair	2013	2,627		20	131	131	186	20
21	Backflow Device	2014	3,198		20	160	160	160	21
22	Parking Lot Paving	2014	14,321		20	477	477	477	22
23	Doors	2014	2,549		20	127	127	127	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)		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,806,825	$ 118,070		$ 87,637	$ (30,433)	$ 498,983	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Drywall / Hallways 100 & 400	2014	44,751	1,305	20	2,238	933	2,238	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 44,751	$ 1,305		$ 2,238	$ 933	$ 2,238	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 44,751	$ 1,305		$ 2,238	$ 933	$ 2,238	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 44,751	$ 1,305		$ 2,238	$ 933	$ 2,238	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	9,589		20	246	246	1,240	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	17,361	551	20	496	(55)	10,665	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	4,402	123	20		(123)	4,402	9
10	Alloc. - S.I.R. Management	1994	14		20			14	10
11	Alloc. - S.I.R. Management	1995	101		20	5	5	98	11
12	Alloc. - S.I.R. Management	1997	6,764	151	20	330	179	5,991	12
13	Alloc. - S.I.R. Management	1999	532		20	27	27	405	13
14	Alloc. - S.I.R. Management	2000	628		20	31	31	457	14
15	Alloc. - S.I.R. Management	2007	2,017	138	20	101	(37)	726	15
16	Alloc. - S.I.R. Management	2008	5,560	531	20	350	(181)	2,399	16
17	Alloc. - S.I.R. Management	2009	13,815	126	20	691	565	3,623	17
18	Alloc. - S.I.R. Management	2011	342	34	20	34		117	18
19	Alloc. - S.I.R. Management	2012	1,094	55	20	55		132	19
20	Alloc. - S.I.R. Management	2014	153		20	4	4	4	20
21	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,063	105	20	5	(100)	14	21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,048		20	52	52	227	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,042	47	20	52	5	302	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2007	304	15	20	15		122	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2002	69		20	3	3	43	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	1999	2,200		20	110	110	1,705	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,051		20	53	53	867	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1997	65		20	3	3	61	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1994	165	4	20	4		165	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1993	282	1	20		(1)	282	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 69,661	$ 1,881		$ 2,667	$ 786	$ 34,061	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 69,661	$ 1,881		$ 2,667	$ 786	$ 34,061	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 69,661	$ 1,881		$ 2,667	$ 786	$ 34,061	34

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 517,167	$ 60,663	$ 52,286	$ (8,377)	10	$ 307,459	71
72	Current Year Purchases	16,987	71	1,189	1,118	10	1,189	72
73	Fully Depreciated Assets	30,921				10	30,921	73
74								74
75	TOTALS	$ 565,075	$ 60,734	$ 53,475	$ (7,259)		$ 339,569	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		2012 DODGE MINIVAN	2012	$ 19,000	$	$ 2,241	$ 2,241	5	$ 6,302	76
77		Allocated from S.I.R. Manageme	2014	1,348	122	144	22	5	777	77
78										78
79										79
80	TOTALS			$ 20,348	$ 122	$ 2,385	$ 2,263		$ 7,079	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)	$ 3,562,248	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,926	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,497	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,429)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 845,631	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	Land	$ 100,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 100,000	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction Project	$ 340,830	92
93			93
94			94
95		$ 340,830	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 Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 14,520 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	Allocated from S.I.R. Management		$	$ 2,612	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,612	21

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

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 145,773	$		$ 145,773	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,359			85,359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			188,507			188,507	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				91,865		91,865	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						21,872		21,872	13
14	TOTAL			$		$ 419,639	$ 113,737		$ 533,376	14

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 19,814	$ 31,500	1
2	Cash-Patient Deposits	17,630	17,630	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,172,190	1,172,190	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,111	40,111	6
7	Other Prepaid Expenses	4,960	4,960	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	83,800	83,800	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,338,505	$ 1,350,191	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		1,358,976	14
15	Leasehold Improvements, at Historical Cost	476,853	1,043,378	15
16	Equipment, at Historical Cost	208,650	807,900	16
17	Accumulated Depreciation (book methods)	(156,640)	(1,065,671)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	448,691	1,211,440	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 977,554	$ 3,526,023	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,316,059	$ 4,876,214	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 234,818	$ (249,994)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,640	17,640	28
29	Short-Term Notes Payable	910,350	910,350	29
30	Accrued Salaries Payable	151,652	151,652	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,059	10,059	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	61,000	32
33	Accrued Interest Payable		10,150	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,000	9,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	311,370	311,370	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,704,889	$ 1,231,227	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,506	9,506	39
40	Mortgage Payable		2,283,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,506	$ 2,293,006	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,714,395	$ 3,524,233	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 601,664	$ 1,351,981	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,316,059	$ 4,876,214	48

***(See instructions.)**

Facility Name & ID Number Neighbors Rehabilitation Ctr **#** 0049973 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 536,065	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 536,065	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	65,599	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	( )	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)**	$ 65,599	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 601,664	24	*

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,297,857	1
2	Discounts and Allowances for all Levels	(1,394,471)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,903,386	3
	B. Ancillary Revenue		
4	Day Care	1,130	4
5	Other Care for Outpatients		5
6	Therapy	1,313,670	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,314,800	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	592	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,290	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,243	19
20	Radiology and X-Ray	1,936	20
21	Other Medical Services	22,833	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 112,894	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,259	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,259	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	15	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,332,354	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,003,641	31
32	Health Care	2,129,124	32
33	General Administration	1,018,925	33
	B. Capital Expense		
34	Ownership	358,739	34
	C. Ancillary Expense		
35	Special Cost Centers	533,376	35
36	Provider Participation Fee	222,950	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,266,755	40
41	**Income before Income Taxes (line 30 minus line 40)****	65,599	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 65,599	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,428,628	44
45	Private Pay - Net Inpatient Revenue	959,944	45
46	Medicare - Net Inpatient Revenue	123,127	46
47	Other-(specify) Hospice	380,014	47
48	Other-(specify) HMO / Insurance	11,673	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,903,386	49

* **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.**

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

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,065	2,331	$ 80,342	$ 34.47	1
2	Assistant Director of Nursing	1,857	2,063	59,139	28.67	2
3	Registered Nurses	5,419	5,703	135,564	23.77	3
4	Licensed Practical Nurses	12,814	13,959	310,418	22.24	4
5	CNAs & Orderlies	52,630	56,867	688,259	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,469	5,888	96,254	16.35	8
9	Activity Director	3,493	4,151	58,555	14.11	9
10	Activity Assistants	3,840	4,154	45,032	10.84	10
11	Social Service Workers	5,090	5,552	67,345	12.13	11
12	Dietician					12
13	Food Service Supervisor	1,817	2,063	32,509	15.76	13
14	Head Cook	6,918	7,135	73,538	10.31	14
15	Cook Helpers/Assistants	11,359	12,112	121,868	10.06	15
16	Dishwashers					16
17	Maintenance Workers	2,825	3,024	43,680	14.44	17
18	Housekeepers	11,361	12,491	135,828	10.87	18
19	Laundry	6,612	7,162	80,492	11.24	19
20	Administrator	1,833	2,063	90,136	43.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,834	7,292	120,619	16.54	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	3,706	4,112	78,346	19.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,942	158,122	$ 2,317,924 *	$ 14.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,875	01-03	35
36	Medical Director	Monthly	9,900	09-03	36
37	Medical Records Consultant	Quarterly	780	10-03	37
38	Nurse Consultant		29,088	10-03	38
39	Pharmacist Consultant	Monthly	5,946	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	49	10a-03	43
44	Activity Consultant	Monthly	1,787	11-03	44
45	Social Service Consultant	Monthly	1,789	12-03	45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	9,696	10a-03	47
48	Consultant-Infectious Disease	4	1,000	10-03	48
49	TOTAL (lines 35 - 48)	5	$ 82,910		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,814	$ 87,556	10-03	50
51	Licensed Practical Nurses	6,986	242,200	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,800	$ 329,756		53

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0	$ 89,136
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,136

B. Administrative - Other

Description	Amount
SIR Management - Dir of Admin Services	$ 29,088
SIR Management - Ancillary Admin Charges	24,240
SIR Management - Consulting Fees	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 53,328
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FROST	Accounting	$ 14,905
Plante Moran	Accounting	4,075
Personnel Planners	Unemployment Consult	2,313
SIR Management	Bookkeeping	49,692
Legal Fees	Collections - Adj on Pg 5A	3,260
SIR Management	Legal Fees	14,544
Neal Gerber & Eisenberg	Legal Fees	4,468
Michael Favia & Assoc	Legal Fees	1,050
Legit Architect	Professional Fees	2,879
SIR Management	Dir of Financial Services	36,000
See Supplemental Schedule		24,498
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 157,684

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,436
Unemployment Compensation Insurance	37,609
FICA Taxes	174,167
Employee Health Insurance	83,315
Employee Meals	9,855
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	7,414
Other Employee Benefits	19,301
TOTAL (agree to Schedule V, line 22, col.8)	$ 373,097

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	8,106
Health Care Worker Background Check	
(Indicate # of checks performed 120)	1,120
Patient Background Checks	
Licenses & Permits	7,621
Dues & Subscriptions	7,731
Allocated from SIR Management	1,416
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,985

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,554
Allocated from SIR Management	397
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,951

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Neighbors Rehabilitation Ctr # 0049973 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 $8,060.**

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

(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. $ **8,558** Line **10-02**

(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. $ **222,950**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **Yes** Has any meal income been offset against related costs? Indicate the amount. $ **592**

(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 out of Schedule V? **Yes**

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