FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049973

Facility Name: Neighbors Rehabilitation Center

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

County: Ogle

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

HFS ID Number:

Date of Initial License for Current Owners: 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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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)	
	(Firm Name & Address)	Marcum, LLP 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
	(Telephone)	(847) 282-6300 Fax # (847) 282-6301

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 282-6300
Email Address:

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,940	3,277	4,403	26,620	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,940	3,277	4,403	26,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.21%

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 2,173

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number: Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	222,790	19,475	22,626	264,891		264,891	(8,629)	256,262			1
2	Food Purchase		160,430		160,430	(10,238)	150,192	(232)	149,960			2
3	Housekeeping	127,595	18,175		145,770		145,770		145,770			3
4	Laundry	81,361	35,079		116,440		116,440		116,440			4
5	Heat and Other Utilities			97,280	97,280		97,280	(15,971)	81,309			5
6	Maintenance	34,950	26,179	126,702	187,831		187,831	(822)	187,009			6
7	Other (specify):*							2,812	2,812			7
8	**TOTAL General Services**	466,696	259,338	246,608	972,642	(10,238)	962,404	(22,842)	939,562			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900		9,900			9
10	Nursing and Medical Records	1,161,930	99,830	338,291	1,600,051		1,600,051	(6,947)	1,593,104			10
10a	Therapy	103,313		10,197	113,510		113,510	(4,625)	108,885			10a
11	Activities	89,504	8,811	1,790	100,105		100,105		100,105			11
12	Social Services	57,770		1,790	59,560		59,560		59,560			12
13	CNA Training											13
14	Program Transportation			2,267	2,267		2,267		2,267			14
15	Other (specify):*							2,917	2,917			15
16	**TOTAL Health Care and Programs**	1,412,517	108,641	364,235	1,885,393		1,885,393	(8,655)	1,876,738			16
	C. General Administration											
17	Administrative	90,366		53,328	143,694		143,694	(1,367)	142,327			17
18	Directors Fees											18
19	Professional Services			204,689	204,689		204,689	(116,145)	88,544			19
20	Dues, Fees, Subscriptions & Promotions			89,459	89,459		89,459	(50,390)	39,069			20
21	Clerical & General Office Expenses	98,498	17,504	135,121	251,123		251,123	(55,321)	195,802			21
22	Employee Benefits & Payroll Taxes			363,934	363,934	10,238	374,172		374,172			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,533	5,533		5,533	562	6,095			24
25	Other Admin. Staff Transportation			9,010	9,010		9,010	3,328	12,338			25
26	Insurance-Prop.Liab.Malpractice			63,471	63,471		63,471	699	64,170			26
27	Other (specify):*							18,799	18,799			27
28	**TOTAL General Administration**	188,864	17,504	924,545	1,130,913	10,238	1,141,151	(199,835)	941,316			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,068,077	385,483	1,535,388	3,988,948		3,988,948	(231,332)	3,757,616			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 Center #0049973 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			37,969	37,969		37,969	109,322	147,291			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,083	43,083		43,083	110,051	153,134			32
33	Real Estate Taxes			59,551	59,551		59,551	2,900	62,451			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles			3,144	3,144		3,144	3,163	6,307			35
36	Other (specify):*											36
37	**TOTAL Ownership**			371,747	371,747		371,747	(2,565)	369,182			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,318	313,448	400,766		400,766	(404)	400,362			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,161	208,161		208,161		208,161			42
43	Other (specify):*	26,894			26,894		26,894	(26,894)	0			43
44	**TOTAL Special Cost Centers**	26,894	87,318	521,609	635,821		635,821	(27,298)	608,523			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,094,971	472,801	2,428,744	4,996,516		4,996,516	(261,195)	4,735,321			45

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(35)	02		4
5	Telephone, TV & Radio in Resident Rooms	(16,461)	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	(35,876)	30		9
10	Interest and Other Investment Income	(20,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(197)	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	(1,033)	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	(92,727)	21		24
25	Fund Raising, Advertising and Promotional	(26,718)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(301)	06		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,398)	20		28
29	Other-Attach Schedule	(82,503)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (279,687)		$	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)	18,492		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,492		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (261,195)		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

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Collections	$ (4,494)	21	1
2	Bank Fees	(9,375)	21	2
3	Marketing Salary	(26,894)	43	3
4	Non-allowable Fees	(13,130)	20	4
5	Non-allowable Legal Fees	(7,371)	19	5
6	Non-allowable Dues	(825)	20	6
7	PAC Dues	(6,061)	20	7
8	Additional R&M	6,767	06	8
9	Capitalized R&M	(3,401)	06	9
10	Bldg Co - Fees	(250)	20	10
11	Bldg Co. - Professional Fees	(14,253)	19	11
12	Real Estate Tax Late Fee	(449)	21	12
13				13
14				14
15				15
16				16
17	Physical Therapy Allocation :			17
18	Utilities	(629)	05	18
19	Maintenance	(819)	06	19
20	Insurance	(410)	26	20
21	Depreciation	(245)	30	21
22	Interest	(278)	32	22
23	Real Estate Taxes	(385)	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**	(82,503)		49

STATE OF ILLINOIS

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(8,629)								(8,629)	1
2	Food Purchase	(232)											(232)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(17,090)			1,119								(15,971)	5
6	Maintenance	2,246	525	(9,772)	6,179								(822)	6
7	Other (specify):*				2,812								2,812	7
8	TOTAL General Services	(15,076)	525	(9,772)	1,481								(22,842)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(10,770)	3,850	(27)							(6,947)	10
10a	Therapy				(4,625)								(4,625)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,670	1,247								2,917	15
16	TOTAL Health Care and Programs			(9,100)	472	(27)							(8,655)	16
	C. General Administration													
17	Administrative			(40,811)	39,444								(1,367)	17
18	Directors Fees													18
19	Professional Services	(21,624)	14,253	(116,272)	7,498								(116,145)	19
20	Fees, Subscriptions & Promotions	(51,415)	250	775									(50,390)	20
21	Clerical & General Office Expenses	(107,045)		51,674	50								(55,321)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			562									562	24
25	Other Admin. Staff Transportation			3,328									3,328	25
26	Insurance-Prop.Liab.Malpractice	(410)		1,001	108								699	26
27	Other (specify):*			10,291	8,508								18,799	27
28	TOTAL General Administration	(180,494)	14,503	(89,452)	55,608								(199,835)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(195,570)	15,028	(108,324)	57,561	(27)							(231,332)	29

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(36,121)	141,980		3,463								109,322	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,716)	134,393	(6,705)	3,079								110,051	32
33	Real Estate Taxes	(385)	(712)		3,997								2,900	33
34	Rent-Facility & Grounds		(228,000)										(228,000)	34
35	Rent-Equipment & Vehicles			3,163									3,163	35
36	Other (specify):*													36
37	TOTAL Ownership	(57,223)	47,661	(3,542)	10,539								(2,565)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(392)	(12)						(404)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(26,894)											(26,894)	43
44	TOTAL Special Cost Centers	(26,894)				(392)	(12)						(27,298)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(279,687)	62,689	(111,866)	68,100	(418)	(12)						(261,195)	45

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 228,000	Neighbors Property, LLC	100.00%	$	$ (228,000)	1
2	V	33	Rental Income- Taxes	62,000	Neighbors Property, LLC	100.00%		(62,000)	2
3	V	19	Professional Fees		Neighbors Property, LLC	100.00%	14,253	14,253	3
4	V	30	Depreciation		Neighbors Property, LLC	100.00%	141,980	141,980	4
5	V	20	Fees		Neighbors Property, LLC	100.00%	250	250	5
6	V	32	Interest - Mortgage		Neighbors Property, LLC	100.00%	114,515	114,515	6
7	V	33	Real Estate Tax	712	Neighbors Property, LLC	100.00%	62,000	61,288	7
8	V	32	Interest - Other		Neighbors Property, LLC	100.00%	19,878	19,878	8
9	V	06	Repair and Maintainance		Neighbors Property, LLC	100.00%	525	525	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 290,712			$ 353,401	$ * 62,689	14

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 12,120	S.I.R. MANAGEMENT, INC.	100.00%	$ 2,348	$ (9,772)	15
16	V								16
17	V	10	NURSING	29,088	S.I.R. MANAGEMENT, INC.	100.00%	18,318	(10,770)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,670	1,670	18
19	V	19	PROFESSIONAL FEES	118,380	S.I.R. MANAGEMENT, INC.	100.00%	1,895	(116,485)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	775	775	20
21	V	21	CLERICAL & GENERAL	14,544	S.I.R. MANAGEMENT, INC.	100.00%	59,400	44,856	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	562	562	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,328	3,328	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,001	1,001	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,145	3,145	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(6,705)	(6,705)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,689	2,689	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	474	474	28
29	V								29
30	V	17	ADMINISTRATIVE	53,328	S.I.R. MANAGEMENT, INC.	100.00%	12,517	(40,811)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	213	213	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	6,818	6,818	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,146	7,146	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 227,460			$ 115,594	$ * (111,866)	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 12,120	S.I.R. MANAGEMENT, INC.	100.00%	$ 3,491	$ (8,629)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	487	487	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,850	3,850	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	533	533	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	39,444	39,444	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,461	7,461	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,508	8,508	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	9,696	S.I.R. MANAGEMENT, INC.	100.00%	5,071	(4,625)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	714	714	25
26	V								26
27	V	6	MAINTENANCE SALARIES	9,982	S.I.R. MANAGEMENT, INC.	100.00%	15,533	5,551	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,325	2,325	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,119	1,119	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	628	628	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	37	37	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	50	50	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	108	108	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,463	3,463	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,079	3,079	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,997	3,997	37
38	V								38
39	Total			$ 31,798			$ 99,898	$ * 68,100	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 2,040	MAC Rx, LLC	100.00%	$ 2,013	$ (27)	15
16	V	39	Ancillary	29,651	MAC Rx, LLC	100.00%	29,260	(392)	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			$ 31,691			$ 31,273	$ * (418)	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary	$ 1,491	Long Term Care Laboratory, LLC	100.00%	$ 1,479	$ (12)	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			$ 1,491			$ 1,479	$ * (12)	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	36.28%	ALBANY CARE INC	EVANSTON	NEIGHBORS PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED PARTNERSHIP	12.75%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST D/T/D 9/1/04	12.75%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	MICHAEL GIANNINI TRUST	10.79%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	RALPH GESUALDO	12.75%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	RALPH GESUALDO CHILDRENS TRUST	12.75%	ELMWOOD CARE, INC.	ELMWOOD PARK	MAC RX LLC	DES PLAINES	PHARMACY	6
7	THOMAS WINTER	1.94%	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			WILSON CARE	CHICAGO				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number: Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
					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	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	0	See Attached	1.48	3.29%		$ 7,382	17-7	1
2	Kirsten Schloss	Relative	Maintenance	0	See Attached	1.85	3.70%		3,555	6-7	2
3	Sarah Barrish	Relative	Administrative	0	See Attached	1.66	3.69%		3,888	17-7	3
4	Michael Giannini	Relative	Administrative	0	See Attached	1.29	3.23%		6,311	17-7	4
5	Nenita Guzman	Relative	Dietary	0	See Attached	1.85	3.70%		3,491	1-7	5
6	Tom Winter	Owner	Administrative	1.94	See Attached	2.21	3.68%		7,382	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	$ 32,009		13

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

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	26,620	$ 2,348	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	26,620	18,318	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		26,620	1,670	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		26,620	1,895	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		26,620	775	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	26,620	59,400	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		26,620	562	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		26,620	3,328	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		26,620	1,001	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		26,620	3,145	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		26,620	(6,705)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		26,620	2,689	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		26,620	474	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	26,620	12,517	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		26,620	213	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	26,620	6,818	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		26,620	7,146	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 115,594	25

Facility Name & ID Number: Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	26,620	$ 3,491	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		26,620	487	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	26,620	3,850	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		26,620	533	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	26,620	39,444	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		26,620	7,461	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		26,620	8,508	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	9,696	5,071	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		9,696	714	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	9,982	15,533	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		9,982	2,325	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		475	1,119	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		475	628	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		475	37	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		475	50	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		475	108	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		475	3,463	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		475	3,079	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		475	3,997	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 99,898	25

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 2,013	1
2	39	Ancillary	Direct Allocation						29,260	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					$	$		$ 31,273	25

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 1,479	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					$	$		$ 1,479	25

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 2,249,046			$ 114,515	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				850,000			21,095	6
7	SIR Loan Account	X		Loan				1,700,000			21,305	7
8	See Supplemental Schedule							5,574			3,484	8
9	TOTAL Facility Related						$	$ 4,804,620			$ 160,399	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,438)	10
11	BLDG Co - Construction Interest		X								19,878	11
12	Alloc - SIR Management	X									(6,705)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,265)	14
15	TOTALS (line 9+line14)						$	$ 4,804,620			$ 153,134	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 9,683 Line # 33

* 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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Van		X	Note Payable			$	$ 5,574			$ 405	8
9	Alloc - SIR Management	X									3,079	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							5,574			3,484	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

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

Line	Description		Amount	
1.	Real Estate Tax accrual used on 2014 report.	$	61,385	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.)	$	63,836	2
3.	Under or (over) accrual (line 2 minus line 1).	$	2,451	3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,000	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.	$		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.	$	62,451	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2010	57,843	8
2011	56,599	9
2012	58,482	10
2013	59,072	11
2014	59,839	12

2015 Accrual = 2014 tax (rounded)
Allocated from SIR Management = $3,997

FOR BHF USE ONLY

Line	Description		Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2014	$		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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Neighbors Rehabilitation Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0049973

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	05-31-201-004	Long Term Care Property	$ 59,839.08	$ 59,839.08
2.	Allocation from SIR Properties	See attached	$ 118,674.75	$ 3,428.09
3.	Allocated from Regency Property	See attached	$ 862,948.02	$ 386.41
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,041,461.85	$ 63,653.58

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0049973

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2008	$ 170,000	1
2					2
3	TOTALS			$ 170,000	3

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 80,171	39	$ 55,769	$ (24,402)	$ 422,915	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	30,221		20	1,511	1,511	10,703	9
10	Various			2009	31,966		20	1,771	1,771	11,988	10
11	Various			2010	29,530		20	2,636	2,636	14,674	11
12	Various			2011	286,651		20	14,333	14,333	65,541	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		88,451	1,639		4,423	2,784	6,660	67
68	Related Party Allocations (Pages 12H & 12I)		76,214	2,152		2,799	647	36,744	68
69	Financial Statement Depreciation			37,969			(37,969)		69
70	TOTAL (lines 4 thru 69)		$ 2,718,033	$ 121,931		$ 83,241	$ (38,690)	$ 569,225	70

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,718,033	$ 121,931		$ 83,241	$ (38,690)	$ 569,225	1
2	Generator Transfer Switch	2012	4,720		20	236	236	944	2
3	Wiring For Emergency Recepticles	2012	3,075		20	154	154	500	3
4	Generator	2012	72,600		20	3,630	3,630	12,100	4
5	Condensing Unit	2012	2,625		20	131	131	405	5
6	Anti Freeze Loop Sprinkler	2013	3,397		20	170	170	510	6
7	Hvac Roof-Top Units	2013	9,471		20	474	474	1,184	7
8	Door Holders And Alarm Devices	2013	2,653		20	133	133	321	8
9	Security System	2013	5,790		20	290	290	627	9
10	Seal Coating & Asphalt Repairs	2013	3,778		20	189	189	488	10
11	Plumbing Backflow Device	2013	2,716		20	136	136	407	11
12	10 Air Conditioners	2013	5,525		20	276	276	737	12
13	Drainage Tile Installation & Gutter Repair	2013	2,627		20	131	131	317	13
14	Backflow Device	2014	3,198		20	160	160	320	14
15	Parking Lot Paving	2014	14,321		20	716	716	1,193	15
16	Doors	2014	2,549		20	127	127	223	16
17	Boiler Repair - New Valve, Pump, And Bearing Assembly	2015	3,401		20	170	170	170	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)		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	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)		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	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)		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	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
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,860,479	$ 121,931		$ 90,363	$ (31,568)	$ 589,671	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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		20	2,238	2,238	4,475	9
10	Drywall / Hallways 200 & 300	2015	43,700	1,639	20	2,185	546	2,185	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)		$ 88,451	$ 1,639		$ 4,423	$ 2,784	$ 6,660	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 88,451	$ 1,639		$ 4,423	$ 2,784	$ 6,660	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 88,451	$ 1,639		$ 4,423	$ 2,784	$ 6,660	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	18,442	473	20	473		2,857	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	16,696	530	20	477	(53)	10,733	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	4,233	118	20		(118)	4,233	9
10	Alloc. - S.I.R. Management	1994	13		20			13	10
11	Alloc. - S.I.R. Management	1995	97		20	3	3	97	11
12	Alloc. - S.I.R. Management	1997	6,504	146	20	317	171	6,078	12
13	Alloc. - S.I.R. Management	1999	511		20	26	26	415	13
14	Alloc. - S.I.R. Management	2000	604		20	30	30	469	14
15	Alloc. - S.I.R. Management	2007	1,940		20	97	97	795	15
16	Alloc. - S.I.R. Management	2008	5,347	535	20	337	(198)	2,644	16
17	Alloc. - S.I.R. Management	2009	13,286	121	20	664	543	4,148	17
18	Alloc. - S.I.R. Management	2011	329	33	20	33		145	18
19	Alloc. - S.I.R. Management	2012	1,052	53	20	53		180	19
20	Alloc. - S.I.R. Management	2014	148	15	20	7	(8)	12	20
21	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,023	72	20	4	(68)	18	21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,008		20	50	50	269	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,003	45	20	50	5	341	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2007	292	6	20	15	9	132	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2002	66		20	3	3	45	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	1999	2,116		20	106	106	1,745	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,011		20	51	51	885	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1997	63		20	3	3	60	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1994	159	4	20		(4)	159	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1993	271	1	20		(1)	271	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 76,214	$ 2,152		$ 2,799	$ 647	$ 36,744	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 76,214	$ 2,152		$ 2,799	$ 647	$ 36,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		$ 76,214	$ 2,152		$ 2,799	$ 647	$ 36,744	34

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 532,735	$ 61,124	$ 54,523	$ (6,601)	10	$ 362,409	71
72	Current Year Purchases	5,410		361	361	10	361	72
73	Fully Depreciated Assets	30,365		2	2	10	30,365	73
74								74
75	TOTALS	$ 568,510	$ 61,124	$ 54,885	$ (6,239)		$ 393,135	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	$	$ 1,905	$ 1,905	5	$ 8,207	76
77		Allocated from S.I.R. Managemer	2015	1,297	113	139	26	5	886	77
78										78
79										79
80	TOTALS			$ 20,297	$ 113	$ 2,044	$ 1,931		$ 9,093	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)	$ 3,619,286	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 183,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 147,292	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,876)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 991,899	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction Project	$ 3,624,868	92
93			93
94			94
95		$ 3,624,868	95

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

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 3,618 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 SIR Management		$	$ 2,689	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,689	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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 132,357	$		$ 132,357	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			33,923			33,923	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			147,168			147,168	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				67,088		67,088	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						20,230		20,230	13
14	TOTAL			$		$ 313,448	$ 87,318		$ 400,766	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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 75,747	$ 91,328	1
2	Cash-Patient Deposits	19,871	19,871	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,049,685	1,049,685	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,119	23,119	6
7	Other Prepaid Expenses	1,990	5,665	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)**	$ 1,254,212	$ 1,273,468	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	1,087,078	15
16	Equipment, at Historical Cost	220,829	820,079	16
17	Accumulated Depreciation (book methods)	(194,609)	(1,245,620)	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): Dues	2,105,401	4,512,368	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,608,474	$ 6,702,881	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,862,686	$ 7,976,349	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 175,893	$ 175,893	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,881	19,881	28
29	Short-Term Notes Payable	2,550,000	2,550,000	29
30	Accrued Salaries Payable	108,109	108,109	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,776	2,776	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable		9,683	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,500	8,500	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	302,064	1,964,182	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,227,223	$ 4,899,024	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,574	5,574	39
40	Mortgage Payable		2,249,046	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)**	$ 5,574	$ 2,254,620	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,232,797	$ 7,153,644	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 629,889	$ 822,705	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,862,686	$ 7,976,349	48

*(See instructions.)

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 601,664	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 601,667	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,222	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)**	$ 28,222	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)**	$ 629,889	24 *

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 4,906,515	1
2	Discounts and Allowances for all Levels	(1,022,598)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,883,917	3
	B. Ancillary Revenue		
4	Day Care	310	4
5	Other Care for Outpatients		5
6	Therapy	986,547	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 986,857	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	35	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,369	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,646	19
20	Radiology and X-Ray	3,339	20
21	Other Medical Services	12,432	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 80,821	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,438	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,438	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	52,705	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52,705	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,024,738	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	972,642	31
32	Health Care	1,885,393	32
33	General Administration	1,130,913	33
	B. Capital Expense		
34	Ownership	371,747	34
	C. Ancillary Expense		
35	Special Cost Centers	427,660	35
36	Provider Participation Fee	208,161	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,996,516	40
41	**Income before Income Taxes (line 30 minus line 40)****	28,222	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 28,222	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,757,773	44
45	Private Pay - Net Inpatient Revenue	662,632	45
46	Medicare - Net Inpatient Revenue	212,030	46
47	Other-(specify) Hospice/Managed Care	285,715	47
48	Other-(specify) Insurance	(34,233)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,883,917	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 Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,835	1,898	$ 63,622	$ 33.52	1
2	Assistant Director of Nursing	1,754	2,078	62,266	29.96	2
3	Registered Nurses	5,101	5,281	134,525	25.47	3
4	Licensed Practical Nurses	10,187	11,175	251,710	22.52	4
5	CNAs & Orderlies	44,299	47,317	574,454	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,963	6,362	103,313	16.24	8
9	Activity Director					9
10	Activity Assistants	6,984	7,459	89,504	12.00	10
11	Social Service Workers	4,311	4,881	57,770	11.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,861	20,811	222,790	10.71	15
16	Dishwashers					16
17	Maintenance Workers	2,126	2,411	34,950	14.50	17
18	Housekeepers	10,709	11,813	127,595	10.80	18
19	Laundry	6,654	7,334	81,361	11.09	19
20	Administrator	1,877	2,086	90,366	43.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,819	6,315	98,498	15.60	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	3,655	3,912	75,353	19.26	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,383	1,383	26,894	19.45	33
34	TOTAL (lines 1 - 33)	132,518	142,516	$ 2,094,971 *	$ 14.70	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,626	01-03	35
36	Medical Director	Monthly	9,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	29,088	10-03	38
39	Pharmacist Consultant	Monthly	1,382	10-03	39
40	Physical Therapy Consultant	2	114	10a-03	40
41	Occupational Therapy Consultant	5	387	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,790	11-03	44
45	Social Service Consultant	Monthly	1,790	12-03	45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	9,696	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	7	$ 76,773		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,446	$ 189,588	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	5,160	118,233	10-03	52
53	TOTAL (lines 50 - 52)	9,606	$ 307,821		53

Facility Name & ID Number: Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0	$ 90,366
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,366

B. Administrative - Other

Description	Amount
SIR Management - Dir of Admin Services	$ 29,088
SIR Management - Ancillary Admin Charges	24,240
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
SIR Management	Bookkeeping	$ 49,692
Personal Planners	Unemployment Consult	1,206
Pinnacle	Customer Satisfaction	1,758
Pension Specialist	401K Specialist	7,506
E-Health	Computer Services	3,300
PayChex	Payroll Services	9,304
Achieve Accrediation	Credentialing Services	10,029
HK Payroll	WOTC Program	2,693
Legat Architecture	Architecture	920
Frost, Ruttenberg & Rothblatt/Marc	Accounting	16,410
Plante Moran PLLC	Accounting	4,475
See Supplemental Schedule		97,396
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 204,688

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,569
Unemployment Compensation Insurance	39,245
FICA Taxes	156,169
Employee Health Insurance	85,618
Employee Meals	10,238
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	9,821
Other Employee Benefits	21,514
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,174

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 1,660
Advertising: Employee Recruitment		14,245
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	256	2,561
Licenses & Permits		2,304
Dues & Subscriptions		17,524
Allocated from SIR Management		775
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 39,069

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	300
Seminar Expense	5,233
Allocated from SIR Management	562
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,095

**See instructions.

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

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

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: $18,367.98**

(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. $ **10,750** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **208,161**
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. $ **10,238** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **35**

(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.