

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0037655 Facility Name: Fairview Nursing Plaza Inc. Address: 321 Arnold Ave . Rockford 61108 County: Winnebago Telephone Number: (815) 397-5531 Fax # (815) 397-7629 HFS ID Number: Date of Initial License for Current Owners: 09/01/91 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Cary Drazner, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax # (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>114</u>	Intermediate (ICF)	<u>114</u>	<u>41,610</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,745</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,600</u>	<u>348</u>	<u>3,055</u>	<u>23,003</u>	8
9	SNF/PED					9
10	ICF	<u>43,843</u>	<u>778</u>	<u>3,427</u>	<u>48,048</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,443</u>	<u>1,126</u>	<u>6,482</u>	<u>71,051</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.39%

D. How many bed-hold days during this year were paid by the Department? 1,013 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/1/1991 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 3,055

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	275,534	49,026	41,540	366,100		366,100	(17,806)	348,294			1
2	Food Purchase		396,981		396,981	(22,356)	374,625	(63)	374,562			2
3	Housekeeping	222,174	42,181		264,355		264,355	(1,453)	262,902			3
4	Laundry	111,125	24,920		136,045		136,045	(13)	136,032			4
5	Heat and Other Utilities			182,768	182,768		182,768	(25,090)	157,678			5
6	Maintenance	86,448	74,838	167,155	328,441		328,441	(17,341)	311,100			6
7	Other (specify):*							4,689	4,689			7
8	TOTAL General Services	695,281	587,946	391,463	1,674,690	(22,356)	1,652,334	(57,077)	1,595,257			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,310,717	192,964	373,179	2,876,860		2,876,860	(36,413)	2,840,447			10
10a	Therapy	135,064	3,582	64,463	203,109		203,109	(15,594)	187,515			10a
11	Activities	198,197	24,901	2,448	225,546		225,546		225,546			11
12	Social Services	200,850	56	6,649	207,555		207,555		207,555			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,918	5,918			15
16	TOTAL Health Care and Programs	2,844,828	221,503	453,939	3,520,270		3,520,270	(46,089)	3,474,181			16
	C. General Administration											
17	Administrative	77,993		528,673	606,666		606,666	(417,974)	188,692			17
18	Directors Fees											18
19	Professional Services			196,613	196,613	(997)	195,616	(129,681)	65,935			19
20	Dues, Fees, Subscriptions & Promotions			54,495	54,495		54,495	(11,136)	43,359			20
21	Clerical & General Office Expenses	193,594	35,682	374,936	604,212		604,212	(205,538)	398,674			21
22	Employee Benefits & Payroll Taxes			543,877	543,877	22,356	566,233		566,233			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,092	6,092		6,092	422	6,514			24
25	Other Admin. Staff Transportation			13,126	13,126		13,126	10,160	23,286			25
26	Insurance-Prop.Liab.Malpractice			146,370	146,370		146,370	1,664	148,034			26
27	Other (specify):*							45,269	45,269			27
28	TOTAL General Administration	271,587	35,682	1,864,182	2,171,451	21,359	2,192,810	(706,814)	1,485,996			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,811,696	845,131	2,709,584	7,366,411	(997)	7,365,414	(809,981)	6,555,433			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			71,548	71,548		71,548	413,315	484,863			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,247	48,247		48,247	543,972	592,219			32
33	Real Estate Taxes					997	997	129,986	130,983			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(960,000)				34
35	Rent-Equipment & Vehicles			6,033	6,033		6,033	7,394	13,427			35
36	Other (specify):*							1	1			36
37	TOTAL Ownership			1,085,828	1,085,828	997	1,086,825	134,667	1,221,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,586	429,785	599,371		599,371		599,371			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,618	396,618		396,618		396,618			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		169,586	826,403	995,989		995,989		995,989			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,811,696	1,014,717	4,621,815	9,448,228	(0)	9,448,228	(675,314)	8,772,914			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

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.)

	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				4
5	Telephone, TV & Radio in Resident Rooms	(27,838)	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	73,868	30		9
10	Interest and Other Investment Income	(50)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(1,100)	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	(304,528)	21		24
25	Fund Raising, Advertising and Promotional	(5,716)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(483)	20		28
29	Other-Attach Schedule	(53,297)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (319,206)		\$	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)	(356,107)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (356,107)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (675,314)		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

ID#

0037655

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Fees	\$ (5,924)	21	1
2	Theft & Damage	(3,722)	21	2
3	Miscellaneous Income	(52)	21	3
4	Capitalized R&M	(5,654)	06	4
5	Non-Allowable Legal	(4,158)	19	5
6	Non-Allowable Seminar-2012	(315)	24	6
7	Additional R&M	2,601	06	7
8	Annual Report	(100)	20	8
9	COPE Dues	(4,971)	20	9
10	State Replacement Tax	(282)	21	10
11	Prior Period Nursing Expenses	(1,331)	10	11
12	Building Company Amortization	(29,066)	36	12
13	Building Company Fees	(309)	20	13
14	Building Company Office Expense	(14)	21	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
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	(53,297)		49

Fairview Nursing Plaza Inc.

Report Period Beginning:Ending:

ID#003765501/01/1112/31/11

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

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.

☒ 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	\$ 960,000	Fairview Nursing Property, LLC	100.00%	\$	\$ (960,000)	1
2	V	32	Interest Income	200	Fairview Nursing Property, LLC	100.00%		(200)	2
3	V	36	Amortization		Fairview Nursing Property, LLC	100.00%	29,066	29,066	3
4	V	30	Depreciation		Fairview Nursing Property, LLC	100.00%	331,713	331,713	4
5	V	20	Fees		Fairview Nursing Property, LLC	100.00%	309	309	5
6	V	32	Interest Expense		Fairview Nursing Property, LLC	100.00%	545,941	545,941	6
7	V	21	Office Expense		Fairview Nursing Property, LLC	100.00%	14	14	7
8	V	33	RE Tax Expense		Fairview Nursing Property, LLC	100.00%	123,084	123,084	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 960,200			\$ 1,030,127	\$ * 69,927	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 11,283	\$ (14,277)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	896	896	16
17	V	10	NURSING	51,120	S.I.R. MANAGEMENT, INC.	100.00%	16,519	(34,601)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,838	2,838	18
19	V	19	PROFESSIONAL FEES	156,132	S.I.R. MANAGEMENT, INC.	100.00%	13,519	(142,613)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,234	1,234	20
21	V	21	CLERICAL & GENERAL	51,120	S.I.R. MANAGEMENT, INC.	100.00%	55,582	4,462	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	737	737	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,160	10,160	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,534	1,534	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,874	4,874	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(9,284)	(9,284)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,394	7,394	27
28	V								28
29	V	17	ADMINISTRATIVE	528,673	S.I.R. MANAGEMENT, INC.	100.00%	28,278	(500,395)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	2,031		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	104,432	104,432	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,785	21,785	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 812,605			\$ 273,812	\$ * (540,824)	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 SALARIES	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,754	\$ (17,806)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,348	1,348	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,066	8,066	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,396	1,396	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	82,421	82,421	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,033	16,033	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,610	18,610	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	25,560	S.I.R. MANAGEMENT, INC.	100.00%	9,966	(15,594)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,684	1,684	25
26	V								26
27	V	6	MAINTENANCE SALARIES	13,018	S.I.R. MANAGEMENT, INC.	100.00%	12,198	(820)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,445	2,445	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,748	2,748	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,124	1,124	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	60	60	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	76	76	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	130	130	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,774	8,774	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,565	7,565	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,902	6,902	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	997	997	38
39	Total			\$ 64,138			\$ 190,297	\$ * 126,159	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	23,968	Xcel Supply, LLC	100.00%	22,515	(1,453)	16
17	V	4	Laundry	213	Xcel Supply, LLC	100.00%	200	(13)	17
18	V	6	Repairs & Maintenance	5,202	Xcel Supply, LLC	100.00%	4,887	(315)	18
19	V	10	Nursing	140,991	Xcel Supply, LLC	100.00%	132,444	(8,547)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation	17,158	Xcel Supply, LLC	100.00%	16,118	(1,040)	23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 187,533			\$ 176,164	\$ * (11,369)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 204,362	\$ 204,362	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	204,362	CCS Employee Beenfits Group	100.00%		(204,362)	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			\$ 204,362			\$ 204,362	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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	GLENDAS TRICKLAND	0.897%	ALBANY CARE INC	EVANSTON	FAIRVIEW NURSING PROPERTY	LINCOLNWOOD	BUILDING CO.	1
2	HARVEY SCOTT	4.484%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	LOUISE BERGTHOLD	2.691%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	MELISSA ROTHNER TRUST	2.242%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	4
5	DANIEL ROTHNER TRUST	2.242%	ELMWOOD CARE, INC.	ELMWOOD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	RACHEL ROTHNER TRUST	2.242%	GREENWOOD CARE, INC.	EVANSTON				6
7	WILLIAM ROTHNER TRUST	2.242%	MAPLEWOOD CARE, INC.	ELGIN				7
8	ADAM VALES TRUST	2.242%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	KIMBERLY RICHMAN TRUST	2.691%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	THOMAS WINTER	0.897%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	MARK SOLOMON	6.726%	WILSON CARE, INC.	CHICAGO				11
12	CELESTE GIANNINI TRUST DTD 3/13/00 K	14.200%	APPLEWOOD REHABILITATION CENTER, LLC	MATTESON				12
13	KATHRYN VALES TRUST	2.242%						13
14	JULIANA BARRISH TRUST DATED 1/26/93	14.200%						14
15	NATHAN & SHIRLEY ROTHNER FAMILY	11.361%						15
16	BRYAN BARRISH TRUST DTD 09/01/2004	14.200%						16
17	MICHAEL R GIANNINI TRUST DTD 3/13/00	14.200%						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

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 Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 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	Tom Winter	Shareholder	Administrative	0.90%	See Attached	5.09	8.48%	Alloc. Salary	\$ 16,966	17-7	1
2	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	1.02	1.70%	Alloc. Salary	3,564	17-7	2
3	Michael Giannini	Shareholder	Administrative	14.20%	See Attached	2.97	7.43%	Alloc. Salary	14,166	17-7	3
4	Bryan Barrish	Shareholder	Administrative	14.20%	See Attached	3.39	7.53%	Alloc. Salary	16,966	17-7	4
5	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	3.39	8.48%	Alloc. Salary	3,820	21-7	5
6	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.24	8.48%	Alloc. Salary	10,158	17-7	6
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.24	8.48%	Alloc. Salary	7,754	1-7	7
8	Adam Vales	Shareholder	Clerical	2.24%	See Attached	1.22	3.05%	Alloc. Salary	2,161	22-7	8
9	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	2,352	17-7	9
10	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.51	1.10%	Alloc. Salary	11,562	17-7	10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect amounts anticipated to be considered										11
12	allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 89,469		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 Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	71,051	\$ 11,283	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		71,051	896	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	71,051	16,519	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		71,051	2,838	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	71,051	13,519	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		71,051	1,234	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	71,051	55,582	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		71,051	737	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		71,051	10,160	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		71,051	1,534	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		71,051	4,874	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		71,051	(9,284)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		71,051	7,394	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	71,051	28,278	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		71,051	2,031	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	71,051	104,432	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		71,051	21,785	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,627		\$ 273,812	25

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	71,051	\$ 7,754	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		71,051	1,348	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	71,051	8,066	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		71,051	1,396	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	71,051	82,421	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		71,051	16,033	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		71,051	18,610	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	25,560	9,966	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		25,560	1,684	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	13,018	12,198	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		13,018	2,445	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		1,093	2,748	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		1,093	1,124	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		1,093	60	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		1,093	76	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		1,093	130	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		1,093	8,774	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		1,093	7,565	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		1,093	6,902	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		1,093	997	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 190,297	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$			1
2	3	Housekeeping	Direct Allocation						22,515	2
3	4	Laundry	Direct Allocation						200	3
4	6	Repairs & Maintenance	Direct Allocation						4,887	4
5	10	Nursing	Direct Allocation						132,444	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation						16,118	9
10	39	Ancillary	Direct Allocation							10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		176,164	25

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 204,362	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					\$	\$		\$ 204,362	25

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 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 Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Facility Name & ID Number Fairview Nursing Plaza Inc. # 0037655 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

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	Centrue Bank		X	Mortgage Payable			\$	7,506,048			\$	485,941	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				2,135,000				48,247	6
7	Centrue Bank		X	Notes Payable - Bldg Co.				765,000				60,000	7
8	See Supplemental Schedule											(1,719)	8
9	TOTAL Facility Related						\$	10,406,048			\$	592,469	9
	B. Non-Facility Related*												
10	Interest Income		X									(50)	10
11	Interest Income - Bldg Co.		X									(200)	11
12		X											12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(250)	14
15	TOTALS (line 9+line14)						\$	10,406,048			\$	592,219	15

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Alloc. - SIR Management						\$	\$			\$ (1,719)	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										(1,719)	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	117,000	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.)				\$	123,986	2
3. Under or (over) accrual (line 2 minus line 1).				\$	6,986	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	123,000	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.)				\$	997	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.				\$	130,983	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2006	101,020	8			
	2007	99,849	9			
	2008	106,335	10			
	2009	111,565	11			
	2010	117,084	12			
2011 Accrued Taxes = \$117,084 x 1.05 = \$123,000						
Allocation SIR Management = \$6,902						

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

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 12-28-203-004	Long-Term Care Property	\$ 117,083.92	\$ 117,083.92
2. See Attached	See Attached	\$ 98,193.53	\$ 6,525.83
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 215,277.45	\$ 123,609.75

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Fairview Nursing Plaza Inc.</u>	COUNTY	<u>Winnebago</u>
---------------	------------------------------------	--------	------------------

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

58,808

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

2

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).

None

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:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213		1991	1977	\$ 7,695,500	\$ 295,679	35	\$ 320,960	\$ 25,281	\$ 1,136,523	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		55,434		20	2,771	2,771	54,258	9
10	Various		1993		68,424		20	3,420	3,420	62,810	10
11	Various		1994		44,837		20	2,242	2,242	40,027	11
12	Various		1995		14,482		20	724	724	11,642	12
13	Various		1996		9,472		20	374	374	7,801	13
14	Various		1997		73,164		20	3,658	3,658	53,524	14
15	Various		1998		23,867		20	949	949	17,019	15
16	Various		1999		46,683		20	2,334	2,334	29,205	16
17	Various		2000		50,948		20	2,347	2,347	30,507	17
18	Various		2001		43,547		20	2,177	2,177	23,708	18
19	Various		2002		39,114		20	3,626	3,626	36,195	19
20	Various		2003		31,242		20	1,562	1,562	13,454	20
21	Various		2004		164,618		20	9,349	9,349	72,076	21
22	Various		2005		126,099		20	7,912	7,912	50,168	22
23	Various		2006		45,816		20	2,291	2,291	13,425	23
24	Various		2007		39,926		20	1,996	1,996	9,536	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	426,561	31,631		27,203	(4,428)	102,016	67
68	Related Party Allocations (Pages 12H & 12I)	139,717	3,992		5,684	1,692	66,800	68
69	Financial Statement Depreciation		71,548			(71,548)		69
70	TOTAL (lines 4 thru 69)	\$ 9,139,451	\$ 402,850		\$ 401,581	\$ (1,269)	\$ 1,830,693	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	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	Totals from Page 12A, Carried Forward		\$ 9,139,451	\$ 402,850		\$ 401,581	\$ (1,269)	\$ 1,830,693	1
2	Telephone System	2008	4,601		20	460	460	1,802	2
3	Cove Base	2008	8,070		20	404	404	1,547	3
4	Generator Switch	2008	4,034		20	202	202	756	4
5	Hvac Burner	2008	5,673		20	284	284	922	5
6	Door Installation	2008	3,260		20	163	163	503	6
7	Lighting Work	2009	4,274		20	214	214	605	7
8	Water Heater	2009	13,282		20	664	664	1,384	8
9	Side Walk	2009	7,628		20	763	763	2,225	9
10	Furnace Burner	2009	5,094		20	509	509	1,104	10
11	Fire Protection System	2009	2,665		20	267	267	755	11
12	Smoke Dampers	2009	2,607		20	261	261	739	12
13	Security Camera	2010	6,100		20	871	871	1,017	13
14	Radiator Guards	2010	5,558		20	1,112	1,112	2,223	14
15	Water Heater	2010	12,628		20	2,526	2,526	3,999	15
16	Window Treatments	2010	10,008		20	2,002	2,002	3,002	16
17	Sewer Pipe	2010	9,800		20	1,960	1,960	3,757	17
18	Straight Cubicle Track	2010	2,941		20	147	147	294	18
19	Excavation	2010	3,100		20	155	155	310	19
20	Bathroom Renovation - Tile, Shower Doors	2010	18,185		20	909	909	1,819	20
21	Roofing	2011	7,695		20	289	289	289	21
22	Masterlock System	2011	4,890		20	204	204	204	22
23	Fire Alarm Panel	2011	4,430		20	166	166	166	23
24	Resident Room Doors	2011	7,102		20	207	207	207	24
25	Elevator Panels	2011	3,800		20	111	111	111	25
26	Hallway Room Signs	2011	7,901		20	461	461	461	26
27	Ceiling Grid And Lighting	2011	41,636		20	1,214	1,214	1,214	27
28	Drywall Repair/Patch	2011	14,060		20	410	410	410	28
29	Window Treatments	2011	11,128		20	371	371	371	29
30	Flooring	2011	27,953		20	932	932	932	30
31	Wall-Base	2011	9,932		20	828	828	828	31
32	Handrails, Crashrails, Corner Guards	2011	76,093		20	1,268	1,268	1,268	32
33	Resident Room Doors	2011	4,929		20	62	62	62	33
34	TOTAL (lines 1 thru 33)		\$ 9,490,508	\$ 402,850		\$ 421,973	\$ 19,123	\$ 1,865,976	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,490,508	\$ 402,850		\$ 421,973	\$ 19,123	\$ 1,865,976	1
2	Room 501 Ceiling, Doors	2011	3,315		20	111	111	111	2
3	Chair Rail: Dining And Activities	2011	8,594		20	72	72	72	3
4	Corner Guards	2011	4,301		20	36	36	36	4
5	Generator Work	2011	19,600		20	163	163	163	5
6	Water Heater	2011	4,208		20	105	105	105	6
7	Hvac Work	2011	4,774		20	80	80	80	7
8	Hvac Work	2011	4,774		20	40	40	40	8
9	Painting	2011	110,575		20	921	921	921	9
10	Drywall Repair	2011	3,800		20	95	95	95	10
11	Electircal Breaker	2011	2,928		20	146	146	146	11
12	Elevator Adjustment	2011	2,726		20	136	136	136	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)		\$ 9,660,103	\$ 402,850		\$ 423,878	\$ 21,028	\$ 1,867,881	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 and Improvement Costs-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	Totals from Page 12C, Carried Forward	\$ 9,660,103	\$ 402,850		\$ 423,878	\$ 21,028	\$ 1,867,881	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)	\$ 9,660,103	\$ 402,850		\$ 423,878	\$ 21,028	\$ 1,867,881	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 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		\$ 9,660,103	\$ 402,850		\$ 423,878	\$ 21,028	\$ 1,867,881	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)		\$ 9,660,103	\$ 402,850		\$ 423,878	\$ 21,028	\$ 1,867,881	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	See Page 12								3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roofing	2008	172,737	4,429	30	5,758	1,329	22,072	9
10	Lighting	2008	18,134	465	20	907	442	3,475	10
11	Rooftop HVAC	2008	35,086	900	20	1,754	854	6,725	11
12	Painting	2008	166,886	25,183	10	16,689	(8,494)	62,582	12
13	Parking Lot Work	2008	25,518	654	20	1,276	622	4,360	13
14	Handrails	2008	8,200		10	820	820	2,802	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 and Improvement Costs-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)	\$ 426,561	\$ 31,631		\$ 27,203	\$ (4,428)	\$ 102,016	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	SIR Properties - SIR Management	1993	38,413	1,219	35	1,098	(121)	19,206	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	9,739	271	20	483	212	9,173	9
10	Alloc. - S.I.R. Management	1994	30		20			30	10
11	Alloc. - S.I.R. Management	1995	223		20	11	11	183	11
12	Alloc. - S.I.R. Management	1997	14,965	335	20	734	399	11,066	12
13	Alloc. - S.I.R. Management	1999	1,177		20	59	59	720	13
14	Alloc. - S.I.R. Management	1999	11,917		20			11,917	14
15	Alloc. - S.I.R. Management	2000	1,389		20	69	69	802	15
16	Alloc. - S.I.R. Management	2007	4,464	412	20	223	(189)	936	16
17	Alloc. - S.I.R. Management	2008	12,301	1,175	20	775	(400)	2,981	17
18	Alloc. - S.I.R. Management	2009	30,567	280	20	1,528	1,248	3,430	18
19	Alloc. - S.I.R. Management	2011	756	31	20	16	(15)	16	19
20									20
21	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,318		20	116	116	155	21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,306	202	20	115	(87)	323	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2007	673	55	20	34	(21)	168	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2002	152		20	8	8	73	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	1999	4,867		20	243	243	3,042	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,326		20	116	116	1,570	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1997	145		20	7	7	112	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1994	366	9	20	18	9	320	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1993	623	3	20	31	28	577	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 and Improvement Costs-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)	\$ 139,717	\$ 3,992		\$ 5,684	\$ 1,692	\$ 66,800	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$565,090	\$8,807	\$56,202	\$47,395	10	\$301,125	71
72	Current Year Purchases	95,732	(1,030)	4,340	5,370	10	5,380	72
73	Fully Depreciated Assets	322,683		19	19	10	322,683	73
74								74
75	TOTALS	\$983,505	\$7,777	\$60,561	\$52,784		\$629,188	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		CHEVY VAN	1996	\$11,516	\$	\$	\$	5	\$11,516	76
77		CHEVY EXPRESS VAN	2005	31,352				5	31,352	77
78		Allocated - SIR Management	2011	2,983	367	422	55	5	591	78
79										79
80	TOTALS			\$45,851	\$367	\$422	\$55		\$43,459	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$10,689,459	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$410,994	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$484,862	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$73,868	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,540,529	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
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: \$ 13,427
- 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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 170,820	\$		\$ 170,820	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,783			85,783	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			173,182			173,182	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				109,709		109,709	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						59,877		59,877	13
14	TOTAL			\$		\$ 429,785	\$ 169,586		\$ 599,371	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

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 68,561	\$ 161,594	1
2	Cash-Patient Deposits	53,150	53,150	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,293,879	2,293,879	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,316	45,316	6
7	Other Prepaid Expenses	2,158	2,158	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,463,064	\$ 2,556,097	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		7,695,500	14
15	Leasehold Improvements, at Historical Cost	855,475	1,282,036	15
16	Equipment, at Historical Cost	1,227,553	1,305,002	16
17	Accumulated Depreciation (book methods)	(1,137,363)	(2,177,657)	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): See Attached Schedule	165,453	165,453	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,111,118	\$ 8,270,334	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,574,182	\$ 10,826,431	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 625,748	\$ 625,748	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,154	53,154	28
29	Short-Term Notes Payable	2,135,000	2,135,000	29
30	Accrued Salaries Payable	376,816	376,816	30
31	Accrued Taxes Payable (excluding real estate taxes)	64,793	64,793	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,000	32
33	Accrued Interest Payable		10,425	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	187	187	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,255,698	\$ 3,389,123	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,271,048	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,271,048	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,255,698	\$ 11,660,171	46
47	TOTAL EQUITY(page 18, line 24)	\$ 318,484	\$ (833,740)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,574,182	\$ 10,826,431	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 369,940	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 369,940	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(51,456)	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)	\$ (51,456)	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)	\$ 318,484	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 8,842,501	1
2	Discounts and Allowances for all Levels	(1,064,832)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,777,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,222,870	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,222,870	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,732	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,479	19
20	Radiology and X-Ray	325	20
21	Other Medical Services	40,455	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,991	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	242,192	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 242,192	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,396,772	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,674,690	31
32	Health Care	3,520,270	32
33	General Administration	2,171,451	33
	B. Capital Expense		
34	Ownership	1,085,828	34
	C. Ancillary Expense		
35	Special Cost Centers	599,371	35
36	Provider Participation Fee	396,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,448,228	40
41	Income before Income Taxes (line 30 minus line 40)**	(51,456)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (51,456)	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.

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	2,256	2,375	\$ 97,104	\$ 40.89	1
2	Assistant Director of Nursing	2,308	2,430	81,833	33.68	2
3	Registered Nurses	9,430	9,927	283,205	28.53	3
4	Licensed Practical Nurses	24,849	26,157	653,929	25.00	4
5	CNAs & Orderlies	81,630	85,927	1,036,277	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,785	7,142	135,064	18.91	8
9	Activity Director	3,198	3,366	83,786	24.89	9
10	Activity Assistants	11,035	11,615	114,411	9.85	10
11	Social Service Workers	16,738	17,618	200,850	11.40	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,098	39,231	18.70	13
14	Head Cook	6,172	6,496	64,639	9.95	14
15	Cook Helpers/Assistants	17,276	18,185	171,664	9.44	15
16	Dishwashers					16
17	Maintenance Workers	5,955	6,269	86,448	13.79	17
18	Housekeepers	22,502	23,686	222,174	9.38	18
19	Laundry	11,678	12,293	111,125	9.04	19
20	Administrator	2,066	2,174	77,993	35.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,690	15,463	193,594	12.52	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	6,287	6,986	158,369	22.67	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	246,848	260,207	\$ 3,811,696 *	\$ 14.65	34

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	\$ 41,540	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	1,752	10-03	37
38	Nurse Consultant	Monthly	51,120	10-03	38
39	Pharmacist Consultant	Monthly	12,771	10-03	39
40	Physical Therapy Consultant	339	17,615	10a-03	40
41	Occupational Therapy Consultant	256	14,949	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	119	6,339	10a-03	43
44	Activity Consultant	51	2,448	11-03	44
45	Social Service Consultant	123	6,649	12-03	45
46	Other(specify)				46
47	Psychiatric Med. Director	Monthly	6,000	10-03	47
48	Specialty Rehab Consult.	Monthly	25,560	10a-03	48
49	TOTAL (lines 35 - 48)	888	\$ 193,943		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,634	\$ 121,157	10-03	50
51	Licensed Practical Nurses	3,649	130,143	10-03	51
52	Certified Nurse Assistants/Aides	2,442	50,236	10-03	52
53	TOTAL (lines 50 - 52)	8,725	\$ 301,536		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberFairview Nursing Plaza Inc.# 0037655Report Period Beginning:01/01/11Ending:12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Thompson	Administrator	0.00%	\$ 77,993
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,993

B. Administrative - Other

Description	Amount
SIR Management - Dir. Of Admin. Services	\$ 51,120
SIR Management - Ancillary Admin Services	51,120
SIR Management - Management Fees	426,433
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Admin. Legal Services	\$ 25,560
SIR Management	Accounting Fees	36,000
Frost, Ruttenberg, & Rothblatt	Accounting Fees	18,919
SIR Management	Bookkeeping Fees	94,572
Personnel Planners	Unemployment Tax Consult	2,774
Pinnacle Consulting	Customer Satisfaction	3,642
eHealth Data	Computer Services	3,600
HDSI	Computer Services	518
Honkamp & Krueger	WOTC Consult.	2,869
Compliance Team	Accreditation Services	769
Book & Clark	Survey Consult	2,750
See Supplemental Schedule		4,641
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 196,614

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 62,415
Unemployment Compensation Insurance	81,092
FICA Taxes	278,916
Employee Health Insurance	105,846
Employee Meals	22,356
Illinois Municipal Retirement Fund (IMRF)*	
401k Matching	5,062
Other Benefits	10,546
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 994
Advertising: Employee Recruitment	9,799
Health Care Worker Background Check (Indicate # of checks performed 117)	4,710
Patient Background Checks	
Advertising & Promotional	6,199
Licenses & Permits	13,088
Dues & Subscriptions	13,534
Allocated from SIR Management	1,234
Less: Public Relations Expense	()
Non-allowable advertising	(5,716)
Yellow page advertising	(483)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	5,777
Allocation from SIR Management	737
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 6,514

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$18,120

(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.

\$1,946

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.

\$396,618

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.

\$22,356

Has any meal income been offset against related costs?

No

Indicate the amount.

\$N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

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) 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.
- SEE ACCOUNTANTS' COMPILATION REPORT