

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,724	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	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	20,438	421	2,626	23,485	8
9	SNF/PED					9
10	ICF	45,719	942	2,559	49,220	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,157	1,363	5,185	72,705	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.26%

D. How many bed-hold days during this year were paid by the Department? 720 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 99 and days of care provided 2,626

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

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

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

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

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	278,463	55,402	43,702	377,567		377,567	(17,908)	359,659			1
2	Food Purchase		364,102		364,102	(20,112)	343,990	(68)	343,922			2
3	Housekeeping	234,762	56,645		291,407		291,407		291,407			3
4	Laundry	108,674	18,389		127,063		127,063		127,063			4
5	Heat and Other Utilities			175,939	175,939		175,939	(27,145)	148,794			5
6	Maintenance	59,873	55,006	195,772	310,651		310,651	(26,496)	284,155			6
7	Other (specify):*							6,346	6,346			7
8	TOTAL General Services	681,772	549,544	415,413	1,646,729	(20,112)	1,626,617	(65,271)	1,561,346			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,357,964	165,699	253,159	2,776,822		2,776,822	(28,250)	2,748,572			10
10a	Therapy	96,421	1,647	30,556	128,624		128,624	(11,935)	116,689			10a
11	Activities	137,889	16,232	2,652	156,773		156,773		156,773			11
12	Social Services	274,066	3,023	3,472	280,561		280,561		280,561			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,100	6,100			15
16	TOTAL Health Care and Programs	2,866,340	186,601	297,039	3,349,980		3,349,980	(34,085)	3,315,895			16
	C. General Administration											
17	Administrative	71,586		328,825	400,411		400,411	(214,117)	186,294			17
18	Directors Fees											18
19	Professional Services			199,673	199,673		199,673	(129,286)	70,387			19
20	Dues, Fees, Subscriptions & Promotions			41,244	41,244		41,244	(19,033)	22,211			20
21	Clerical & General Office Expenses	195,577	22,418	397,666	615,661		615,661	(206,221)	409,440			21
22	Employee Benefits & Payroll Taxes			619,854	619,854	20,112	639,966		639,966			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,224	6,224		6,224	1,012	7,236			24
25	Other Admin. Staff Transportation			11,614	11,614		11,614	10,495	22,109			25
26	Insurance-Prop.Liab.Malpractice			148,673	148,673		148,673	1,733	150,406			26
27	Other (specify):*							51,490	51,490			27
28	TOTAL General Administration	267,163	22,418	1,753,773	2,043,354	20,112	2,063,466	(503,928)	1,559,538			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,815,275	758,563	2,466,225	7,040,063		7,040,063	(603,284)	6,436,779			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			121,737	121,737		121,737	431,506	553,243			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,870	124,870		124,870	438,560	563,430			32
33	Real Estate Taxes							130,592	130,592			33
34	Rent-Facility & Grounds			1,090,000	1,090,000		1,090,000	(1,090,000)				34
35	Rent-Equipment & Vehicles			6,583	6,583		6,583	6,696	13,279			35
36	Other (specify):*											36
37	TOTAL Ownership			1,343,190	1,343,190		1,343,190	(82,646)	1,260,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,209	451,632	576,841		576,841		576,841			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			543,654	543,654		543,654		543,654			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		125,209	995,286	1,120,495		1,120,495		1,120,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,815,275	883,772	4,804,701	9,503,748		9,503,748	(685,930)	8,817,818			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	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	(29,731)	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	89,918	30		9
10	Interest and Other Investment Income	(624)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	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	(315,955)	21		24
25	Fund Raising, Advertising and Promotional	(8,438)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(419)	20		28
29	Other-Attach Schedule	(48,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (315,712)		\$	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)	(370,218)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (370,218)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (685,930)		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

Report Period Beginning:

Ending:

ID#

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01/01/12

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (6,167)	21	1
2	Theft & Damage	(1,166)	21	2
3				3
4	Capitalized R&M	(2,727)	06	4
5	Non-Allowable Legal	(8,401)	19	5
6	Additional Seminar	315	24	6
7	Additional R&M	(9,805)	06	7
8				8
9	COPE Dues	(8,687)	20	9
10	Non Allowable Expense	(5,749)	21	10
11	Non Allowable Professional fees	(429)	19	11
12	Building Company Amortization	(2,084)	36	12
13	Building Company Fees	(275)	20	13
14	Building Company Office Expense	(36)	21	14
15	Building Company Professional Fees	(3,183)	19	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	(48,395)		49

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Report Period Beginning:

01/01/12

Ending:

12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

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	\$ 1,090,000	Fairview Nursing Property, LLC	100.00%	\$	\$ (1,090,000)	1
2	V	32	Interest Income	107	Fairview Nursing Property, LLC	100.00%		(107)	2
3	V	36	Amortization		Fairview Nursing Property, LLC	100.00%	2,084	2,084	3
4	V	30	Depreciation		Fairview Nursing Property, LLC	100.00%	331,714	331,714	4
5	V	20	Fees		Fairview Nursing Property, LLC	100.00%	275	275	5
6	V	32	Interest Expense		Fairview Nursing Property, LLC	100.00%	440,776	440,776	6
7	V	21	Office Expense		Fairview Nursing Property, LLC	100.00%	36	36	7
8	V	33	RE Tax Expense		Fairview Nursing Property, LLC	100.00%	126,687	126,687	8
9	V	19	Professional Fees		Fairview Nursing Property, LLC	100.00%	3,183	3,183	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,090,107			\$ 904,755	\$ * (185,352)	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%	\$ 9,459	\$ (16,101)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	741	741	16
17	V	10	NURSING	53,676	S.I.R. MANAGEMENT, INC.	100.00%	16,968	(36,708)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,854	2,854	18
19	V	19	PROFESSIONAL FEES	151,020	S.I.R. MANAGEMENT, INC.	100.00%	13,860	(137,160)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	511	511	20
21	V	21	CLERICAL & GENERAL	51,120	S.I.R. MANAGEMENT, INC.	100.00%	64,720	13,600	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	697	697	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,495	10,495	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,597	1,597	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	11,452	11,452	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,778)	(8,778)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,696	6,696	27
28	V								28
29	V	17	ADMINISTRATIVE	328,825	S.I.R. MANAGEMENT, INC.	100.00%	28,911	(299,914)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	239	239	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	109,137	109,137	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,330	21,330	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 610,201			\$ 290,889	\$ * (319,312)	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%	\$ 7,652	\$ (17,908)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,298	1,298	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,458	8,458	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,423	1,423	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	85,797	85,797	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,404	16,404	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,708	18,708	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,004	S.I.R. MANAGEMENT, INC.	100.00%	11,069	(11,935)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,823	1,823	25
26	V								26
27	V	6	MAINTENANCE SALARIES	22,149	S.I.R. MANAGEMENT, INC.	100.00%	23,685	1,536	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,307	4,307	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,586	2,586	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	601	601	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	61	61	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	79	79	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	136	136	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,874	9,874	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,293	7,293	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,905	3,905	37
38	V								38
39	Total			\$ 70,713			\$ 205,159	\$ * 134,446	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%	\$ 117,764	\$ 117,764	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	117,764	CCS Employee Benefits Group	100.00%		(117,764)	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			\$ 117,764			\$ 117,764	\$ *	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	39	Ancillary	\$ 6,342	Long Term Care Laboratory, LLC	100.00%	\$ 6,342	\$	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			\$ 6,342			\$ 6,342	\$ *	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 (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

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	ADAM VALES TRUST	2.242%	ALBANY CARE INC	EVANSTON	FAIRVIEW NURSING PROPERTY	LINCOLNWOOD	BUILDING CO.	1
2	KATHRYN VALES TRUST	2.242%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST DTD 09/01/2004	14.200%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CELESTE GIANNINI TRUST DTD 3/13/00 K	14.200%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	DANIEL ROTHNER TRUST	2.242%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	GLENDA STRICKLAND	0.897%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	HARVEY SCOTT	4.484%	GREENWOOD CARE, INC.	EVANSTON				7
8	JULIANA BARRISH TRUST DATED 1/26/93	14.200%	MAPLEWOOD CARE, INC.	ELGIN				8
9	KIMBERLY RICHMAN TRUST	2.691%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	LOUISE BERGTHOLD	2.691%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	MARK SOLOMON	6.726%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	MELISSA ROTHNER TRUST	2.242%	WILSON CARE, INC.	CHICAGO				12
13	MICHAEL R GIANNINI TRUST DTD 3/13/00	14.200%						13
14	NATHAN & SHIRLEY ROTHNER FAMILY	11.361%						14
15	RACHEL ROTHNER TRUST	2.242%						15
16	THOMAS WINTER	0.897%						16
17	WILLIAM ROTHNER TRUST	2.242%						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: 01/01/12 Ending: 12/31/12

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	5.11	8.52%	Alloc. Salary	\$ 17,047	17-7	1
2	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	5.11	8.52%	Alloc. Salary	17,047	17-7	2
3	Michael Giannini	Relative	Administrative	0.00%	See Attached	2.98	7.45%	Alloc. Salary	14,319	17-7	3
4	Bryan Barrish	Relative	Administrative	0.00%	See Attached	3.41	7.58%	Alloc. Salary	17,047	17-7	4
5	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	3.14	7.85%	Alloc. Salary	3,971	21-7	5
6	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.26	8.52%	Alloc. Salary	10,308	17-7	6
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.26	8.52%	Alloc. Salary	7,652	1-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.78	1.95%	Alloc. Salary	1,429	22-7	8
9	David Winter	Relative	Clerical	0.00%	See Attached	0.55	8.46%	Alloc. Salary	289	21-7	9
10	Matthew Winter	Relative	Clerical	0.00%	See Attached	0.14	8.75%	Alloc. Salary	74	21-7	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	\$ 89,183		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: 01/01/12 Ending: 12/31/12

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

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	852,976	13	\$ 110,978	\$ 47,841	72,705	\$ 9,459	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		72,705	741	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	72,705	16,968	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		72,705	2,854	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	72,705	13,860	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		72,705	511	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	72,705	64,720	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		72,705	697	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		72,705	10,495	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		72,705	1,597	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		72,705	11,452	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		72,705	(8,778)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		72,705	6,696	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	72,705	28,911	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		72,705	239	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	72,705	109,137	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		72,705	21,330	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 290,889	25

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

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	852,976	13	\$ 89,778	\$ 89,778	72,705	\$ 7,652	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		72,705	1,298	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	72,705	8,458	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		72,705	1,423	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	72,705	85,797	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		72,705	16,404	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		72,705	18,708	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	23,004	11,069	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		23,004	1,823	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	22,149	23,685	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		22,149	4,307	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		1,098	2,586	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		1,098	601	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		1,098	61	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		1,098	79	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		1,098	136	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		1,098	9,874	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		1,098	7,293	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		1,098	3,905	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 205,159	25

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

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			\$	\$		\$ 117,764	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					\$	\$		\$ 117,764	25

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

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

	1	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	39	Ancillary	Direct Allocation			\$	\$		\$ 6,342	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					\$	\$		\$ 6,342	25

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

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

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

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

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

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

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

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

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			\$	7,252,361			\$	392,548	1
2	Wells Fargo		X	Note Payable				487,383					2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				1,400,000				124,870	6
7	Centrue Bank		X	Notes Payable - Bldg Co.				466,358				48,228	7
8	See Supplemental Schedule							515,000				7,293	8
9	TOTAL Facility Related						\$	10,121,102			\$	572,939	9
	B. Non-Facility Related*												
10	Interest Income		X									(624)	10
11	Interest Income - Bldg Co.		X									(107)	11
12	Alloc. - S.I.R. Management											(8,778)	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(9,509)	14
15	TOTALS (line 9+line14)						\$	10,121,102			\$	563,430	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	Shareholder Loans		X				\$		\$ 515,000			\$	8
9	Alloc. - S.I.R. Management		X									7,293	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								515,000			7,293	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	123,000	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.)		\$	125,592	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,592	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	130,592	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	99,849	8	
		2008	106,335	9	
		2009	111,565	10	
		2010	117,084	11	
		2011	121,687	12	
2012 Accrued Taxes = \$121,787 x 1.05 = \$128,000					
Allocation SIR Management = \$3,905					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-28-203-004</u>	<u>Long-Term Care Property</u>	\$ <u>121,686.62</u>	\$ <u>121,686.62</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>101,165.17</u>	\$ <u>6,754.60</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>222,851.79</u>	\$ <u>128,441.22</u>

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 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.)

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

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? YES NO

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

C. Tax Bills

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

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	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	213		2008	1977	\$ 7,695,500	\$ 138,975	35	\$ 320,960	\$ 181,985	\$ 1,457,483
5										
6										
7										
8										
	Improvement Type**									
9	Various		1992		55,434		20	1,164	1,164	55,422
10	Various		1993		68,424		20	3,408	3,408	66,219
11	Various		1994		44,837		20	2,242	2,242	42,268
12	Various		1995		14,482		20	724	724	12,366
13	Various		1996		9,472		20	374	374	8,175
14	Various		1997		28,011		20	1,401	1,401	21,999
15	Various		1998		23,867		20	949	949	17,968
16	Various		1999		46,683		20	2,334	2,334	31,539
17	Various		2000		24,848		20	1,042	1,042	16,884
18	Various		2001		32,547		20	1,827	1,827	21,114
19	Various		2002		39,114		20	2,426	2,426	38,621
20	Various		2003		31,242		20	1,562	1,562	15,016
21	Various		2004		164,618		20	9,349	9,349	81,426
22	Various		2005		111,099		20	7,162	7,162	52,642
23	Various		2006		45,816		20	2,291	2,291	15,715
24	Various		2007		39,926		20	1,996	1,996	11,533
25	Various		2008		25,639		20	1,512	1,512	7,042
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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		315,986	117,526		12,184	(105,342)	114,200	67
68		166,422	5,200		6,348	1,148	75,564	68
69			121,737			(121,737)		69
70		\$ 8,983,966	\$ 383,438		\$ 381,255	\$ (2,183)	\$ 2,163,195	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:

01/01/12

Ending:

12/31/12

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		\$ 8,983,966	\$ 383,438		\$ 381,255	\$ (2,183)	\$ 2,163,195	1
2	Lighting Work	2009	4,274		20	214	214	819	2
3	Water Heater	2009	13,282		20	664	664	2,048	3
4	Side Walk	2009	7,628		20	763	763	2,988	4
5	Furnace Burner	2009	5,094		20	509	509	1,613	5
6	Fire Protection System	2009	2,665		20	267	267	1,022	6
7	Smoke Dampers	2009	2,607		20	261	261	999	7
8	Security Camera	2010	6,100		20	871	871	1,888	8
9	Radiator Guards	2010	5,558		20	1,112	1,112	3,335	9
10	Water Heater	2010	12,628		20	2,526	2,526	6,524	10
11	Window Treatments	2010	10,008		20	2,002	2,002	5,004	11
12	Sewer Pipe	2010	9,800		20	1,960	1,960	5,717	12
13	Straight Cubicle Track	2010	2,941		20	294	294	686	13
14	Excavation	2010	3,100		20	310	310	646	14
15	Roofing	2011	7,695		20	385	385	673	15
16	Masterlock System	2011	4,890		20	245	245	448	16
17	Fire Alarm Panel	2011	4,430		20	222	222	388	17
18	Resident Room Doors	2011	7,102		20	355	355	562	18
19	Elevator Panels	2011	3,800		20	190	190	301	19
20	Hallway Room Signs	2011	7,901		20	790	790	1,251	20
21	Ceiling Grid And Lighting	2011	41,636		20	2,082	2,082	3,296	21
22	Drywall Repair/Patch	2011	14,060		20	703	703	1,113	22
23	Window Treatments	2011	11,128		20	556	556	927	23
24	Flooring	2011	27,953		20	1,398	1,398	2,329	24
25	Wall-Base	2011	9,932		20	1,986	1,986	2,814	25
26	Handrails, Crashrails, Corner Guards	2011	76,093		20	3,805	3,805	5,073	26
27	Resident Room Doors	2011	4,929		20	246	246	308	27
28	Room 501 Ceiling, Doors	2011	3,315		20	332	332	442	28
29	Chair Rail: Dining And Activities	2011	8,594		20	430	430	501	29
30	Corner Guards	2011	4,301		20	215	215	251	30
31	Generator Work	2011	19,600		20	980	980	1,143	31
32	Water Heater	2011	4,208		20	210	210	316	32
33	Hvac Work	2011	4,774		20	955	955	1,034	33
34	TOTAL (lines 1 thru 33)		\$ 9,335,992	\$ 383,438		\$ 409,090	\$ 25,652	\$ 2,219,655	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:

01/01/12

Ending:

12/31/12

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 12B, Carried Forward		\$ 9,335,992	\$ 383,438		\$ 409,090	\$ 25,652	\$ 2,219,655	1
2	Painting	2011	110,575		20	5,529	5,529	6,450	2
3	Drywall Repair	2011	3,800		20	190	190	285	3
4	Electrical Breaker	2011	2,928		20	146	146	232	4
5	Elevator Adjustment	2011	2,726		20	136	136	204	5
6	Remodel Bathroom; Metal Stairs And Rails	2011	4,978		20	249	249	498	6
7	Replaced Toilet And Sink, Repaired Pipes, Installed Towel And G	2011	3,665		20	183	183	367	7
8	Flooring On 1St Floor	2011	67,137		20	3,357	3,357	6,714	8
9	Drained Sprinkler System, Replaced Sprinkler Heads, And Install	2012	5,441		20	544	544	544	9
10	Metal Stair Rails	2012	3,650		20	365	365	365	10
11	Tear Out Old Bathroom-New Painting, Plumbing,Electrical,Dry V	2012	4,978		20	498	498	498	11
12	Bathroom Tile Upgrade	2012	3,228		20	296	296	296	12
13	Tear Out Old Bathroom-New Tile, Dry Wall, Fixtures,Painting	2012	3,665		20	336	336	336	13
14	Flooring-1St Floor	2012	9,192		20	383	383	383	14
15	Van Gogh Flooring For First Floor Resident Rooms	2012	150,217		20	6,259	6,259	6,259	15
16	Built-In Closet Cabinetry	2012	95,790		20	6,386	6,386	6,386	16
17	Privacy Curtains	2012	17,105		20	713	713	713	17
18	3/4" Round Trim For Wall Base In Hallways; Kamdean Flooring	2012	4,558		20	228	228	228	18
19	Cut Out And Connect 8 Em Receptacles, 2 In Each Hallway	2012	4,260		20	107	107	107	19
20	Room Signs	2012	6,063		20	303	303	303	20
21	First Floor Karndean Wood Look Hallway Tile	2012	135,854		20	6,793	6,793	6,793	21
22	Nurses Station - 1St Floor	2012	13,000		20	325	325	325	22
23	Nurses Station - 2Nd Floor	2012	13,000		20	325	325	325	23
24	Roofing (Contract+Extras)	2012	38,869		20	972	972	972	24
25	Air Conditioning Units	2012	26,167		20	109	109	109	25
26	Water Heater	2012	4,778		20	20	20	20	26
27	Draperies - 1St Floor	2012	69,610		20	870	870	870	27
28	Hvac Unit #8 Repair	2012	2,727		20	136	136	136	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	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 12C, Carried Forward		\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	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)		\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	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 12D, Carried Forward		\$10,143,954	\$383,438		\$444,848	\$61,410	\$2,260,371	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)		\$10,143,954	\$383,438		\$444,848	\$61,410	\$2,260,371	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								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)	\$ 315,986	\$ 117,526		\$ 12,184	\$ (105,342)	\$ 114,200	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:

01/01/12

Ending:

12/31/12

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	SIR Properties - SIR Management	2009	21,314		35	550	550	1,673	3
4	SIR Properties - SIR Management	1993	38,592	1,225	35	1,103	(122)	21,501	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	9,784	274	20	488	214	9,673	9
10	Alloc. - S.I.R. Management	1994	31		20			31	10
11	Alloc. - S.I.R. Management	1995	224		20	11	11	195	11
12	Alloc. - S.I.R. Management	1997	15,034	337	20	738	401	11,855	12
13	Alloc. - S.I.R. Management	1999	1,182		20	59	59	783	13
14	Alloc. - S.I.R. Management	1999	11,917		20			11,917	14
15	Alloc. - S.I.R. Management	2000	1,396		20	70	70	875	15
16	Alloc. - S.I.R. Management	2007	4,484	306	20	224	(82)	1,165	16
17	Alloc. - S.I.R. Management	2008	12,359	1,181	20	779	(402)	3,774	17
18	Alloc. - S.I.R. Management	2009	30,709	281	20	1,535	1,254	4,982	18
19	Alloc. - S.I.R. Management	2011	760	76	20	76		106	19
20	Alloc. - S.I.R. Management	2012	2,431	51	20	51		51	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,364	1,258	20	10	(1,248)	10	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,329		20	78	78	183	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,317	145	20	116	(29)	440	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	676	54	20	34	(20)	203	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	153		20	8	8	81	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	4,890		20	245	245	3,301	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,337		20	117	117	1,694	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	145		20	7	7	120	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	368	9	20	18	9	340	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	626	3	20	31	28	611	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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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)		\$166,422	\$5,200		\$6,348	\$1,148	\$75,564	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	\$1,327,612	\$79,294	\$66,816	\$(12,478)	10	\$358,791	71
72	Current Year Purchases	303,786	172	41,127	40,955	10	41,127	72
73	Fully Depreciated Assets	331,016				10	331,016	73
74								74
75	TOTALS	\$1,962,414	\$79,466	\$107,943	\$28,477		\$730,934	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 from SIR Management	2011	2,997	424	455	31	5	1,048	78
79										79
80	TOTALS			\$45,865	\$424	\$455	\$31		\$43,916	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)	\$12,152,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$463,328	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$553,246	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$89,918	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,035,221	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: \$ 13,279
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 178,292	\$		\$ 178,292	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			96,641			96,641	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			175,923			175,923	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				96,754		96,754	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					776	28,455		29,231	13
14	TOTAL			\$		\$ 451,632	\$ 125,209		\$ 576,841	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	\$ 8,557	\$ 57,890	1
2	Cash-Patient Deposits	66,455	66,455	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,838,513	1,838,513	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,276	45,276	6
7	Other Prepaid Expenses	4,150	4,150	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)	\$ 1,962,951	\$ 2,012,284	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	1,458,838	1,885,399	15
16	Equipment, at Historical Cost	1,544,816	1,622,265	16
17	Accumulated Depreciation (book methods)	(1,259,100)	(2,631,108)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		10,416	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	179,869	179,869	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,924,423	\$ 8,762,341	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,887,374	\$ 10,774,625	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,568	\$ 411,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,455	66,455	28
29	Short-Term Notes Payable	1,915,000	1,915,000	29
30	Accrued Salaries Payable	365,158	365,158	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,171	37,171	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,000	32
33	Accrued Interest Payable		7,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	255,405	255,405	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,050,757	\$ 3,186,160	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	487,383	487,383	39
40	Mortgage Payable		7,718,719	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)	\$ 487,383	\$ 8,206,102	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,538,140	\$ 11,392,262	46
47	TOTAL EQUITY(page 18, line 24)	\$ 349,234	\$ (617,637)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,887,374	\$ 10,774,625	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 318,484	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 318,483	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,751	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)	\$ 30,751	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)	\$ 349,234	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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,981,797	1
2	Discounts and Allowances for all Levels	(898,485)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,083,312	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,035,495	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,035,495	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	90,916	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,849	19
20	Radiology and X-Ray	142	20
21	Other Medical Services	60,999	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,906	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 624	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	254,162	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 254,162	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,534,499	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,646,729	31
32	Health Care	3,349,980	32
33	General Administration	2,043,354	33
	B. Capital Expense		
34	Ownership	1,343,190	34
	C. Ancillary Expense		
35	Special Cost Centers	576,841	35
36	Provider Participation Fee	543,654	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,503,748	40
41	Income before Income Taxes (line 30 minus line 40)**	30,751	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,751	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,101,050	44
45	Private Pay - Net Inpatient Revenue	197,196	45
46	Medicare - Net Inpatient Revenue	483,275	46
47	Other-(specify) Hospice	257,267	47
48	Other-(specify) Insurance/Prior Period Revenues	44,524	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,083,312	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	2,084	2,237	\$ 93,165	\$ 41.65	1
2	Assistant Director of Nursing	1,890	2,069	62,175	30.05	2
3	Registered Nurses	10,524	11,115	315,620	28.40	3
4	Licensed Practical Nurses	24,146	25,688	637,921	24.83	4
5	CNAs & Orderlies	84,207	89,647	1,095,482	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,096	6,243	96,421	15.44	8
9	Activity Director	1,763	2,095	34,103	16.28	9
10	Activity Assistants	11,661	13,352	103,786	7.77	10
11	Social Service Workers	18,428	19,987	274,066	13.71	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,184	41,857	19.17	13
14	Head Cook	5,205	6,082	62,587	10.29	14
15	Cook Helpers/Assistants	17,376	18,644	174,019	9.33	15
16	Dishwashers					16
17	Maintenance Workers	4,329	4,673	59,873	12.81	17
18	Housekeepers	21,529	23,473	234,762	10.00	18
19	Laundry	11,434	12,261	108,674	8.86	19
20	Administrator	1,712	2,041	71,586	35.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,203	13,633	195,577	14.35	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	5,975	6,518	153,601	23.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	241,477	261,942	\$ 3,815,275 *	\$ 14.57	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	\$ 43,702	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	1,800	10-03	37
38	Nurse Consultant	Monthly	52,398	10-03	38
39	Pharmacist Consultant	Monthly	14,102	10-03	39
40	Physical Therapy Consultant	41	2,126	10a-03	40
41	Occupational Therapy Consultant	28	1,661	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	468	2,487	10a-03	43
44	Activity Consultant	55	2,652	11-03	44
45	Social Service Consultant	64	3,472	12-03	45
46	Other(specify)				46
47	Psychiatric Med Dir	Monthly	4,500	10-03	47
48	Specialized Rehab	Monthly	24,282	10a-03	48
49	TOTAL (lines 35 - 48)	656	\$ 160,382		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,568	\$ 72,144	10-03	50
51	Licensed Practical Nurses	2,174	77,554	10-03	51
52	Certified Nurse Assistants/Aides	1,490	30,661	10-03	52
53	TOTAL (lines 50 - 52)	5,232	\$ 180,359		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number				STATE OF ILLINOIS		Page 21		
Fairview Nursing Plaza Inc.				# 0037655		Report Period Beginning: 01/01/12 Ending: 12/31/12		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mark Thompson	Administrator	Administrato	\$ 71,586	Workers' Compensation Insurance	\$ 54,675	IDPH License Fee	\$ 1,988	
				Unemployment Compensation Insurance	131,233	Advertising: Employee Recruitment	7,746	
				FICA Taxes	284,313	Health Care Worker Background Check	3,553	
				Employee Health Insurance	137,869	(Indicate # of checks performed 355)		
				Employee Meals	20,112	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	1,212	
				401k Matching	5,600	Dues & Subscriptions	7,201	
				Other Benefits	6,164	Allocated from SIR Management	511	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 71,586					
B. Administrative - Other								
Description			Amount					
SIR Management - Dir. Of Admin. Services			\$ 51,120			Less: Public Relations Expense	()	
SIR Management - Ancillary Admin Services			56,520			Non-allowable advertising	()	
SIR Management - Management Fees			221,185			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 328,825	TOTAL (agree to Schedule V, line 22, col.8)	\$ 639,966	TOTAL (agree to Sch. V, line 20, col. 8) \$ 22,211		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
SIR Management	Admin. Legal Services		\$ 25,560					
SIR Management	Accounting Fees		36,000					
Frost, Ruttenberg, & Rothblatt	Accounting Fees		21,084					
SIR Management	Bookkeeping Fees		89,460				In-State Travel	
Personnel Planners	Unemployment Tax Consult		4,199					
Pinnacle Consulting	Customer Satisfaction		3,699					
eHealth Data	Computer Services		3,600					
Olympic Engineering	Engineering Services		1,000				Seminar Expense	6,539
Honkamp & Krueger	WOTC Consult.		752				Allocated from SIR Management	697
Compliance Team	Accreditation Services		600					
Perkon Consulting	Consulting Services		1,250					
See Supplemental Schedule			12,470				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 199,674				TOTAL	\$ 7,236
				* Attach copy of IMRF notifications		**See instructions.		
SEE ACCOUNTANTS' COMPILATION REPORT								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	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 \$7,201

(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.

\$1,991

Line10

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$543,654

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.

\$20,112

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?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT