

Facility Name & ID Number Fairview Nursing Plaza# 0037655 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>20,872</u>	<u>454</u>	<u>2,479</u>	<u>23,805</u>	8
9	SNF/PED					9
10	ICF	<u>46,689</u>	<u>1,017</u>	<u>183</u>	<u>47,889</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,561</u>	<u>1,471</u>	<u>2,662</u>	<u>71,694</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.22%

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

1,392 (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 09/01/1991

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

YES Date 09/01/1991 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 1,181Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

* 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: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,922	43,863	36,243	308,028		308,028	(13,355)	294,673		1
2	Food Purchase		316,947		316,947	(17,757)	299,190	(65)	299,125		2
3	Housekeeping	195,658	35,728		231,386		231,386	897	232,283		3
4	Laundry	74,232	31,893		106,125		106,125	(8,094)	98,031		4
5	Heat and Other Utilities			172,079	172,079		172,079	3,127	175,206		5
6	Maintenance	51,388	27,826	117,655	196,869		196,869	(10,872)	185,997		6
7	Other (specify):*							2,763	2,763		7
8	TOTAL General Services	549,200	456,257	325,977	1,331,434	(17,757)	1,313,677	(25,599)	1,288,078		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	2,031,121	108,446	149,081	2,288,648		2,288,648	(27,370)	2,261,278		10
10a	Therapy	109,112	7,563	11,736	128,411		128,411	(5,693)	122,718		10a
11	Activities	113,454	17,517	2,603	133,574		133,574		133,574		11
12	Social Services	212,226		5,054	217,280		217,280		217,280		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,426	4,426		15
16	TOTAL Health Care and Programs	2,465,913	133,526	175,074	2,774,513		2,774,513	(28,637)	2,745,876		16
	C. General Administration										
17	Administrative	112,896		83,316	196,212		196,212	10,807	207,019		17
18	Directors Fees										18
19	Professional Services			202,047	202,047	(149)	201,898	(150,839)	51,059		19
20	Dues, Fees, Subscriptions & Promotions			49,274	49,274		49,274	(30,324)	18,950		20
21	Clerical & General Office Expenses	127,777	23,256	91,198	242,231		242,231	8,237	250,468		21
22	Employee Benefits & Payroll Taxes			426,915	426,915	17,757	444,672		444,672		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,757	3,757		3,757	344	4,101		24
25	Other Admin. Staff Transportation			10,464	10,464		10,464	5,164	15,628		25
26	Insurance-Prop.Liab.Malpractice			165,144	165,144		165,144	1,116	166,260		26
27	Other (specify):*							35,187	35,187		27
28	TOTAL General Administration	240,673	23,256	1,032,115	1,296,044	17,608	1,313,652	(120,308)	1,193,344		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,255,786	613,039	1,533,166	5,401,991	(149)	5,401,842	(174,544)	5,227,298		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

#0037655

Report Period Beginning: 01/01/07 Ending: 12/31/07

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			90,036	90,036		90,036	1,669	91,705		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			49,731	49,731		49,731	(3,644)	46,087		32
33	Real Estate Taxes			103,120	103,120	149	103,269	8,839	112,108		33
34	Rent-Facility & Grounds			521,410	521,410		521,410		521,410		34
35	Rent-Equipment & Vehicles			6,942	6,942		6,942	5,648	12,590		35
36	Other (specify):*										36
37	TOTAL Ownership			771,239	771,239	149	771,388	12,512	783,900		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		72,718	160,661	233,379		233,379	(838)	232,541		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	TOTAL Special Cost Centers		72,718	277,279	349,997		349,997	(838)	349,159		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,255,786	685,757	2,581,684	6,523,227		6,523,227	(162,870)	6,360,357		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:

01/01/07

Ending:

12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(5,123)	30		9
10	Interest and Other Investment Income	(7,062)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(65)	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	(20,162)	20		18
19	Entertainment				19
20	Contributions	(750)	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	(60,801)	21		24
25	Fund Raising, Advertising and Promotional	(5,240)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,214)	20		28
29	Other-Attach Schedule	(53,707)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,124)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(5,746)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,746)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (162,870)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Misc Income	\$ (692)	21	1
2 Veterans Service Purchased	(72)	10	2
3 Theft & Damage	(1,810)	21	3
4 Train Fees	(300)	20	4
5 Boat Replacement Tax	(7,250)	21	5
6 COPE	(2,321)	20	6
7 Collection	(202)	21	7
8 Capitalized R&M	(3,298)	00	8
9 Nonallowable Legal	(28,827)	19	9
10 Prior Period Ancillary	(838)	39	10
11 Prior Period Laundry	(4,109)	04	11
12 Capitalized R&M	(3,985)	00	12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(53,707)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary					(13,355)							(13,355)	1
2	Food Purchase	(65)											(65)	2
3	Housekeeping			897									897	3
4	Laundry	(8,094)											(8,094)	4
5	Heat and Other Utilities			1,421	1,706								3,127	5
6	Maintenance	(3,298)		1,247	(8,821)								(10,872)	6
7	Other (specify):*				1,089	1,674							2,763	7
8	TOTAL General Services	(11,457)		3,565	(6,026)	(11,681)							(25,599)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(72)			(23,135)				(4,163)				(27,370)	10
10a	Therapy						(5,693)						(5,693)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,674	752							4,426	15
16	TOTAL Health Care and Programs	(72)			(19,461)	(4,941)			(4,163)				(28,637)	16
	C. General Administration													
17	Administrative			21,218	(66,297)	60,206	(4,320)						10,807	17
18	Directors Fees													18
19	Professional Services	(28,827)		(122,919)	577	17,586	(17,256)						(150,839)	19
20	Fees, Subscriptions & Promotions	(32,987)		297	2,366								(30,324)	20
21	Clerical & General Office Expenses	(70,758)		70,189	8,711	95							8,237	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			28	316								344	24
25	Other Admin. Staff Transportation			1,048	4,116								5,164	25
26	Insurance-Prop.Liab.Malpractice			391	625	100							1,116	26
27	Other (specify):*			13,484	6,654	15,049							35,187	27
28	TOTAL General Administration	(132,572)		(16,264)	(42,932)	93,036	(21,576)						(120,308)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(144,101)		(12,699)	(68,419)	81,355	(26,517)		(4,163)				(174,544)	29

STATE OF ILLINOIS

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,123)		1,786	5,006								1,669	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,062)		(69)	3,487								(3,644)	32
33	Real Estate Taxes			3,067	5,772								8,839	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			2,495	2,071	1,082							5,648	35
36	Other (specify):*													36
37	TOTAL Ownership	(12,185)		7,279	16,336	1,082							12,512	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(838)											(838)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(838)											(838)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(157,124)		(5,420)	(52,083)	82,436	(26,517)		(4,163)				(162,870)	45

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/07

Ending:

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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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* 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: 01/01/07

Ending: 12/31/07

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%	\$ 897	\$ 897	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,421	1,421	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,247	1,247	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	21,218	21,218	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,010	1,010	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	297	297	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	70,189	70,189	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	28	28	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,048	1,048	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	391	391	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	13,484	13,484	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,786	1,786	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(69)	(69)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	3,067	3,067	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,495	2,495	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	123,929	PREFERRED BOOKKEEPING	100.00%		(123,929)	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		\$ 129,041			\$ 123,621	\$ * (5,420)	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: 01/01/07

Ending: 12/31/07

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%	\$ 1,706	\$ 1,706	15
16	V	6 REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	10,355	(8,821)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,089	1,089	17
18	V	10 NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	19,045	(23,135)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,674	3,674	19
20	V	17 ADMINISTRATIVE	78,996	S.I.R. MANAGEMENT, INC.	100.00%	12,699	(66,297)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	577	577	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,366	2,366	22
23	V	21 CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	30,443	8,711	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	316	316	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,116	4,116	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	625	625	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,654	6,654	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,006	5,006	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,487	3,487	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,772	5,772	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,071	2,071	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 162,084			\$ 110,001	\$ * (52,083)	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: 01/01/07

Ending: 12/31/07

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%	\$ 8,377	\$ (13,355)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,674	1,674	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	58,427	58,427	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	17,586	17,586	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,778	11,778	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,239	1,239	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	71	71	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	46	46	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,658	1,658	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	628	628	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	540	540	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	24	24	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	53	53	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,613	1,613	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	454	454	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 21,732				\$ 104,168	\$ * 82,436	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: 01/01/07

Ending: 12/31/07

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%	3,763	\$	(5,693)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	752		752	16
17	V								17
18	V	6 REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%				18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%				19
20	V								20
21	V								21
22	V								22
23	V								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 COUNCIL DUES	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		\$ 31,032			\$ 4,515	\$ *	(26,517)	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%	\$ 148,925	\$ 148,925	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	148,925	CCS EMPLOYEE BENEFIT GROUP	100.00%		(148,925)	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			\$ 148,925			\$ 148,925	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	51,612	Xcel Supply, LLC	100.00%	47,450	(4,163)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 51,612			\$ 47,450	\$ * (4,163)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Eric Rothner	Relative	Administrative	N/A	See Attached	0.82	1.78%	Alloc. Salary	\$ 11,376	17-7	1
2	Nenita Guzman	Relative	Dietary	N/A	See Attached	5.86	11.72%	Alloc. Salary	8,377	1-7	2
3	Louise Bergthold	Shareholder	Administrative	2.63	See Attached	6.45	11.73%	Alloc. Salary	21,106	17-7	3
4	Tom Winter	Shareholder	Administrative	0.88	See Attached	7.07	11.78%	Alloc. Salary	21,218	17-7	4
5	Mark Solomon	Shareholder	Administrative	6.58	None	45	100.00%	Salary	112,896	17-1	5
6	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.8	2.29%	Alloc. Salary	705	22-7	6
7	Adam Vales	Relative	Clerical	N/A	See Attached	0.92	2.30%	Alloc. Salary	1,282	22-7	7
8	Bryan Barnish	Relative	Administrative	N/A	See Attached	1.3	3.25%	Alloc. Salary	1,239	17-7	8
9	Mike Giannini	Relative	Administrative	N/A	See Attached	1.67	4.18%	Alloc. Salary	540	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 178,739		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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 1,051,322	10	\$ 7,611	\$	123,929	\$ 897	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		123,929	1,421	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		123,929	1,247	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	123,929	21,218	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		123,929	1,010	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		123,929	297	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	123,929	70,189	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		123,929	28	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		123,929	1,048	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		123,929	391	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		123,929	13,484	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		123,929	1,786	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		123,929	(69)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		123,929	3,067	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		123,929	2,495	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				\$ 1,005,342	\$ 699,081		\$ 123,621	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	611,427	10	\$ 14,547	\$ 71,694	\$ 1,706	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	52,015	71,694	10,355	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289	71,694	1,089	71,694	3
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	162,421	71,694	19,045	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333	71,694	3,674	71,694	5
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	108,301	71,694	12,699	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925	71,694	577	71,694	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178	71,694	2,366	71,694	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	203,511	71,694	30,443	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693	71,694	316	71,694	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101	71,694	4,116	71,694	11
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328	71,694	625	71,694	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748	71,694	6,654	71,694	13
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694	71,694	5,006	71,694	14
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739	71,694	3,487	71,694	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229	71,694	5,772	71,694	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659	71,694	2,071	71,694	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 938,122	\$ 526,247	\$ 110,001		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	611,427	10	\$ 71,444	\$ 71,694	71,694	\$ 8,377	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275	71,694	71,694	1,674	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	71,694	58,427	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980	71,694	71,694	17,586	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448	71,694	71,694	11,778	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	1	1,239	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10			1		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275		1	71	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824		1	46	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750		1	1,658	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272		1	628	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	2	540	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425		2	24	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959		2	53	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968		2	1,613	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144		2	454	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 947,979	\$ 601,659		\$ 104,168	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 42,868	\$ 42,868	9,456	\$ 3,763	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566		9,456	752	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	78,758			4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737				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					\$ 145,929	\$ 121,626		\$ 4,515	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 148,925	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				\$	\$		\$ 148,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$	1
2	3	Housekeeping	Direct Allocation						2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					47,450	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$		\$	47,450

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
A. Directly Facility Related																					
Long-Term																					
1						\$	\$			\$	1										
2											2										
3											3										
4											4										
5											5										
6											6										
7	TOTAL Long-Term										7										
Working Capital																					
8	<u>Alloc-Preferred Bookkeeping</u>		X			\$	\$			\$ (69)	8										
9	<u>Alloc.-S.I.R. Management</u>		X							3,487	9										
10											10										
11											11										
12											12										
13											13										
14	TOTAL Working Capital									3,418	14										
B. Non-Facility Related*																					
15						\$	\$			\$	15										
16											16										
17											17										
18											18										
19											19										
20	TOTAL Non-Facility Related										20										

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

** 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 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 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>12-28-203-004</u>	<u>Long Term Care Property</u>	\$ <u>101,019.90</u>	\$ <u>101,019.90</u>
2.	<u>See Attached</u>	<u>See Attached</u>	\$ <u>94,525.44</u>	\$ <u>7,846.15</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>195,545.34</u>	\$ <u>108,866.05</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Fairview Nursing Plaza

0037655 Report Period Beginning:

01/01/07 Ending:

12/31/07

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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1992		55,434		20	2,772	2,772	43,174	9
10	Various		1993		68,424		20	3,421	3,421	49,131	10
11	Various		1994		44,837		20	2,242	2,242	31,059	11
12	Various		1995		14,482		20	724	724	8,747	12
13	Various		1996		9,472		20	374	374	6,307	13
14	Various		1997		73,164		20	3,658	3,658	38,893	14
15	Various		1998		23,867		20	1,436	1,436	12,775	15
16	Various		1999		58,600		20	2,930	2,930	24,785	16
17	Various		2000		50,948		20	2,525	2,525	21,117	17
18	Various		2001		43,547		20	2,176	2,176	14,998	18
19	Various		2002		39,114		20	3,779	3,779	21,692	19
20	Various		2003		31,242		20	1,562	1,562	7,204	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:

01/01/07

Ending:

12/31/07

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		103,721	3,912		3,899	(13)	47,841	68
69			90,036			(90,036)		69
70		\$ 616,852	\$ 93,948		\$ 31,498	\$ (62,450)	\$ 327,723	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:

01/01/07

Ending:

12/31/07

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 12A, Carried Forward		\$ 616,852	\$ 93,948		\$ 31,498	\$ (62,450)	\$ 327,723	1
2	Flooring	2004	138,715		20	6,936	6,936	26,009	2
3	Carpeting	2004	3,538		20	177	177	575	3
4	Bi-Fold Doors	2004	1,109		20	111	111	425	4
5	Water Lines To Washing Machine	2004	1,021		20	102	102	392	5
6	Remodel Shower Room	2004	2,850		20	285	285	1,069	6
7	Electrical Repair	2004	2,309		20	231	231	866	7
8	Electrical Repair	2004	2,659		20	266	266	997	8
9	Elevator Repair	2004	1,683		20	168	168	603	9
10	Generator Room Repair	2004	1,574		20	157	157	564	10
11	Ac Repair	2004	1,171		20	117	117	420	11
12	Miniblinds	2004	1,002		20	100	100	334	12
13	Remodel Shower Room	2004	2,600		20	260	260	845	13
14	Repair Asphalt	2004	1,200		20	120	120	390	14
15	Install Ceramic Floor Tile	2004	750		20	75	75	238	15
16	New Heat Exchanger - Hvac	2004	2,436		20	244	244	954	16
17	Bathroom Work	2005	3,200		20	160	160	480	17
18	Fire Alarm	2005	2,400		20	120	120	350	18
19	Parking Lot	2005	2,000		20	100	100	258	19
20	Parking Lot	2005	16,400		20	820	820	2,118	20
21	Hvac Work	2005	1,760		20	88	88	257	21
22	Hvac Work	2005	23,519		20	1,176	1,176	3,332	22
23	Elevator Work	2005	2,129		20	106	106	302	23
24	Painting	2005	15,000		20	750	750	1,688	24
25	Rooftop Bdp Unit	2005	23,041		20	1,152	1,152	2,400	25
26	Hvac	2005	32,140		20	3,214	3,214	6,696	26
27	Heater Baseboard	2005	2,310		20	116	116	347	27
28	Roof	2005	2,200		20	110	110	293	28
29	Fire Door	2006	5,512		20	276	276	436	29
30	Generator	2006	34,268		20	1,713	1,713	3,284	30
31	Office Remodel	2006	3,000		20	150	150	238	31
32	Hvac	2006	3,036		20	152	152	304	32
33	Hot Water Heater	2007	12,524		20	574	574	574	33
34	TOTAL (lines 1 thru 33)		\$ 965,908	\$ 93,948		\$ 51,624	\$ (42,324)	\$ 385,761	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 965,908	\$ 93,948		\$ 51,624	\$ (42,324)	\$ 385,761	1
2	Flooring	2007	6,872		20	286	286	286	2
3	Wall Papering	2007	7,604		20	317	317	317	3
4	Furnace-Motor	2007	2,222		20	83	83	83	4
5	Door Alarm	2007	3,510		20	117	117	117	5
6	Hvac Work	2007	3,896		20	146	146	146	6
7	Fire Door	2007	2,340		20	59	59	59	7
8	Roof Repair	2007	3,298		20	27	27	27	8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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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)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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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)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 995,650	\$ 93,948		\$ 52,659	\$ (41,289)	\$ 386,796	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:

01/01/07

Ending:

12/31/07

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
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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:

01/01/07

Ending:

12/31/07

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
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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:

01/01/07

Ending:

12/31/07

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* [*]	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	S.I.R Properties-Preferred Bookkeeping	1993	1993	\$ 16,645	\$ 528	35	\$ 476	\$ (52)	\$ 6,896	4
5	S.I.R. Properties-S.I.R. Management	1993	1993	31,332	995	35	895	(100)	12,980	5
6										6
7										7
8										8
	Improvement Type**									
9	S.I.R Properties-Preferred Bookkeeping		2007	291	15	20	15		15	9
10	S.I.R Properties-Preferred Bookkeeping		2002	66		20	3	3	18	10
11	S.I.R Properties-Preferred Bookkeeping		1999	2,109	211	20	105	(106)	896	11
12	S.I.R Properties-Preferred Bookkeeping		1998	1,008	101	20	50	(51)	479	12
13	S.I.R Properties-Preferred Bookkeeping		1997	63	3	20	3		36	13
14	S.I.R Properties-Preferred Bookkeeping		1994	159	4	20	8	4	107	14
15	S.I.R Properties-Preferred Bookkeeping		1993	270	1	20	13	12	196	15
16										16
17	Preferred Bookkeeping-Allocation		1997	20,787	466	20	1,039	573	11,234	17
18	Preferred Bookkeeping-Allocation		1999	165		20	8	8	70	18
19	Preferred Bookkeeping-Allocation		2000	1,043		20	52	52	387	19
20										20
21	S.I.R. Properties-S.I.R. Management		2007	549	27	20	27		27	21
22	S.I.R. Properties-S.I.R. Management		2002	124		20	6	6	34	22
23	S.I.R. Properties-S.I.R. Management		1999	3,970	397	20	199	(198)	1,687	23
24	S.I.R. Properties-S.I.R. Management		1998	1,897	190	20	95	(95)	901	24
25	S.I.R. Properties-S.I.R. Management		1997	118	6	20	6		68	25
26	S.I.R. Properties-S.I.R. Management		1994	298	8	20	15	7	201	26
27	S.I.R. Properties-S.I.R. Management		1993	508	3	20	25	22	369	27
28										28
29	S.I.R. Management-Allocation		1993	13,457	375	20	667	292	10,008	29
30	S.I.R. Management-Allocation		1994	42	-	20	-		42	30
31	S.I.R. Management-Allocation		1995	308	-	20	15	15	191	31
32	S.I.R. Management-Allocation		1999	1,462	-	20	73	73	600	32
33	S.I.R. Management-Allocation		2000	882	-	20	44	44	339	33
34	S.I.R. Management-Allocation		2007	6,168	582	20	60	(522)	60	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:

01/01/07

Ending:

12/31/07

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				
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59								59				
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61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	103,721	\$	3,912	\$	3,899	\$	(13)	\$	47,841	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: 01/01/07 Ending: 12/31/07

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	\$ 376,656	\$ 744	\$ 29,560	\$ 28,816	10	\$ 248,888	71
72	Current Year Purchases	71,540	2,138	3,151	1,013	10	3,151	72
73	Fully Depreciated Assets	213,434				10	213,434	73
74								74
75	TOTALS	\$ 661,630	\$ 2,882	\$ 32,711	\$ 29,829		\$ 465,473	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		6,337	6,337	5	16,566	77
78										78
79										79
80	TOTALS			\$ 42,868	\$	\$ 6,337	\$ 6,337		\$ 28,082	80

E. Summary of Care-Related Assets

	1 Description	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)	\$ 1,700,148	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,830	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,707	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,123)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 880,351	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		\$ 521,410			3
4	Additions							4
5								5
6								6
7	TOTAL		213		\$ 521,410			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>12/31/2008</u>	\$ <u>894,068</u>
13.	<u>12/31/2009</u>	\$ <u>894,068</u>
14.	<u>12/31/2010</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: \$ 9,795 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	<u>Alloc.-S.I.R. Management</u>		\$ _____	\$ <u>2,794</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>2,794</u>	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)	
TOTAL TRAINED	

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

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

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

	Service	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	\$		\$ 76,219	\$		\$ 76,219	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			355			355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			84,087			84,087	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				60,771		60,771	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						11,947		11,947	13
14	TOTAL			\$		\$ 160,661	\$ 72,718		\$ 233,379	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 31,280	\$	1
2	Cash-Patient Deposits	12,302		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	984,219		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,227		6
7	Other Prepaid Expenses	1,697		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,871		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,072,596	\$	10
	B. Long-Term Assets			
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	447,698		15
16	Equipment, at Historical Cost	890,344		16
17	Accumulated Depreciation (book methods)	(840,791)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	85,169		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 582,420	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,655,016	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 224,247	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,507		28
29	Short-Term Notes Payable	449,252		29
30	Accrued Salaries Payable	227,790		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,371		31
32	Accrued Real Estate Taxes(Sch.IX-B)	154,910		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,094,077	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,094,077	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 560,939	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,655,016	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 221,892	1
2	Restatements (describe):		2
3	<u>Rounding</u>	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 221,893	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	453,046	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	(114,000)	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)	\$ 339,046	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 560,939	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,645,983	1
2	Discounts and Allowances for all Levels	(200,709)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,445,274	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	442,120	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 442,120	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,410	19
20	Radiology and X-Ray	1,993	20
21	Other Medical Services	1,715	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 63,730	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,062	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,062	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	18,087	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,087	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,976,273	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,331,434	31
32	Health Care	2,774,513	32
33	General Administration	1,296,044	33
B. Capital Expense			
34	Ownership	771,239	34
C. Ancillary Expense			
35	Special Cost Centers	233,379	35
36	Provider Participation Fee	116,618	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,523,227	40
41	Income before Income Taxes (line 30 minus line 40)**	453,046	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 453,046	43

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

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

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

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending:

12/31/07

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	2,105	2,210	\$ 67,605	\$ 30.59	1
2	Assistant Director of Nursing	2,066	2,193	56,979	25.98	2
3	Registered Nurses	295	381	12,883	33.81	3
4	Licensed Practical Nurses	26,609	28,548	647,576	22.68	4
5	CNAs & Orderlies	83,429	90,006	1,084,011	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,109	8,718	109,112	12.52	8
9	Activity Director	2,118	2,261	30,161	13.34	9
10	Activity Assistants	7,425	8,014	83,293	10.39	10
11	Social Service Workers	15,719	16,826	212,226	12.61	11
12	Dietician					12
13	Food Service Supervisor	1,949	2,086	34,316	16.45	13
14	Head Cook	4,102	4,488	38,073	8.48	14
15	Cook Helpers/Assistants	18,013	18,949	155,533	8.21	15
16	Dishwashers					16
17	Maintenance Workers	3,832	4,133	51,388	12.43	17
18	Housekeepers	20,879	21,893	195,658	8.94	18
19	Laundry	8,749	9,232	74,232	8.04	19
20	Administrator	1,877	2,086	112,896	54.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,018	12,592	127,777	10.15	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	7,439	7,802	162,067	20.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	226,733	242,418	\$ 3,255,786 *	\$ 13.43	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	\$ 14,511	01-03	35
36	Medical Director	Monthly	6,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	42,180	10-03	38
39	Pharmacist Consultant	Monthly	4,067	10-03	39
40	Physical Therapy Consultant	34	1,755	10a-03	40
41	Occupational Therapy Consultant	9	525	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,603	11-03	44
45	Social Service Consultant	91	5,054	12-03	45
46	Other(specify) Dir of Food Services	Monthly	21,732	01-03	46
47	Psychiatric Med Dir	Monthly	6,000	10-03	47
48	Specialized Rehab Consultant	Monthly	9,456	10a-03	48
49	TOTAL (lines 35 - 48)	188	\$ 114,483		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	764	\$ 27,513	10-03	50
51	Licensed Practical Nurses	2,065	68,342	10-03	51
52	Certified Nurse Assistants/Aides	66	979	10-03	52
53	TOTAL (lines 50 - 52)	2,895	\$ 96,834		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/07

Ending: 12/31/07

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%	\$ 112,896	Workers' Compensation Insurance	\$ 47,204	IDPH License Fee	\$		
				Unemployment Compensation Insurance	45,402	Advertising: Employee Recruitment	4,067		
				FICA Taxes	238,294	Health Care Worker Background Check	434		
				Employee Health Insurance	80,586	(Indicate # of checks performed 43)			
				Employee Meals	17,757	Patient Background Checks	57		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	7,513		
				401K Expenses	7,200	Dues and Subscriptions	2,343		
				Other Emolyee Benefits	8,229	Advertising and Promotion	5,240		
						Licenses and Fees	1,353		
						See Supplemental Schedule	6,877		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(5,240)		
						Yellow page advertising	(4,214)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 444,672	\$ 18,949			
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-Ancillary Administrative Services			\$ 47,892				Out-of-State Travel	\$	
SIR Management-Dir of Administrative Services			31,104						
SIR Management-Owners Council Dues			4,320				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		3,757
							Alloc.-Preferred Bookkeeping		28
							Alloc.-S.I.R. Management		316
							Entertainment Expense		()
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL		\$ 4,101
Vendor/Payee	Type		Amount						
FR&R	Accounting		\$ 16,440						
Preferred Bookkeeping	Accounting		37,025						
Preferred Bookkeeping	Bookkeeping		86,904						
Preferred Bookkeeping	Computer Consultatant		5,112						
E-Health Data Solution	MDS Software		5,052						
LTC Solutions	Computer Software		1,320						
Personnel Planners	Unemployment Consultatant		2,730						
SIR Management	Regulatory Consultant		17,256						
Foley & Lardnerr, LLP	Legal		1,381						
Prior Period Legal	Legal (Adj out on pg#5)		28,827						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Fairview Nursing Plaza

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

