FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0037655

Facility Name: Fairview Nursing Plaza

Address: 321 Arnold Avenue (Number) Rockford (City) 61108 (Zip Code)

County: Winnebago

Telephone Number: (815) 397-5531 **Fax #** (815) 397-7629

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 10/01/09

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,610	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,797	308	5,029	25,134	8
9	SNF/PED					9
10	ICF	44,283	688	339	45,310	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,080	996	5,368	70,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.61%

D. How many bed-hold days during this year were paid by the Department?
396 (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 2,624

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	264,808	47,152	39,474	351,434		351,434	(15,221)	336,213			1
2	Food Purchase		369,889		369,889	(21,079)	348,810	(52)	348,758			2
3	Housekeeping	227,038	42,453		269,491		269,491	(2,598)	266,893			3
4	Laundry	91,642	33,410		125,052		125,052	(12,204)	112,848			4
5	Heat and Other Utilities			165,370	165,370		165,370	2,621	167,991			5
6	Maintenance	81,458	50,286	183,082	314,826		314,826	(72,239)	242,587			6
7	Other (specify):*							4,378	4,378			7
8	**TOTAL General Services**	664,946	543,190	387,926	1,596,062	(21,079)	1,574,983	(95,315)	1,479,668			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,160,993	130,988	241,382	2,533,363		2,533,363	(33,064)	2,500,299			10
10a	Therapy	151,571	6,647	43,151	201,369		201,369	(15,592)	185,777			10a
11	Activities	194,529	28,108	2,652	225,289		225,289		225,289			11
12	Social Services	196,882		3,786	200,668		200,668		200,668			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,971	4,971			15
16	**TOTAL Health Care and Programs**	2,703,975	165,743	298,171	3,167,889		3,167,889	(43,685)	3,124,204			16
	C. General Administration											
17	Administrative	113,275		488,865	602,140		602,140	(375,909)	226,231			17
18	Directors Fees											18
19	Professional Services			196,284	196,284	(372)	195,912	(131,621)	64,291			19
20	Dues, Fees, Subscriptions & Promotions			56,263	56,263		56,263	(18,561)	37,702			20
21	Clerical & General Office Expenses	141,226	31,525	394,127	566,878		566,878	(201,995)	364,883			21
22	Employee Benefits & Payroll Taxes			513,575	513,575	21,079	534,654		534,654			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,344	4,344		4,344	1,413	5,757			24
25	Other Admin. Staff Transportation			14,932	14,932		14,932	8,582	23,514			25
26	Insurance-Prop.Liab.Malpractice			180,158	180,158		180,158	1,558	181,716			26
27	Other (specify):*							44,265	44,265			27
28	**TOTAL General Administration**	254,501	31,525	1,848,548	2,134,574	20,707	2,155,281	(672,268)	1,483,013			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,623,422	740,458	2,534,645	6,898,525	(372)	6,898,153	(811,268)	6,086,885			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.

Facility Name & ID Number Fairview Nursing Plaza #0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,869	67,869		67,869	401,732	469,601			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,321	29,321		29,321	530,113	559,434			32
33	Real Estate Taxes					372	372	120,724	121,096			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(960,000)				34
35	Rent-Equipment & Vehicles			7,133	7,133		7,133	9,888	17,021			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,064,323	1,064,323	372	1,064,695	102,457	1,167,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,103	372,162	474,265		474,265		474,265			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,618	116,618		116,618		116,618			42
43	Other (specify):*			333	333		333	(333)				43
44	**TOTAL Special Cost Centers**		102,103	489,113	591,216		591,216	(333)	590,883			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,623,422	842,561	4,088,081	8,554,064		8,554,064	(709,144)	7,844,920			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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(24,072)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	60,617	30		9
10	Interest and Other Investment Income	(65)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(13,585)	06		18
19	Entertainment				19
20	Contributions	(3,235)	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	(308,447)	21		24
25	Fund Raising, Advertising and Promotional	(7,227)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(193)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,384)	20		28
29	Other-Attach Schedule	(83,568)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (381,211)		$	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)	(327,933)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (327,933)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (709,144)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (81)	21	1
2	Bank Fees	(5,796)	21	2
3	Theft & Damages	(2,949)	21	3
4	COPE Dues	(6,963)	20	4
5	Non-allowable Legal	(1,562)	19	5
6	Capitalized R & M	(24,226)	06	6
7	Capitalized R & M - Mattresses	(11,384)	04	7
8	Additional Seminar Expense	364	24	8
9	Marketing Expense	(333)	43	9
10				10
11	Building Co:			11
12	Amortization	(30,329)	36	12
13	Fees	(309)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(83,568)		49

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza # 0037655 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(15,221)								(15,221)	1
2	Food Purchase	(52)											(52)	2
3	Housekeeping					(2,598)							(2,598)	3
4	Laundry	(11,384)				(820)							(12,204)	4
5	Heat and Other Utilities				2,621								2,621	5
6	Maintenance	(61,883)		(9,065)	(1,291)								(72,239)	6
7	Other (specify):*			1,040	3,338								4,378	7
8	**TOTAL General Services**	(73,319)		(8,025)	(10,553)	(3,418)							(95,315)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(29,792)	8,038	(6,277)		(5,033)					(33,064)	10
10a	Therapy				(15,592)								(15,592)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,534	2,437								4,971	15
16	**TOTAL Health Care and Programs**			(27,258)	(5,117)	(6,277)		(5,033)					(43,685)	16
	C. General Administration													
17	Administrative			(448,514)	72,605								(375,909)	17
18	Directors Fees													18
19	Professional Services	(1,562)		(146,261)	16,202								(131,621)	19
20	Fees, Subscriptions & Promotions	(19,118)	309	248									(18,561)	20
21	Clerical & General Office Expenses	(317,466)		115,395	76								(201,995)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	364		1,049									1,413	24
25	Other Admin. Staff Transportation			8,582									8,582	25
26	Insurance-Prop.Liab.Malpractice			1,427	131								1,558	26
27	Other (specify):*			29,001	15,264								44,265	27
28	**TOTAL General Administration**	(337,782)	309	(439,073)	104,278								(672,268)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(411,101)	309	(474,356)	88,608	(9,695)		(5,033)					(811,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Nursing Plaza **#** 0037655 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	60,617	331,714		9,401								401,732	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(65)	559,124	(36,778)	7,832								530,113	32
33	Real Estate Taxes		116,565		4,159								120,724	33
34	Rent-Facility & Grounds		(960,000)										(960,000)	34
35	Rent-Equipment & Vehicles			9,888									9,888	35
36	Other (specify):*	(30,329)	30,329											36
37	**TOTAL Ownership**	30,223	77,732	(26,890)	21,392								102,457	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(333)											(333)	43
44	**TOTAL Special Cost Centers**	(333)											(333)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(381,211)	78,041	(501,246)	110,000	(9,695)		(5,033)					(709,144)	45

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Fairview Nursing		Building Co.
				Property, LLC		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 960,000	Fairview Nursing Property, LLC	100.00%	$	$ (960,000)	1
2	V	32	Interest	305	Fairview Nursing Property, LLC	100.00%	559,429	559,124	2
3	V	36	Amortization		Fairview Nursing Property, LLC	100.00%	30,329	30,329	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%	309	309	5
6	V	33	Real Estate Tax		Fairview Nursing Property, LLC	100.00%	116,565	116,565	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 960,305			$ 1,038,346	$ * 78,041	14

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 23,004	S.I.R. MANAGEMENT, INC.	100.00%	$ 13,939	$ (9,065)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,040	1,040	16
17	V	10	NURSING	46,008	S.I.R. MANAGEMENT, INC.	100.00%	16,216	(29,792)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,534	2,534	18
19	V	19	PROFESSIONAL FEES	148,452	S.I.R. MANAGEMENT, INC.	100.00%	2,191	(146,261)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	248	248	20
21	V	21	CLERICAL & GENERAL	46,008	S.I.R. MANAGEMENT, INC.	100.00%	61,618	15,610	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,049	1,049	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,582	8,582	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,427	1,427	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,636	8,636	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(36,778)	(36,778)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,888	9,888	27
28	V								28
29	V	17	ADMINISTRATIVE	477,357	S.I.R. MANAGEMENT, INC.	100.00%	28,843	(448,514)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,092		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	99,785	99,785	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,365	20,365	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 740,829			$ 240,675	$ * (501,246)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 23,004	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,783	$ (15,221)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,229	1,229	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,038	8,038	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,265	1,265	18
19	V	17	ADMIN./LEGAL SALARIES	11,508	S.I.R. MANAGEMENT, INC.	100.00%	84,113	72,605	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,140	16,140	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,264	15,264	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,004	S.I.R. MANAGEMENT, INC.	100.00%	7,412	(15,592)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,172	1,172	25
26	V								26
27	V	6	MAINTENANCE SALARIES	13,294	S.I.R. MANAGEMENT, INC.	100.00%	11,146	(2,148)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,109	2,109	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,621	2,621	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	857	857	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	62	62	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	76	76	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	131	131	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,401	9,401	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,832	7,832	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,159	4,159	37
38	V								38
39	Total			$ 70,810			$ 180,810	$ * 110,000	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	38,984	Xcel Supply, LLC	100.00%	36,386	(2,598)	16
17	V	4	Laundry	12,313	Xcel Supply, LLC	100.00%	11,493	(820)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	94,197	Xcel Supply, LLC	100.00%	87,920	(6,277)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 145,494			$ 135,799	$ * (9,695)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 184,451	$ 184,451	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	184,451	CCS Employee Benefits Group	100.00%		(184,451)	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			$ 184,451			$ 184,451	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Supplies - Enterals	$ 11,705	Care Centers Health Systems		$ 6,672	$ (5,033)	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			$ 11,705			$ 6,672	$ * (5,033)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Solomon	Shareholder	Administrative	6.72%	See Attached	23.63	54.53%	Alloc. Salary	$ 53,682	17-1, 17-7	1
2	Tom Winter	Shareholder	Administrative	0.90%	See Attached	5.25	8.75%	Alloc. Salary	17,511	17-7	2
3	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	2.45	4.08%	Alloc. Salary	8,539	17-7	3
4	Michael Giannini	Shareholder	Administrative	14.20%	See Attached	3.06	7.65%	Alloc. Salary	14,603	17-7	4
5	Bryan Barrish	Shareholder	Administrative	14.20%	See Attached	3.5	7.78%	Alloc. Salary	17,511	17-7	5
6	Kristen Barrish	Relative	Clerical	0.00%	See Attached	1.49	8.76%	Alloc. Salary	3,254	21-7	6
7	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.38	8.76%	Alloc. Salary	9,331	17-7	7
8	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.38	8.76%	Alloc. Salary	7,783	1-7	8
9	Adam Vales	Shareholder	Clerical	2.24%	See Attached	0.97	2.43%	Alloc. Salary	1,694	22-7	9
10	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.25	1.12%	Alloc. Salary	865	17-7	10
11	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.53	1.14%	Alloc. Salary	8,755	17-7	11
12	Where applicable, the amounts reported on these pages have been adjusted from the actual costs to reflect amounts anticipated to be considered allowable by IL Dept. of HFS										12
13								TOTAL	$ 143,528		13

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

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	804,585	12	$ 159,205	$ 76,299	70,444	$ 13,939	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		70,444	1,040	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	70,444	16,216	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		70,444	2,534	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	70,444	2,191	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		70,444	248	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	70,444	61,618	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		70,444	1,049	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		70,444	8,582	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		70,444	1,427	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		70,444	8,636	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		70,444	(36,778)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		70,444	9,888	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	70,444	28,843	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		70,444	1,092	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	70,444	99,785	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		70,444	20,365	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,748,883	$ 2,300,573		$ 240,675	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	804,585	12	$ 88,890	$ 88,890	70,444	$ 7,783	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		70,444	1,229	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	70,444	8,038	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		70,444	1,265	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	70,444	84,113	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		70,444	16,140	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		70,444	15,264	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	23,004	7,412	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	273,888	12	13,949		23,004	1,172	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018	13,294	11,146	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079		13,294	2,109	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		1,128	2,621	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		1,128	857	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		1,128	62	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		1,128	76	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		1,128	131	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		1,128	9,401	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		1,128	7,832	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		1,128	4,159	23
24										24
25	TOTALS					$ 2,238,902	$ 1,499,668		$ 180,810	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						36,386	2
3	4	Laundry	Direct Allocation						11,493	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						87,920	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation							10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation							12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 135,799	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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			$	$		$ 184,451	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					$	$		$ 184,451	25

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Care Centers Health Systems
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Supplies - Enterals	Direct Allocation			$	$		$ 6,672	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					$	$		$ 6,672	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X	Vehicle	$591.42		$	$			$ 109	1
2	Centrue Bank		X	Mortgage Payable				7,723,402			499,429	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				1,020,000			29,147	6
7	Centrue Bank		X	Notes Payable - Bldg Co.				797,500			60,000	7
8	See Supplemental Schedule										7,832	8
9	TOTAL Facility Related				$591.42		$	$ 9,540,902			$ 596,517	9
	B. Non-Facility Related*											
10	Interest Income - Bldg Co.		X								(305)	10
11	Interest Income - SIR Mgmt	X									(36,778)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (37,083)	14
15	TOTALS (line 9+line14)						$	$ 9,540,902			$ 559,434	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. - S.I.R. Management	X					$	$			$ 7,832	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,832	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	112,000	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.)	$	115,724	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,724	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	117,000	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.	$	372	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.	$	121,096	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	99,256	8
	2006	101,020	9
	2007	99,849	10
	2008	106,335	11
	2009	111,565	12

2010 Accrual = $111,565 x 1.05 = $117,000

Allocation S.I.R. Management = $4,159

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-28-203-004	Long Term Care Property	$ 111,565.08	$ 111,565.08
2.	See Attached	See Attached	$ 80,891.59	$ 5,548.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 192,456.67	$ 117,113.62

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	55,434		20	2,771	2,771	51,487	9
10	Various			1993	68,424		20	3,420	3,420	59,390	10
11	Various			1994	44,837		20	2,242	2,242	37,785	11
12	Various			1995	14,482		20	724	724	10,918	12
13	Various			1996	9,472		20	374	374	7,427	13
14	Various			1997	73,164		20	3,658	3,658	49,866	14
15	Various			1998	23,867		20	949	949	16,069	15
16	Various			1999	46,683		20	2,334	2,334	26,870	16
17	Various			2000	50,948		20	2,347	2,347	28,160	17
18	Various			2001	43,547		20	2,177	2,177	21,530	18
19	Various			2002	39,114		20	3,626	3,626	32,570	19
20	Various			2003	31,242		20	1,562	1,562	11,892	20
21	Various			2004	164,618		20	9,349	9,349	62,727	21
22	Various			2005	126,099		20	7,912	7,912	42,256	22
23	Various			2006	45,816		20	2,291	2,291	11,134	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		8,122,061	323,969		348,163	24,194	890,375	67
68	Related Party Allocations (Pages 12H & 12I)		143,039	4,317		5,786	1,469	63,827	68
69	Financial Statement Depreciation			67,869			(67,869)		69
70	TOTAL (lines 4 thru 69)		$ 9,102,847	$ 396,155		$ 399,686	$ 3,531	$ 1,424,283	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,102,847	$ 396,155		$ 399,686	$ 3,531	$ 1,424,283	1
2	Hot Water Heater	2007	12,524		20	626	626	2,453	2
3	Flooring	2007	6,872		20	344	344	1,317	3
4	Wall Papering	2007	7,604		20	380	380	1,457	4
5	Furnace-Motor	2007	2,222		20	111	111	417	5
6	Door Alarm	2007	3,510		20	176	176	644	6
7	Hvac Work	2007	3,896		20	195	195	731	7
8	Roof Repair	2007	3,298		20	165	165	522	8
9	Telephone System	2008	4,601		20	460	460	1,342	9
10	Cove Base	2008	8,070		20	404	404	1,143	10
11	Generator Switch	2008	4,034		20	202	202	555	11
12	Hvac Burner	2008	5,673		20	284	284	638	12
13	Door Installation	2008	3,260		20	163	163	340	13
14	Lighting Work	2009	4,274		20	214	214	392	14
15	Water Heater	2009	13,282		20	664	664	719	15
16	Side Walk	2009	7,628		20	763	763	1,462	16
17	Furnace Burner	2009	5,094		20	509	509	594	17
18	Fire Protection System	2009	2,665		20	267	267	489	18
19	Smoke Dampers	2009	2,607		20	261	261	478	19
20	Security Camera	2010	6,100		20	145	145	145	20
21	Radiator Guards	2010	5,558		20	1,112	1,112	1,112	21
22	Water Heater	2010	12,628		20	1,473	1,473	1,473	22
23	Window Treatments	2010	10,008		20	1,001	1,001	1,001	23
24	Sewer Pipe	2010	9,800		20	1,797	1,797	1,797	24
25	Straight Cubicle Track	2010	2,941		20	147	147	147	25
26	Excavation	2010	3,100		20	155	155	155	26
27	Bathroom Renovation - Tile, Shower Doors	2010	18,185		20	909	909	909	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,272,281	$ 396,155		$ 412,611	$ 16,455	$ 1,446,714	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1977	7,695,500	296,766	35	320,960	24,194	815,563	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roofing	2008	172,737	5,758	30	5,758		16,314	9
10	Lighting	2008	18,134	907	20	907		2,569	10
11	Rooftop HVAC	2008	35,086	1,754	20	1,754		4,970	11
12	Painting	2008	166,886	16,689	10	16,689		45,894	12
13	Parking Lot Work	2008	25,518	1,276	20	1,276		3,084	13
14	Handrails	2008	8,200	820	10	820		1,982	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.

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information 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 (12F & 12G lines 1 thru 33)		$ 8,122,061	$ 323,969		$ 348,163	$ 24,194	$ 890,375	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	S.I.R. Properties - S.I.R. Management	1993	39,646	1,259	35	1,133	(126)	19,823	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	10,052	280	20	498	218	8,970	9
10	Alloc. - S.I.R. Management	1994	31		10			31	10
11	Alloc. - S.I.R. Management	1995	230		20	12	12	177	11
12	Alloc. - S.I.R. Management	1997	15,445	346	20	772	426	10,664	12
13	Alloc. - S.I.R. Management	1999	1,214		20	61	61	683	13
14	Alloc. - S.I.R. Management	1999	11,917		20			11,917	14
15	Alloc. - S.I.R. Management	2000	1,434		20	72	72	756	15
16	Alloc. - S.I.R. Management	2007	4,607	493	20	230	(263)	736	16
17	Alloc. - S.I.R. Management	2008	12,696	1,270	20	800	(470)	2,276	17
18	Alloc. - S.I.R. Management	2009	31,549	289	20	1,577	1,288	1,963	18
19									19
20	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,392		20	40	40	40	20
21	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,380	292	20	119	(173)	214	21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2007	694	75	20	35	(40)	139	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2002	157		20	8	8	67	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,024		20	251	251	2,889	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,401		20	120	120	1,500	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	1997	149		20	7	7	108	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1994	378	10	20	19	9	311	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1993	643	3	20	32	29	563	28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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)		$ 143,039	$ 4,317		$ 5,786	$ 1,469	$ 63,827	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 # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 490,202	$ 12,514	$ 41,525	$ 29,011	10	$ 245,296	71
72	Current Year Purchases	87,663	142	10,723	10,581	10	10,723	72
73	Fully Depreciated Assets	313,178		70	70	10	313,178	73
74								74
75	TOTALS	$ 891,043	$ 12,656	$ 52,318	$ 39,662		$ 569,197	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CHEVY VAN	1996	$ 11,516	$	$	$	5	$ 11,516	76
77		CHEVY EXPESS VAN	2005	31,352		4,500	4,500	5	31,352	77
78		Allocated - SIR Management	1988	2,321	174	174		5	174	78
79										79
80	TOTALS			$ 45,189	$ 174	$ 4,674	$ 4,500		$ 43,042	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,208,513	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 408,985	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 469,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 60,617	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,058,953	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.

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 17,021 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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$ 222,882	$		$ 222,882	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,945			9,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			139,335			139,335	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				73,250		73,250	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						28,853		28,853	13
14	TOTAL			$		$ 372,162	$ 102,103		$ 474,265	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

STATE OF ILLINOIS

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 20,453	$ 66,858	1
2	Cash-Patient Deposits	135,374	135,374	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,513,850	1,513,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,414	45,414	6
7	Other Prepaid Expenses	19,766	19,766	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)**	$ 1,734,857	$ 1,781,262	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	484,843	911,404	15
16	Equipment, at Historical Cost	1,119,523	1,196,972	16
17	Accumulated Depreciation (book methods)	(1,065,815)	(1,774,396)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		29,066	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 538,551	$ 8,058,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,273,408	$ 9,839,808	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 393,085	$ 393,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	141,345	141,345	28
29	Short-Term Notes Payable	1,020,000	1,020,000	29
30	Accrued Salaries Payable	324,077	324,077	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,961	24,961	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,000	32
33	Accrued Interest Payable		10,796	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,903,468	$ 2,031,264	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,520,902	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,520,902	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,903,468	$ 10,552,166	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 369,940	$ (712,358)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,273,408	$ 9,839,808	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Fairview Nursing Plaza **#** 0037655 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 573,036	1
2	Restatements (describe):		2
3	**Rounding**	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 573,041	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,901)	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	(89,200)	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)**	$ (203,101)	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)**	$ 369,940	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,540,649	1
2	Discounts and Allowances for all Levels	(254,069)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,286,580	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	816,869	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 816,869	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	95,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,692	19
20	Radiology and X-Ray	319	20
21	Other Medical Services	10,483	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 110,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	65	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 65	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	225,902	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 225,902	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,440,163	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,596,062	31
32	Health Care	3,167,889	32
33	General Administration	2,134,574	33
	B. Capital Expense		
34	Ownership	1,064,323	34
	C. Ancillary Expense		
35	Special Cost Centers	474,598	35
36	Provider Participation Fee	116,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,554,064	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,901)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,901)	43

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

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

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

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,101	2,150	$ 82,053	$ 38.16	1
2	Assistant Director of Nursing	1,635	1,669	49,662	29.76	2
3	Registered Nurses	6,374	6,726	187,512	27.88	3
4	Licensed Practical Nurses	24,812	26,284	622,691	23.69	4
5	CNAs & Orderlies	80,291	86,387	1,052,581	12.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,880	7,749	151,571	19.56	8
9	Activity Director	2,227	2,348	85,474	36.40	9
10	Activity Assistants	11,423	12,110	109,055	9.01	10
11	Social Service Workers	16,676	18,132	196,882	10.86	11
12	Dietician					12
13	Food Service Supervisor	1,803	2,086	37,193	17.83	13
14	Head Cook	5,791	6,414	62,190	9.70	14
15	Cook Helpers/Assistants	16,903	17,949	165,425	9.22	15
16	Dishwashers					16
17	Maintenance Workers	5,792	6,394	81,458	12.74	17
18	Housekeepers	23,194	24,480	227,038	9.27	18
19	Laundry	9,729	10,512	91,642	8.72	19
20	Administrator	2,149	2,443	106,041	43.41	20
21	Assistant Administrator	429	517	7,234	13.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,575	11,536	141,226	12.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,472	7,265	166,494	22.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	235,256	253,151	$ 3,623,422 *	$ 14.31	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 16,470	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	876	10-03	37
38	Nurse Consultant	Monthly	46,008	10-03	38
39	Pharmacist Consultant	Monthly	12,409	10-03	39
40	Physical Therapy Consultant	224	11,623	10a-03	40
41	Occupational Therapy Consultant	146	8,524	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	2,652	11-03	44
45	Social Service Consultant	70	3,786	12-03	45
46	Other(specify) Dir of Food Service	Monthly	23,004	01-03	46
47	Psychiatric Med. Director	Monthly	6,000	10-03	47
48	Specialized Rehab Consultant	Monthly	23,004	10a-03	48
49	TOTAL (lines 35 - 48)	495	$ 161,556		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,538	$ 70,752	10-03	50
51	Licensed Practical Nurses	2,131	75,996	10-03	51
52	Certified Nurse Assistants/Aides	1,426	29,341	10-03	52
53	TOTAL (lines 50 - 52)	5,095	$ 176,089		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon	Administrator	6.73%	$ 53,148
Mark Thompson	Administrator	0.00%	34,676
Michael Toral	Administrator	0.00%	18,217
Shelley Burger	Asst Admin.	0.00%	7,234
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,275

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 384,057
SIR Management - Dir of Admin. Services	46,008
SIR Management - Owners Council Dues	11,508
See Supplemetal Schedule	47,292
TOTAL (agree to Schedule V, line 17, col. 3)	$ 488,865
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenburg, & Rothblatt	Accounting	$ 20,435
SIR Management	Accounting	36,000
SIR Management	Bookkeeping Services	89,448
Personnel Planners	Unemployment Tax Consult	4,124
e-Health Data Solutions	Computer Services	3,600
Pinnacle Consulting	Customer Satisfaction	3,412
The Compliance Team	Accreditation Services	79
MDI Achieve	Computer Services	4,295
See Attached	Legal	11,887
SIR Management	Admin. Legal Services	23,004
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 196,284

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	120,070
FICA Taxes	269,563
Employee Health Insurance	104,832
Employee Meals	21,079
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching Contribution	4,843
Employee Benefits - Other	14,267
TOTAL (agree to Schedule V, line 22, col.8)	$ 534,654

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 911
Advertising: Employee Recruitment	8,585
Health Care Worker Background Check	
(Indicate # of checks performed 67)	2,150
Patient Background Checks	
Dues & Subscriptions	10,824
Advertising & Promotions	7,227
Yellow Page Advertising	1,384
Licenses & Fees	14,984
See Supplemental Schedule	248
Less: Public Relations Expense	( )
Non-allowable advertising	(7,227)
Yellow page advertising	(1,384)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,702

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,708
Allocated from SIR Management	1,049
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,757

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Fairview Nursing Plaza **#** 0037655 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N/A

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC $16,512

(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? No

(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. $ 1,929 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 116,618
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 21,079 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 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.