

		FOR BHF USE					

LL1

**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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

**I. IDPH Facility ID Number:** 0037655

**Facility Name:** Fairview Nursing Plaza

**Address:** 321 Arnold Avenue Rockford 61108  
 Number City Zip Code

**County:** Winnebago

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

**HFS ID Number:** 363782675001

**Date of Initial License for Current Owners:** 09/01/91

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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 C. Buxbaum, 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: 01/01/05 Ending: 12/31/05

## 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 bedsN/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,464</u>	<u>709</u>	<u>2,509</u>	<u>23,682</u>	8
9	SNF/PED					9
10	ICF	<u>45,776</u>	<u>1,587</u>	<u>207</u>	<u>47,570</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,240</u>	<u>2,296</u>	<u>2,716</u>	<u>71,252</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.65%

D. How many bed-hold days during this year were paid by the Department?

1,357 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 09/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 09/01/91 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number  
of beds certified 28 and days of care provided 1,617Medicare Intermediary Adminastar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/05 Fiscal Year: 12/31/05

\* 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: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	195,730	34,859	34,932	265,521		265,521	(19,705)	245,816			1
2	Food Purchase		334,847		334,847	(18,779)	316,068	(108)	315,960			2
3	Housekeeping	162,590	30,749		193,339		193,339	702	194,041			3
4	Laundry	76,176	30,669		106,845		106,845	(91)	106,754			4
5	Heat and Other Utilities			172,121	172,121		172,121	2,554	174,675			5
6	Maintenance	48,607	23,585	104,423	176,615		176,615	(15,169)	161,446			6
7	Other (specify):*							4,306	4,306			7
8	<b>TOTAL General Services</b>	<b>483,103</b>	<b>454,709</b>	<b>311,476</b>	<b>1,249,288</b>	<b>(18,779)</b>	<b>1,230,509</b>	<b>(27,511)</b>	<b>1,202,998</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,934,545	119,574	220,048	2,274,167		2,274,167	(26,299)	2,247,868			10
10a	Therapy		6,058	12,268	18,326		18,326	(3,741)	14,585			10a
11	Activities	104,098	16,890	2,352	123,340		123,340		123,340			11
12	Social Services	149,466		11,282	160,748		160,748		160,748			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,744	5,744			15
16	<b>TOTAL Health Care and Programs</b>	<b>2,188,109</b>	<b>142,522</b>	<b>253,150</b>	<b>2,583,781</b>		<b>2,583,781</b>	<b>(24,296)</b>	<b>2,559,485</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	96,707		79,056	175,763		175,763	2,984	178,747			17
18	Directors Fees											18
19	Professional Services			151,307	151,307		151,307	(103,628)	47,679			19
20	Dues, Fees, Subscriptions & Promotions			34,040	34,040		34,040	(10,800)	23,240			20
21	Clerical & General Office Expenses	146,201	20,814	90,338	257,353		257,353	(15,812)	241,541			21
22	Employee Benefits & Payroll Taxes			423,132	423,132	18,779	441,911		441,911			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,892	2,892		2,892	373	3,265			24
25	Other Admin. Staff Transportation			7,179	7,179		7,179	3,120	10,299			25
26	Insurance-Prop.Liab.Malpractice			162,117	162,117		162,117	930	163,047			26
27	Other (specify):*							24,193	24,193			27
28	<b>TOTAL General Administration</b>	<b>242,908</b>	<b>20,814</b>	<b>950,061</b>	<b>1,213,783</b>	<b>18,779</b>	<b>1,232,562</b>	<b>(98,640)</b>	<b>1,133,922</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,914,120</b>	<b>618,045</b>	<b>1,514,687</b>	<b>5,046,852</b>		<b>5,046,852</b>	<b>(150,447)</b>	<b>4,896,405</b>			<b>29</b>

\*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: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			67,672	67,672	67,672	13,181	80,853			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			88,072	88,072	88,072	(1,011)	87,061			32
33	Real Estate Taxes			100,761	100,761	100,761	7,087	107,848			33
34	Rent-Facility & Grounds			540,000	540,000	540,000		540,000			34
35	Rent-Equipment & Vehicles			16,319	16,319	16,319	4,487	20,806			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			812,824	812,824	812,824	23,744	836,568			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		64,720	140,315	205,035	205,035	(580)	204,455			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):*										43
44	<b>TOTAL Special Cost Centers</b>		64,720	256,933	321,653	321,653	(580)	321,073			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,914,120	682,765	2,584,444	6,181,329	6,181,329	(127,283)	6,054,046			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:

01/01/05

Ending:

12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,788	30		9
10	Interest and Other Investment Income	(514)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,850)	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	(64,783)	21		24
25	Fund Raising, Advertising and Promotional	(2,864)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,646)	20		28
29	Other-Attach Schedule	(17,024)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (82,001)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,282)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (45,282)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	<b>\$ (127,283)</b>		<b>37</b>

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

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

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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
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
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18		18
19		19
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86		86
87		87
88		88
89		89
90		90
91		91
92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101		101
<b>Total</b>	(17,024)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary					(14,351)	(5,354)						(19,705)	1
2	Food Purchase	(108)											(108)	2
3	Housekeeping			702									702	3
4	Laundry								(91)				(91)	4
5	Heat and Other Utilities			975	1,579								2,554	5
6	Maintenance	(4,510)		1,159	(11,515)		(303)						(15,169)	6
7	Other (specify):*				1,076	1,510	1,720						4,306	7
8	<b>TOTAL General Services</b>	<b>(4,618)</b>		<b>2,836</b>	<b>(8,860)</b>	<b>(12,841)</b>	<b>(3,937)</b>		<b>(91)</b>				<b>(27,511)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(19,255)				(7,044)				(26,299)	10
10a	Therapy						(3,741)						(3,741)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,575		1,169						5,744	15
16	<b>TOTAL Health Care and Programs</b>				<b>(14,680)</b>		<b>(2,572)</b>		<b>(7,044)</b>				<b>(24,296)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			17,940	(64,180)	53,544	(4,320)						2,984	17
18	Directors Fees													18
19	Professional Services	(1,760)		(102,340)	1,022	16,706	(17,256)						(103,628)	19
20	Fees, Subscriptions & Promotions	(10,988)		76	112								(10,800)	20
21	Clerical & General Office Expenses	(72,329)		63,125	(6,608)								(15,812)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			116	257								373	24
25	Other Admin. Staff Transportation			672	2,448								3,120	25
26	Insurance-Prop.Liab.Malpractice			385	545								930	26
27	Other (specify):*			11,534	4,276	8,383							24,193	27
28	<b>TOTAL General Administration</b>	<b>(85,077)</b>		<b>(8,492)</b>	<b>(62,128)</b>	<b>78,633</b>	<b>(21,576)</b>						<b>(98,640)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(89,695)</b>		<b>(5,656)</b>	<b>(85,668)</b>	<b>65,792</b>	<b>(28,085)</b>		<b>(7,135)</b>				<b>(150,447)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	8,788		1,708	2,685								13,181	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(514)		(316)	(181)								(1,011)	32
33	Real Estate Taxes			2,438	4,649								7,087	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			2,600	1,887								4,487	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>8,274</b>		<b>6,430</b>	<b>9,040</b>								<b>23,744</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(580)											(580)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>(580)</b>											<b>(580)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(82,001)</b>		<b>774</b>	<b>(76,628)</b>	<b>65,792</b>	<b>(28,085)</b>		<b>(7,135)</b>				<b>(127,283)</b>	<b>45</b>

**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		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	<b>Total</b>		\$			\$	\$ *

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 702	\$ 702	15	
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	975	975	16	
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,159	1,159	17	
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,940	17,940	18	
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,640	1,640	19	
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	76	76	20	
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	63,125	63,125	21	
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	116	116	22	
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	672	672	23	
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	385	385	24	
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,534	11,534	25	
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,708	1,708	26	
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(316)	(316)	27	
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,438	2,438	28	
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,600	2,600	29	
30	V							30	
31	V							31	
32	V	19 ACCOUNT./BOOKKEEPING	103,980	PREFERRED BOOKKEEPING	100.00%		(103,980)	32	
33	V	19 COMPUTER	5,112	PREFERRED BOOKKEEPING	100.00%	5,112		33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 109,092			\$ 109,866	\$ *	774	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: 01/01/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,579	\$ 1,579	15
16	V	6 REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	7,661	(11,515)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,076	1,076	17
18	V	10 NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	22,925	(19,255)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,575	4,575	19
20	V	17 ADMINISTRATIVE	74,736	S.I.R. MANAGEMENT, INC.	100.00%	10,556	(64,180)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,022	1,022	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	112	112	22
23	V	21 CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	15,124	(6,608)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	257	257	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,448	2,448	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	545	545	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,276	4,276	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,685	2,685	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(181)	(181)	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,649	4,649	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,887	1,887	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 157,824			\$ 81,196	\$ * (76,628)	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: 01/01/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 21,732	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,381	\$ (14,351)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,510	1,510	16
17	V	17	ADMIN./LEGAL SALARIES	0	S.I.R. MANAGEMENT, INC.	100.00%	53,544	53,544	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	16,706	16,706	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,383	8,383	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	0		26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	0		28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	0		29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	0		30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	0		31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	0		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 21,732				\$ 87,524	\$ * 65,792	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: 01/01/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10A SPECIAL REHAB	9,456	S.I.R. MANAGEMENT, INC.	100.00%	5,715	\$	(3,741)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,169		1,169	16
17	V								17
18	V	6 REPAIRS AND MAINT.	864	S.I.R. MANAGEMENT, INC.	100.00%	561		(303)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	115		115	19
20	V								20
21	V								21
22	V	1 DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,846		(5,354)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,605		1,605	23
24	V								24
25	V	19 LEGAL FEES	17,256	S.I.R. MANAGEMENT, INC.	100.00%			(17,256)	25
26	V								26
27	V	17 FEES	4,320	S.I.R. MANAGEMENT, INC.	100.00%			(4,320)	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		\$ 45,096			\$ 17,011	\$ *	(28,085)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 122,115	\$ 122,115	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	122,115	CCS EMPLOYEE BENEFIT GROUP	100.00%		(122,115)	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			\$ 122,115			\$ 122,115	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$ 0	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 0		15
16	V	02 FOOD	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		16
17	V	03 HOUSEKEEPING	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		17
18	V	04 LAUNDRY	922	XCEL MEDICAL SUPPLY, LLC	100.00%	831	(91)	18
19	V	06 REPAIRS & MAINTENANCE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		19
20	V	10 NURSING	71,047	XCEL MEDICAL SUPPLY, LLC	100.00%	64,003	(7,044)	20
21	V	11 ACTIVITIES	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		22
23	V	21 CLERICAL & GENERAL OFFICE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		23
24	V	22 EMPLOYEE BENEFITS	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		24
25	V	39 ANCILLARY	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		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		\$ 71,969			\$ 64,834	\$ * (7,135)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	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: 01/01/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Solomon	Owner	Administrator	6.58%	None	40.00	100.00%	Salary	\$ 96,707	17-1	1
2	Tom Winter	Owner	Administrative	0.88%	See Attached	6.67	11.12%	Alloc. Salary	17,940	17-7	2
3	Louise Bergthold	Owner	Administrative	2.63%	See Attached	6.16	11.20%	Alloc. Salary	21,337	17-7	3
4	Nenita Guzman	Relative	Dietary		See Attached	5.60	11.20%	Alloc. Salary	7,381	1-7	4
5	Kim Rudolph	Relative	Clerical		See Attached	0.61	1.74%	Alloc. Salary	602	22-7	5
6	Adam Vales	Relative	Clerical		See Attached	0.81	2.03%	Alloc. Salary	995	22-7	6
7	Eric Rothner	Relative	Administrative		See Attached	0.81	1.76%	Alloc. Salary	10,478	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 155,440		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 936,008	10	\$ 6,321	\$	103,980	\$ 702	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 936,008	10	8,775		103,980	975	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 936,008	10	10,437		103,980	1,159	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 936,008	10	161,494	161,494	103,980	17,940	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 936,008	10	14,763		103,980	1,640	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 936,008	10	685		103,980	76	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 936,008	10	568,241	511,444	103,980	63,125	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 936,008	10	1,042		103,980	116	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 936,008	10	6,051		103,980	672	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 936,008	10	3,462		103,980	385	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 936,008	10	103,823		103,980	11,534	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 936,008	10	15,373		103,980	1,708	12
13	32	INTEREST	BOOK./ACCNT.INCOME 936,008	10	(2,849)		103,980	(316)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 936,008	10	21,946		103,980	2,438	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 936,008	10	23,404		103,980	2,600	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					5,112	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 942,968	\$ 672,937		\$ 109,866	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	636,443	10	\$ 14,105	\$ 71,252	\$ 1,579	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	636,443	10	68,426	46,969	71,252	7,661	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	636,443	10	9,610		71,252	1,076	3
4	10	NURSING	PATIENT DAYS	636,443	10	204,773	204,773	71,252	22,925	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	636,443	10	40,863		71,252	4,575	5
6	17	ADMINISTRATIVE	PATIENT DAYS	636,443	10	94,293	94,293	71,252	10,556	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	636,443	10	9,125		71,252	1,022	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	636,443	10	999		71,252	112	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	636,443	10	135,090	96,485	71,252	15,124	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	636,443	10	2,293		71,252	257	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	636,443	10	21,870		71,252	2,448	11
12	26	INSURANCE	PATIENT DAYS	636,443	10	4,867		71,252	545	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	636,443	10	38,192		71,252	4,276	13
14	30	DEPRECIATION	PATIENT DAYS	636,443	10	23,979		71,252	2,685	14
15	32	INTEREST	PATIENT DAYS	636,443	10	(1,613)		71,252	(181)	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	636,443	10	41,530		71,252	4,649	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	636,443	10	16,852		71,252	1,887	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 725,254	\$ 442,521	\$ 81,196		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	636,443	10	\$ 65,932	\$ 71,252	\$ 7,381	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	636,443	10	13,490	71,252	1,510	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	636,443	10	478,274	478,274	53,544	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	636,443	10	149,224	71,252	16,706	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	636,443	10	74,875	71,252	8,383	5
6									6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	16,008	16,008		7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	789			8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,626			9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	1,444			10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	24,215			11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,400			12
13									13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	10,035	10,035		14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	457			15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	662			16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	23,622			17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	5,242			18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 871,295	\$ 570,249	\$ 87,524	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 65,110	\$ 65,110	9,456	\$ 5,715	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,322	9,456	1,169		2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	144,648	10	93,966	93,966	864	561	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	144,648	10	19,226	864	115		5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	74,533	74,533	13,200	7,846	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	15,250	13,200	1,605		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					\$ 281,405	\$ 233,608		\$ 17,011	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 122,115	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				\$	\$		\$ 122,115	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 W. MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation						3
4	04	LAUNDRY	Direct Allocation					831	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					64,003	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation						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					\$		\$	64,834

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	GMAC		X	Vehicle	\$591.42		\$ 31,352	\$ 30,952	11/23/2010	4.9000	\$ 191	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Lake Forest Bank		X	Line of Credit				1,490,000		5.2500	87,881	6								
7												7								
8	See Supplemental Schedule										(497)	8								
9	TOTAL Facility Related				\$591.42		\$ 31,352	\$ 1,520,952			\$ 87,575	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(514)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(514)	14								
15	TOTALS (line 9+line14)						\$ 31,352	\$ 1,520,952			\$ 87,061	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:

01/01/05

Ending:

12/31/05

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
<b>Working Capital</b>																				
8	Alloc. Preferred Bookkeeping		X				\$	\$			\$	(316)	8							
9	Alloc. SIR Management		X									(181)	9							
10													10							
11													11							
12													12							
13													13							
14	<b>TOTAL Working Capital</b>											(497)	14							
<b>B. Non-Facility Related*</b>																				
15							\$	\$			\$		15							
16													16							
17													17							
18													18							
19													19							
20	<b>TOTAL Non-Facility Related</b>												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.)

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

**2004 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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-28-203-004</u>	<u>Long Term Care Property</u>	\$ <u>94,861.00</u>	\$ <u>94,861.00</u>
2. <u>See Attached</u>	<u>See Attaches</u>	\$ <u>86,511.09</u>	\$ <u>6,825.30</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>181,372.09</u>	\$ <u>101,686.30</u>

**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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

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**Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

**2004 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 2004 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 2004.

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

**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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Fairview Nursing Plaza

# 0037655 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 58,808 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

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

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

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

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

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

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**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
<b>Improvement Type**</b>											
9	Various			1992	55,434		20	2,772	2,772	37,629	9
10	Various			1993	68,424		20	3,421	3,421	42,289	10
11	Various			1994	44,837		20	2,242	2,242	26,575	11
12	Various			1995	14,482		20	724	724	7,297	12
13	Various			1996	9,472		20	574	574	5,376	13
14	Various			1997	73,164		20	3,658	3,658	31,576	14
15	Various			1998	23,867		20	1,436	1,436	9,900	15
16	Various			1999	58,600		20	2,930	2,930	18,923	16
17	Various			2000	50,948		20	2,704	2,704	15,887	17
18	Various			2001	43,547		20	2,176	2,176	10,643	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67	<a href="#">Related Building Company (Pages 12-BLDG &amp; 12A-BLDG)</a>								67
68	<a href="#">Related Party Allocations (Pages 12-REP &amp; 12A-REP)</a>								68
69	<a href="#">Financial Statement Depreciation</a>								69
70	<b>TOTAL (lines 4 thru 69)</b>								70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 534,591	\$ 70,802		\$ 26,296	\$ (44,506)	\$ 244,213	1
2	Door Replacement	2002	2,298		20	460	460	1,685	2
3	Mini Blinds	2002	1,014		20	101	101	363	3
4	Hvac	2002	20,225		20	2,023	2,023	6,236	4
5	Water Heater	2002	4,993		20	499	499	1,956	5
6	Greast Trap	2002	3,181		20	318	318	1,007	6
7	Roof	2002	800		20	80	80	320	7
8	Drywall	2002	3,150		20	315	315	1,234	8
9	Storeroom Door	2002	1,168		20	117	117	428	9
10	Sidewalk/Landscaping	2002	1,675		20	112	112	400	10
11	Nurses Station Counter	2002	610		20	61	61	198	11
12	Bath Wall	2003	1,950		20	98	98	276	12
13	Bath Wall	2003	2,700		20	135	135	383	13
14	Kitchen Wall	2003	1,450		20	73	73	205	14
15	Elevator Door	2003	1,545		20	77	77	219	15
16	Parking Lot Work	2003	3,960		20	198	198	512	16
17	Bath Wall	2003	1,900		20	95	95	245	17
18	Medication Room	2003	1,200		20	60	60	150	18
19	Shower Room	2003	2,400		20	120	120	270	19
20	Bath Wall	2003	1,200		20	60	60	135	20
21	Shower Room	2003	2,800		20	140	140	303	21
22	Bi-Fold Doors	2003	1,267		20	63	63	190	22
23	Burners & Wall Thermostat	2003	1,847		20	92	92	277	23
24	Doors	2003	1,747		20	87	87	255	24
25	Extra Large Mini Blinds	2003	1,003		20	50	50	142	25
26	Grout Dishwashing Area	2003	550		20	28	28	71	26
27	Replace Blower Wheels & Bearings	2003	1,659		20	83	83	207	27
28	Solid Core Birch Doors	2003	1,061		20	53	53	128	28
29	1 Miniblinds"	2003	1,003		20	50	50	113	29
30	Flooring	2004	138,715		20	6,936	6,936	12,138	30
31	Carpeting	2004	3,538		20	177	177	221	31
32	Bi-Fold Doors	2004	1,109		20	111	111	203	32
33	Water Lines To Washing Machine	2004	1,021		20	102	102	187	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 749,330	\$ 70,802		\$ 39,270	\$ (31,532)	\$ 274,870	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:

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**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 749,330	\$ 70,802		\$ 39,270	\$ (31,532)	\$ 274,870	1
2	Remodel Shower Room	2004	2,850		20	285	285	499	2
3	Electrical Repair	2004	2,309		20	231	231	404	3
4	Electrical Repair	2004	2,659		20	266	266	465	4
5	Elevator Repair	2004	1,683		20	168	168	266	5
6	Generator Room Repair	2004	1,574		20	157	157	249	6
7	Ac Repair	2004	1,171		20	117	117	185	7
8	Miniblinds	2004	1,002		20	100	100	134	8
9	Remodel Shower Room	2004	2,600		20	260	260	325	9
10	Repair Asphalt	2004	1,200		20	120	120	150	10
11	Install Ceramic Floor Tile	2004	750		20	75	75	88	11
12	New Heat Exchanger - Hvac	2004	2,436		20	244	244	467	12
13	Bathroom Work	2005	3,200		20	160	160	160	13
14	Fire Alarm	2005	2,400		20	110	110	110	14
15	Parking Lot	2005	2,000		20	58	58	58	15
16	Parking Lot	2005	16,400		20	478	478	478	16
17	Hvac Work	2005	1,760		20	81	81	81	17
18	Hvac Work	2005	23,519		20	980	980	980	18
19	Elevator Work	2005	2,129		20	89	89	89	19
20	Painting	2005	15,000		20	188	188	188	20
21	Rooftop Bdp Unit	2005	23,041		20	96	96	96	21
22	Hvac	2005	32,140		20	268	268	268	22
23	Install Heater Baseboard	2005	2,310		20	116	116	116	23
24	Rooftop Unit	2005	2,200		20	64	64	64	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)		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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
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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)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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:

01/01/05

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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:

01/01/05

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
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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)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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:

01/01/05

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790	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:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12J, Carried Forward	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 895,663	\$ 70,802		\$ 43,981	\$ (26,821)	\$ 280,790		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:

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**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF 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
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	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:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF 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	SIR		1993	1993	\$ 29,915	\$ 950	35	\$ 855	\$ (95)	\$ 10,684	4
5	SIR		1993	1993	15,686	498	35	501	3	5,602	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Preferred Bookkeeping - Allocation			1997	19,590	439	20	979	540	8,628	9
10	Preferred Bookkeeping - Allocation			1999	155	-	20	8	8	51	10
11	Preferred Bookkeeping - Allocation			2000	983	-	20	49	49	266	11
12											
13	SIR Properties -Preferred Bookkeeping - Allocation			2002	119	-	20	6	6	21	13
14	SIR Properties -Preferred Bookkeeping - Allocation			1999	3,791	379	20	190	(189)	1,232	14
15	SIR Properties -Preferred Bookkeeping - Allocation			1998	1,811	181	20	91	(90)	679	15
16	SIR Properties -Preferred Bookkeeping - Allocation			1997	113	11	20	6	(5)	54	16
17	SIR Properties -Preferred Bookkeeping - Allocation			1994	285	7	20	14	7	164	17
18	SIR Properties -Preferred Bookkeeping - Allocation			1993	485	2	20	24	22	303	18
19											
20	SIR Properties -SIR Management - Allocation			2002	62	-	20	3	3	11	20
21	SIR Properties - SIR Management - Allocation			1999	1,988	199	20	99	(100)	646	21
22	SIR Properties - SIR Management - Allocation			1998	950	95	20	47	(48)	356	22
23	SIR Properties - SIR Management - Allocation			1997	59	6	20	3	(3)	28	23
24	SIR Properties - SIR Management - Allocation			1994	149	4	20	7	3	86	24
25	SIR Properties - SIR Management - Allocation			1993	254	1	20	13	12	159	25
26											
27	SIR Management - Allocation			1993	12,848	358	20	637	279	8,281	27
28	SIR Management - Allocation			1994	40	-		-		40	28
29	SIR Management - Allocation			1995	294	-	20	15	15	153	29
30	SIR Management - Allocation			1999	1,396	-	20	70	70	434	30
31				2000	843	-	20	42	42	240	31
32											
33											
34											
35											
36											

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:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		91,816	3,130		3,659	529	38,118	

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: 01/01/05 Ending: 12/31/05

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	\$ 407,484	\$ 1,082	\$ 34,732	\$ 33,650	10	\$ 267,236	71
72	Current Year Purchases	16,075	180	963	783	10	963	72
73	Fully Depreciated Assets	123,438				10	123,438	73
74								74
75	TOTALS	\$ 546,997	\$ 1,262	\$ 35,695	\$ 34,433		\$ 391,637	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 EXPRESS VAN	2005	31,352		1,176	1,176	5	1,176	77
78										78
79										79
80	TOTALS			\$ 42,868	\$	\$ 1,176	\$ 1,176		\$ 12,692	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)	\$ 1,485,528	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,064	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,852	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,788	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 685,119	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Brier Glen Partnership

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:		213		\$ 540,000			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		213		\$ 540,000			7

10. Effective dates of current rental agreement:

Beginning 02/1996

Ending 09/2011

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

Fiscal Year Ending                      Annual Rent

12.	<u>/2006</u>	\$ <u>881,110</u>
13.	<u>/2007</u>	\$ <u>894,068</u>
14.	<u>/2008</u>	\$ <u>894,068</u>

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 20,806 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	<b>TOTAL</b>		\$	\$	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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	\$		\$ 56,707	\$		\$ 56,707	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			127			127	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			83,481			83,481	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 prescripts				43,979		43,979	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						20,741		20,741	13
14	TOTAL			\$		\$ 140,315	\$ 64,720		\$ 205,035	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,699	\$	1
2	Cash-Patient Deposits	32,626		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,512,024		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,373		6
7	Other Prepaid Expenses	1,779		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>	7,831		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,585,332	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	433,222		15
16	Equipment, at Historical Cost	742,504		16
17	Accumulated Depreciation (book methods)	(658,569)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 517,157	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,102,489	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 292,555	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,744		28
29	Short-Term Notes Payable	1,520,952		29
30	Accrued Salaries Payable	153,534		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,439		31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	443		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,120,767	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,120,767	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (18,278)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,102,489	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (605,447)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (605,447)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	587,169	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 587,169	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (18,278)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,344,879	1
2	Discounts and Allowances for all Levels	(36,155)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,308,724</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	401,180	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 401,180</b>	8
<b>C. Other Operating Revenue</b>			
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	39,974	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,596	19
20	Radiology and X-Ray	903	20
21	Other Medical Services	2,677	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 46,150</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	514	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 514</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	11,930	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 11,930</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,768,498</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,249,288	31
32	Health Care	2,583,781	32
33	General Administration	1,213,783	33
<b>B. Capital Expense</b>			
34	Ownership	812,824	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	205,035	35
36	Provider Participation Fee	116,618	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,181,329</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>587,169</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 587,169</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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:

01/01/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,435	2,528	\$ 78,129	\$ 30.91	1
2	Assistant Director of Nursing	1,301	1,366	32,319	23.66	2
3	Registered Nurses	10,294	10,843	203,753	18.79	3
4	Licensed Practical Nurses	22,275	23,827	495,762	20.81	4
5	CNAs & Orderlies	81,493	87,873	1,007,105	11.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,929	2,086	27,783	13.32	9
10	Activity Assistants	6,890	8,148	76,315	9.37	10
11	Social Service Workers	11,999	11,823	149,466	12.64	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,086	32,152	15.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,856	22,054	163,578	7.42	15
16	Dishwashers					16
17	Maintenance Workers	4,008	4,258	48,607	11.42	17
18	Housekeepers	19,443	20,861	162,590	7.79	18
19	Laundry	9,978	10,468	76,176	7.28	19
20	Administrator	1,825	2,086	96,707	46.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,493	15,185	146,201	9.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,868	6,265	117,477	18.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	217,032	231,757	\$ 2,914,120 *	\$ 12.57	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 13,200	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	15	600	10-03	37
38	Nurse Consultant	Monthly	42,180	10-03	38
39	Pharmacist Consultant	Monthly	3,911	10-03	39
40	Physical Therapy Consultant	22	1,159	10a-03	40
41	Occupational Therapy Consultant	28	1,653	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,352	11-03	44
45	Social Service Consultant	95	5,282	12-03	45
46	Other(specify) <u>Psycho/Social Consult</u>	Monthly	6,000	12-03	46
47	<u>Dir of Food Service</u>	Monthly	21,732	01-03	47
48	<u>Specialized Rehab Consultant</u>	Monthly	9,456	10a-03	48
49	TOTAL (lines 35 - 48)	208	\$ 114,725		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,215	\$ 151,703	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,418	21,654	10-03	52
53	TOTAL (lines 50 - 52)	5,633	\$ 173,357		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

# 0037655

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Mark Solomon	Administrator	6.58	\$ 96,707	Workers' Compensation Insurance	\$ 27,763	IDPH License Fee	\$				
				Unemployment Compensation Insurance	92,801	Advertising: Employee Recruitment	11,573				
				FICA Taxes	216,894	Health Care Worker Background Check	618				
				Employee Health Insurance	74,752	(Indicate # of checks performed <u>8</u> )					
				Employee Meals	18,779	Licenses & Permits	1,131				
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	7,506				
				401 K Expense	3,460	Dues & Subscriptions	2,224				
				Other Employee Benefits	7,462	Alloc. Preferred Bookkeeping	76				
						Alloc. S.I.R. Management	112				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 96,707	TOTAL (agree to Schedule V, line 22, col.8)			\$ 441,911	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,240	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description			Line #	Amount	Description		Amount
SIR MANAGEMENT, INC. - FEES			\$ 4,320						Out-of-State Travel		\$
SIR MANAGEMENT, INC. - Ancillary Admin Charges			47,892						In-State Travel		
SIR MANAGEMENT, Inc. - Director of Admin. Services			26,844						Seminar Expense		2,892
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 79,056	TOTAL					Alloc. Preferred Bookkeeping		116
(Attach a copy of any management service agreement)									Alloc. S.I.R. Management		257
C. Professional Services									Entertainment Expense		( )
Vendor/Payee	Type	Amount							(agree to Sch. V, line 24, col. 8)		\$ 3,265
Frost, Ruttenberg & Rothblatt	Accounting	\$ 15,485									
Preferred Bookkeeping	Accounting	27,300									
SIR Management	Regulatory Consultant	17,256									
Preferred Bookkeeping	Bookkeeping	76,680									
Personnel Planners	Unemployment Consultant	2,430									
LTC Solutions	Computer Services	1,320									
E-Health Data Solutions	MDS Software	3,540									
ICS Solutions	Website	180									
Preferred Bookkeeping	Computer Consultant	5,112									
Neal, Gerber & Eisenberg	Legal	165									
Ashman & Stein	Legal	79									
Adjusted Out on Page 5	Legal	1,760									
TOTAL (agree to Schedule V, line 19, column 3)			\$ 151,307								
(If total legal fees exceed \$2500 attach copy of invoices.)											

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Fairview Nursing Plaza

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC - \$ 7,506
- (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? \_\_\_\_\_
- (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. \$ 1,952 Line 10 Years
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 18,779 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT