

Facility Name & ID Number Neighbors Rehabilitation Center

0049973 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,865</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>3,012</u>	<u>3,012</u>	8
9	SNF/PED					9
10	ICF	<u>20,120</u>	<u>7,954</u>	<u>2,389</u>	<u>30,463</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,120</u>	<u>7,954</u>	<u>5,401</u>	<u>33,475</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.80%

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)
Daycare

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 101 and days of care provided 3,012

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Neighbors Rehabilitation Center # 0049973 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	239,952	19,241	20,598	279,791		279,791	(7,793)	271,998		1
2	Food Purchase		139,765		139,765	(7,172)	132,593	(2,082)	130,511		2
3	Housekeeping	116,355	15,749		132,104		132,104	(660)	131,444		3
4	Laundry	70,173	22,604		92,777		92,777	(140)	92,637		4
5	Heat and Other Utilities			98,442	98,442		98,442	232	98,674		5
6	Maintenance	55,217	8,397	83,670	147,284		147,284	(14,801)	132,483		6
7	Other (specify):*							1,048	1,048		7
8	TOTAL General Services	481,697	205,756	202,710	890,163	(7,172)	882,991	(24,195)	858,795		8
	B. Health Care and Programs										
9	Medical Director			9,900	9,900		9,900		9,900		9
10	Nursing and Medical Records	1,590,468	81,915	57,618	1,730,001		1,730,001	(15,508)	1,714,493		10
10a	Therapy	97,836	2,105	11,089	111,030		111,030	(8,143)	102,887		10a
11	Activities	118,050	9,207	1,901	129,158		129,158		129,158		11
12	Social Services	46,268		1,657	47,925		47,925		47,925		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,115	2,115		15
16	TOTAL Health Care and Programs	1,852,622	93,227	82,165	2,028,014		2,028,014	(21,536)	2,006,478		16
	C. General Administration										
17	Administrative	71,776		244,360	316,136		316,136	(183,637)	132,499		17
18	Directors Fees										18
19	Professional Services			128,197	128,197		128,197	(80,208)	47,989		19
20	Dues, Fees, Subscriptions & Promotions			44,301	44,301		44,301	(30,086)	14,215		20
21	Clerical & General Office Expenses	95,780	24,908	189,141	309,829		309,829	(104,652)	205,177		21
22	Employee Benefits & Payroll Taxes			404,339	404,339	7,172	411,511		411,511		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,276	6,276		6,276	(2,622)	3,654		24
25	Other Admin. Staff Transportation			6,416	6,416		6,416	4,048	10,464		25
26	Insurance-Prop.Liab.Malpractice			77,717	77,717		77,717	122	77,839		26
27	Other (specify):*							20,706	20,706		27
28	TOTAL General Administration	167,556	24,908	1,100,747	1,293,211	7,172	1,300,383	(376,329)	924,054		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,501,875	323,891	1,385,622	4,211,388		4,211,388	(422,060)	3,789,328		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			12,200	12,200		12,200	94,757	106,957			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,382	23,382		23,382	150,379	173,761			32
33	Real Estate Taxes			60,000	60,000		60,000	9,604	69,604			33
34	Rent-Facility & Grounds			220,500	220,500		220,500	(220,500)				34
35	Rent-Equipment & Vehicles			13,519	13,519		13,519	4,635	18,154			35
36	Other (specify):*											36
37	TOTAL Ownership			329,601	329,601		329,601	38,875	368,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,414	281,761	406,175		406,175		406,175			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298		55,298		55,298			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		124,414	337,059	461,473		461,473		461,473			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,501,875	448,305	2,052,282	5,002,462		5,002,462	(383,185)	4,619,277			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,751)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,616)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(48,817)	30		9
10	Interest and Other Investment Income	(2,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	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	(85)	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	(142,072)	21		24
25	Fund Raising, Advertising and Promotional	(27,505)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,640)	20		28
29	Other-Attach Schedule	(39,499)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (281,113)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,072)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,072)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (383,185)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Income	\$ (641)	25	1
2	Bank Charges	(3,330)	21	2
3	Theft & Damage	(47)	21	3
4	2010 Seminar Expense	(2,817)	24	4
5	Additional R & M	1,147	06	5
6				6
7				7
8				8
9				9
10	Building Co:			10
11	Amortization	(16,750)	36	11
12	Professional Fees	(12,804)	19	12
13				13
14	Day Care Income:			14
15	Dietary Cost	(94)	01	15
16	Housekeeping	(291)	03	16
17	Utilities	(291)	05	17
18	Maintenance	(291)	06	18
19	Clerical	(291)	21	19
20	Nursing	(291)	10	20
21				21
22	PT Area Adjustments:			22
23	Utilities	(636)	05	23
24	Maintenance	(952)	06	24
25	Insurance	(502)	26	25
26	Depreciation	(79)	30	26
27	Interest	(151)	32	27
28	Real Estate Taxes	(388)	33	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	(39,499)		49

Neighbors Rehabilitation Center

ID# 0049973

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(94)			(7,693)	(6)							(7,793)	1
2	Food Purchase	(2,082)											(2,082)	2
3	Housekeeping	(291)				(369)							(660)	3
4	Laundry					(140)							(140)	4
5	Heat and Other Utilities	(927)			1,159								232	5
6	Maintenance	(9,712)		(5,192)	103								(14,801)	6
7	Other (specify):*			459	589								1,048	7
8	TOTAL General Services	(13,106)		(4,733)	(5,842)	(515)							(24,195)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(291)		(14,381)	3,682	(4,518)							(15,508)	10
10a	Therapy				(8,143)								(8,143)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,121	994								2,115	15
16	TOTAL Health Care and Programs	(291)		(13,260)	(3,467)	(4,518)							(21,536)	16
	C. General Administration													
17	Administrative			(226,137)	42,500								(183,637)	17
18	Directors Fees													18
19	Professional Services	(12,804)	12,804	(87,662)	7,454								(80,208)	19
20	Fees, Subscriptions & Promotions	(30,230)		144									(30,086)	20
21	Clerical & General Office Expenses	(151,740)		47,054	34								(104,652)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,817)		195									(2,622)	24
25	Other Admin. Staff Transportation	(641)		4,689									4,048	25
26	Insurance-Prop.Liab.Malpractice	(502)		555	69								122	26
27	Other (specify):*			12,120	8,586								20,706	27
28	TOTAL General Administration	(198,734)	12,804	(249,042)	58,643								(376,329)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(212,131)	12,804	(267,035)	49,334	(5,032)							(422,060)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(48,896)	138,103		5,550								94,757	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,948)	162,061	(12,363)	3,629								150,379	32
33	Real Estate Taxes	(388)	6,519		3,473								9,604	33
34	Rent-Facility & Grounds		(220,500)										(220,500)	34
35	Rent-Equipment & Vehicles			4,635									4,635	35
36	Other (specify):*	(16,750)	16,750											36
37	TOTAL Ownership	(68,982)	102,933	(7,728)	12,652								38,875	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(281,113)	115,737	(274,763)	61,986	(5,032)							(383,185)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 220,500	Neighbors Property, LLC	100.00%	\$	\$ (220,500)	1
2	V	33 Rental Income - Taxes	60,000	Neighbors Property, LLC	100.00%		(60,000)	2
3	V	36 Amortization of Loan Fees		Neighbors Property, LLC	100.00%	16,750	16,750	3
4	V	32 Interest - Mortgage		Neighbors Property, LLC	100.00%	160,622	160,622	4
5	V	32 Interest - Other		Neighbors Property, LLC	100.00%	1,439	1,439	5
6	V	19 Professional Fees		Neighbors Property, LLC	100.00%	12,804	12,804	6
7	V	33 Real Estate Tax		Neighbors Property, LLC	100.00%	66,519	66,519	7
8	V	30 Depreciation Expense		Neighbors Property, LLC	100.00%	138,103	138,103	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 280,500			\$ 396,237	\$ * 115,737	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 10,908	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,716	\$ (5,192)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	459	459
17	V	10 NURSING	21,816	S.I.R. MANAGEMENT, INC.	100.00%	7,435	(14,381)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,121	1,121
19	V	19 PROFESSIONAL FEES	89,316	S.I.R. MANAGEMENT, INC.	100.00%	1,244	(88,072)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	144	144
21	V	21 CLERICAL & GENERAL	21,816	S.I.R. MANAGEMENT, INC.	100.00%	17,034	(4,782)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	195	195
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,689	4,689
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	555	555
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,181	2,181
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(12,363)	(12,363)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,635	4,635
28	V						
29	V	17 ADMINISTRATIVE	238,900	S.I.R. MANAGEMENT, INC.	100.00%	12,763	(226,137)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	410	410
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	51,836	51,836
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,939	9,939
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 382,756			\$ 107,993	\$ * (274,763)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 10,908	S.I.R. MANAGEMENT, INC.	100.00%	\$ 3,215	\$ (7,693)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	497	497	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,682	3,682	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	560	560	18
19	V	17	ADMIN./LEGAL SALARIES	5,460	S.I.R. MANAGEMENT, INC.	100.00%	47,960	42,500	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,426	7,426	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,586	8,586	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	10,908	S.I.R. MANAGEMENT, INC.	100.00%	2,765	(8,143)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	434	434	25
26	V								26
27	V	6	MAINTENANCE SALARIES	736	S.I.R. MANAGEMENT, INC.	100.00%	507	(229)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	92	92	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,159	1,159	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	332	332	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	28	28	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	34	34	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	69	69	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,550	5,550	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,629	3,629	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,473	3,473	37
38	V								38
39	Total		\$ 28,012				\$ 89,998	\$ * 61,986	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 61	Xcel Supply, LLC	100.00%	\$ 55	\$ (6)
16	V	3 Housekeeping	4,021	Xcel Supply, LLC	100.00%	3,652	(369)
17	V	4 Laundry	1,521	Xcel Supply, LLC	100.00%	1,382	(140)
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%		
19	V	10 Nursing	49,197	Xcel Supply, LLC	100.00%	44,679	(4,518)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%		
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary		Xcel Supply, LLC	100.00%		
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 54,801			\$ 49,768	\$ * (5,032)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 114,533	\$ 114,533	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	114,533	CCS Employee Benefits Group	100.00%		(114,533)	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		\$ 114,533			\$ 114,533	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Member	Administrative	11.62%	See Attached	1.25	3.13%	Alloc.Salary	\$ 8,097	17-7	1
2	Michael Giannini	Member	Administrative	9.83%	See Attached	1.45	3.63%	Alloc.Salary	6,932	17-7	2
3	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.29	0.62%	Alloc.Salary	4,152	17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	2.08	4.16%	Alloc.Salary	3,215	1-7	4
5	Sarah Barrish	Relative	Administrative	0.00%	See Attached	1.66	4.15%	Alloc.Salary	4,234	17-7	5
6	Adam Vales	Relative	Clerical	0.00%	See Attached	0.67	1.68%	Alloc.Salary	1,202	22-7	6
7	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	0.71	4.18%	Alloc.Salary	561	21-7	7
8	Tom Winter	Owner	Administrative	1.77%	See Attached	2.39	3.98%	Alloc.Salary	7,756	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,149		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

S.I.R. MANAGEMENT, INC.

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 675 -7979

Fax Number

(847) 675 -0555

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	33,475	\$ 5,716	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		33,475	459	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	33,475	7,435	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		33,475	1,121	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	33,475	1,244	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		33,475	144	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	33,475	17,034	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		33,475	195	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		33,475	4,689	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		33,475	555	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		33,475	2,181	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		33,475	(12,363)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		33,475	4,635	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	33,475	12,763	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		33,475	410	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	33,475	51,836	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		33,475	9,939	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 107,993	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	806,183	12	\$ 77,418	\$ 77,418	33,475	\$ 3,215	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		33,475	497	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	33,475	3,682	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		33,475	560	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	33,475	47,960	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		33,475	7,426	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		33,475	8,586	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	10,908	2,765	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		10,908	434	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	736	507	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		736	92	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		528	1,159	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		528	332	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		528	28	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		528	34	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		528	69	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		528	5,550	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		528	3,629	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		528	3,473	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 89,998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 55	1
2	3	Housekeeping	Direct Allocation					3,652	2
3	4	Laundry	Direct Allocation					1,382	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					44,679	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 49,768	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 114,533	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				\$	\$		\$ 114,533	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		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			\$	\$ 2,554,725			\$ 161,910	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6	Private Bank		X	Line of Credit				350,000			23,382	6							
7	Alloc.- S.I.R. Management	X									3,629	7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$ 2,904,725			\$ 188,921	9							
	B. Non-Facility Related*																		
10	Interest Income		X								(2,797)	10							
11	Alloc.- S.I.R. Management	X									(12,363)	11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ (15,160)	14							
15	TOTALS (line 9+line14)						\$	\$ 2,904,725			\$ 173,761	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

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																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

* 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:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	2,175,000	72,266		55,769	(16,497)	88,301	67
68	Related Party Allocations (Pages 12H & 12I)	60,258	2,698		2,121	(577)	21,591	68
69	Financial Statement Depreciation		12,121			(12,121)		69
70	TOTAL (lines 4 thru 69)	\$ 2,235,258	\$ 87,085		\$ 57,890	\$ (29,195)	\$ 109,892	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,235,258	\$ 87,085		\$ 57,890	\$ (29,195)	\$ 109,892	1
2	2009	30,221		20	1,511	1,511	1,511	2
3	2009	3,451		20	230	230	230	3
4	2009	16,260		20	678	678	678	4
5	2009	5,560		20	232	232	232	5
6	2009	6,695		20	223	223	223	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		\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	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)	\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	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)	\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	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)	\$ 2,297,445	\$ 87,085		\$ 60,764	\$ (26,321)	\$ 112,766	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1971	2,175,000	72,266	39	55,769	(16,497)	88,301	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,175,000	\$ 72,266		\$ 55,769	\$ (16,497)	\$ 88,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Alloc.- S.I.R. Properties - S.I.R. Management	1993	18,558	589	35	530	(59)	8,749	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc.- S.I.R. Properties - S.I.R. Management	2009	1,114	637	20	45	(592)	45	9
10	Alloc.- S.I.R. Properties - S.I.R. Management	2007	325	45	20	16	(29)	49	10
11	Alloc.- S.I.R. Properties - S.I.R. Management	2002	74		20	4	4	28	11
12	Alloc.- S.I.R. Properties - S.I.R. Management	1999	2,352	118	20	118		1,235	12
13	Alloc.- S.I.R. Properties - S.I.R. Management	1998	1,124		20	56	56	646	13
14	Alloc.- S.I.R. Properties - S.I.R. Management	1997	70		20	3	3	47	14
15	Alloc.- S.I.R. Properties - S.I.R. Management	1994	177	5	20	9	4	137	15
16	Alloc.- S.I.R. Properties - S.I.R. Management	1993	301	2	20	15	13	248	16
17									17
18	Alloc.- S.I.R. Management	1993	4,705	131	20	233	102	3,965	18
19	Alloc.- S.I.R. Management	1994	15		20			15	19
20	Alloc.- S.I.R. Management	1995	108		20	5	5	77	20
21	Alloc.- S.I.R. Management	1997	7,230	162	20	361	199	4,630	21
22	Alloc.- S.I.R. Management	1999	568		20	28	28	291	22
23	Alloc.- S.I.R. Management	2000	671		20	34	34	320	23
24	Alloc.- S.I.R. Management	2007	2,156	385	20	108	(277)	237	24
25	Alloc.- S.I.R. Management	2008	5,943	594	20	375	(219)	691	25
26	Alloc.- S.I.R. Management	2009	14,767	30	20	181	151	181	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 60,258	\$ 2,698		\$ 2,121	\$ (577)	\$ 21,591	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 418,264	\$ 68,601	\$ 45,211	\$ (23,390)	10	\$ 72,757	71
72	Current Year Purchases	29,790	87	833	746	10	833	72
73	Fully Depreciated Assets	15,533		148	148	10	15,533	73
74								74
75	TOTALS	\$ 463,587	\$ 68,688	\$ 46,192	\$ (22,496)		\$ 89,123	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,761,032	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,773	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,956	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (48,817)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 201,889	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 18,154 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	110,336	\$		\$	110,336	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				10,534				10,534	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				160,891				160,891	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					109,204			109,204	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							15,210			15,210	13
14	TOTAL			\$		\$	281,761	\$	124,414	\$	406,175	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 113,436	\$ 116,628	1
2	Cash-Patient Deposits	6,241	6,241	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	998,399	998,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,204	42,204	6
7	Other Prepaid Expenses	438	438	7
8	Accounts Receivable (owners or related parties)	260,000	260,000	8
9	Other(specify): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,420,718	\$ 1,423,910	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		70,000	13
14	Buildings, at Historical Cost		1,624,325	14
15	Leasehold Improvements, at Historical Cost	39,361	295,786	15
16	Equipment, at Historical Cost	91,122	690,372	16
17	Accumulated Depreciation (book methods)	(15,644)	(232,855)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		83,752	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(26,521)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,890	859,390	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 116,729	\$ 3,364,249	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,537,447	\$ 4,788,159	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 215,350	\$ 215,350	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,137	7,137	28
29	Short-Term Notes Payable	350,000	350,000	29
30	Accrued Salaries Payable	192,268	192,268	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,849	9,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable		13,383	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,850	6,850	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		260,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 841,454	\$ 1,114,837	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,554,725	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,554,725	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 841,454	\$ 3,669,562	46
47	TOTAL EQUITY(page 18, line 24)	\$ 695,993	\$ 1,118,597	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,537,447	\$ 4,788,159	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 332,365	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 332,362	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	383,631	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) <u>Members Contribution</u>	(20,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 363,631	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)	\$ 695,993	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Neighbors Rehabilitation Center**# **0049973**Report Period Beginning: **01/01/09**Ending: **12/31/09**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,948,128	1
2	Discounts and Allowances for all Levels	(484,587)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,463,541	3
B. Ancillary Revenue			
4	Day Care	1,550	4
5	Other Care for Outpatients		5
6	Therapy	716,666	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 718,216	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	12,061	13
14	Non-Patient Meals	1,751	14
15	Telephone, Television and Radio	2,230	15
16	Rental of Facility Space		16
17	Sale of Drugs	105,083	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,444	19
20	Radiology and X-Ray	4,384	20
21	Other Medical Services	6,544	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 136,497	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,797	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	65,042	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,042	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,386,093	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	890,163	31
32	Health Care	2,028,014	32
33	General Administration	1,293,211	33
B. Capital Expense			
34	Ownership	329,601	34
C. Ancillary Expense			
35	Special Cost Centers	406,175	35
36	Provider Participation Fee	55,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,002,462	40
41	Income before Income Taxes (line 30 minus line 40)**	383,631	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 383,631	43

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

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

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

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

Facility Name & ID Number Neighbors Rehabilitation Center

0049973

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,930	2,143	\$ 66,827	\$ 31.18	1
2	Assistant Director of Nursing	1,935	2,130	51,321	24.09	2
3	Registered Nurses	10,095	10,998	270,898	24.63	3
4	Licensed Practical Nurses	14,327	16,633	355,183	21.35	4
5	CNAs & Orderlies	58,755	66,486	766,674	11.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,090	6,015	97,836	16.27	8
9	Activity Director	3,844	4,356	57,541	13.21	9
10	Activity Assistants	4,201	4,645	60,509	13.03	10
11	Social Service Workers	3,330	3,888	46,268	11.90	11
12	Dietician					12
13	Food Service Supervisor	3,799	4,248	60,471	14.24	13
14	Head Cook	8,484	9,493	103,514	10.90	14
15	Cook Helpers/Assistants	7,778	8,515	75,967	8.92	15
16	Dishwashers					16
17	Maintenance Workers	3,706	4,153	55,217	13.30	17
18	Housekeepers	10,289	11,544	116,355	10.08	18
19	Laundry	6,349	7,193	70,173	9.76	19
20	Administrator	1,900	2,086	71,776	34.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,774	6,229	95,780	15.38	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	3,528	4,112	79,565	19.35	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	155,114	174,867	\$ 2,501,875 *	\$ 14.31	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 20,598	01-03	35
36	Medical Director	Monthly	9,900	09-03	36
37	Medical Records Consultant	Monthly	1,200	10-03	37
38	Nurse Consultant	Monthly	21,816	10-03	38
39	Pharmacist Consultant	Monthly	1,100	10-03	39
40	Physical Therapy Consultant	Monthly	118	10a-03	40
41	Occupational Therapy Consultant	Monthly	63	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,901	11-03	44
45	Social Service Consultant	Monthly	1,657	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	10,908	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,261		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	20	\$ 1,093	10-03	50
51	Licensed Practical Nurses	586	13,732	10-03	51
52	Certified Nurse Assistants/Aides	731	18,677	10-03	52
53	TOTAL (lines 50 - 52)	1,337	\$ 33,502		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Pawn Thammarath</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 71,776</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 85,857</u>	<u>IDPH License Fee</u>	<u>\$ 941</u>	
				<u>Unemployment Compensation Insurance</u>	<u>15,120</u>	<u>Advertising: Employee Recruitment</u>	<u>3,510</u>	
				<u>FICA Taxes</u>	<u>188,605</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>86,622</u>	<u>(Indicate # of checks performed <u>192</u>)</u>	<u>1,925</u>	
				<u>Employee Meals</u>	<u>7,172</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>7,240</u>	
				<u>401k Contribution</u>	<u>16,905</u>	<u>Licenses & Permits</u>	<u>454</u>	
				<u>Employee Benefits- Other</u>	<u>11,230</u>	<u>Advertising & Promotion</u>	<u>27,505</u>	
						<u>Yellow Pages Advertising</u>	<u>2,640</u>	
						<u>See Supplemental Schedule</u>	<u>144</u>	
TOTAL (agree to Schedule V, line 17, col. 1)						<u>Less: Public Relations Expense</u>	<u>()</u>	
(List each licensed administrator separately.)			<u>\$ 71,776</u>			<u>Non-allowable advertising</u>	<u>(27,505)</u>	
						<u>Yellow page advertising</u>	<u>(2,640)</u>	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
					<u>\$ 411,511</u>	<u>\$ 14,214</u>		
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
<u>S.I.R. Management- Dir of Admin Services</u>			<u>\$ 21,816</u>	Description	Line #	Amount	Description	Amount
<u>S.I.R. Management- Ancillary Admin Charges</u>			<u>22,428</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>S.I.R. Management- Owners Council Dues</u>			<u>5,460</u>					
<u>See Supplemental Schedule</u>			<u>194,656</u>				<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			<u>\$ 244,360</u>					
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>3,459</u>
C. Professional Services							<u>Alloc.- S.I.R. Management</u>	<u>195</u>
Vendor/Payee	Type		Amount					
<u>Frost, Ruttenberg, & Rothblatt</u>	<u>Accounting</u>		<u>\$ 18,005</u>				<u>Entertainment Expense</u>	<u>()</u>
<u>S.I.R. Management</u>	<u>Accounting</u>		<u>36,000</u>				<u>(agree to Sch. V, line 24, col. 8)</u>	
<u>S.I.R. Management</u>	<u>Bookkeeping</u>		<u>42,408</u>				TOTAL	<u>\$ 3,654</u>
<u>Personnel Planners</u>	<u>Unemployment Tax Cnsltg</u>		<u>1,448</u>					
<u>e-Health Data Solutions</u>	<u>Computer Services</u>		<u>3,600</u>					
<u>Boyer & Associates, LLC</u>	<u>Compliance Consulting</u>		<u>2,213</u>					
<u>Pinnacle Consulting</u>	<u>Customer Satisfaction</u>		<u>1,746</u>					
<u>Accumed Services</u>	<u>MDS Software</u>		<u>4,068</u>					
<u>Pension Specialists</u>	<u>401k Services</u>		<u>4,378</u>					
<u>S.I.R. Management</u>	<u>Administrative Legal Services</u>		<u>10,908</u>					
<u>Stephen N. Sher</u>	<u>Legal</u>		<u>3,015</u>					
<u>See Supplemental Schedule</u>			<u>408</u>					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		<u>\$</u>		
(If total legal fees exceed \$5,000, attach copy of invoices.)			<u>\$ 128,197</u>					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Neighbors Rehabilitation Center# 0049973Report Period Beginning: 01/01/09Ending: 12/31/09**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 - \$6,965
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,335 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,298
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,172 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,215
- (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? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.