

Facility Name & ID Number Fairview Nursing Plaza

0037655 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 10/01/09

	1	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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>20,607</u>	<u>185</u>	<u>3,571</u>	<u>24,363</u>	8	
9	SNF/PED					9	
10	ICF	<u>46,096</u>	<u>414</u>	<u>210</u>	<u>46,720</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>66,703</u>	<u>599</u>	<u>3,781</u>	<u>71,083</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.43%

D. How many bed-hold days during this year were paid by the Department? 1,122 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 2,080

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Fairview Nursing Plaza # 0037655 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	255,744	53,363	41,004	350,111		350,111	(16,178)	333,933		1
2	Food Purchase		359,061		359,061	(20,312)	338,749	(30)	338,719		2
3	Housekeeping	198,090	37,641		235,731		235,731	(1,412)	234,319		3
4	Laundry	105,911	29,613		135,524		135,524	(1,348)	134,176		4
5	Heat and Other Utilities			177,843	177,843		177,843	2,460	180,303		5
6	Maintenance	80,822	51,661	177,831	310,314		310,314	(54,738)	255,576		6
7	Other (specify):*							3,757	3,757		7
8	TOTAL General Services	640,567	531,339	396,678	1,568,584	(20,312)	1,548,272	(67,488)	1,480,783		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,029,157	103,292	296,888	2,429,337		2,429,337	(31,043)	2,398,294		10
10a	Therapy	128,932	8,853	36,471	174,256		174,256	(17,172)	157,084		10a
11	Activities	143,073	23,502	2,458	169,033		169,033		169,033		11
12	Social Services	221,732		3,540	225,272		225,272		225,272		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,484	4,484		15
16	TOTAL Health Care and Programs	2,522,894	135,647	346,557	3,005,098		3,005,098	(43,731)	2,961,367		16
	C. General Administration										
17	Administrative	98,251		486,095	584,346		584,346	(357,154)	227,192		17
18	Directors Fees										18
19	Professional Services			182,773	182,773		182,773	(132,511)	50,262		19
20	Dues, Fees, Subscriptions & Promotions			39,183	39,183		39,183	(18,789)	20,394		20
21	Clerical & General Office Expenses	145,840	28,272	202,290	376,402		376,402	(45,180)	331,222		21
22	Employee Benefits & Payroll Taxes			442,937	442,937	20,312	463,249		463,249		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,177	3,177		3,177	50	3,227		24
25	Other Admin. Staff Transportation			17,135	17,135		17,135	9,957	27,092		25
26	Insurance-Prop.Liab.Malpractice			155,720	155,720		155,720	1,324	157,044		26
27	Other (specify):*							43,968	43,968		27
28	TOTAL General Administration	244,091	28,272	1,529,310	1,801,673	20,312	1,821,985	(498,335)	1,323,650		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,407,552	695,258	2,272,545	6,375,355		6,375,355	(609,555)	5,765,800		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			69,982	69,982		69,982	382,854	452,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,717	23,717		23,717	553,203	576,920			32
33	Real Estate Taxes							121,308	121,308			33
34	Rent-Facility & Grounds			945,000	945,000		945,000	(945,000)				34
35	Rent-Equipment & Vehicles			6,795	6,795		6,795	9,843	16,638			35
36	Other (specify):*											36
37	TOTAL Ownership			1,045,494	1,045,494		1,045,494	122,208	1,167,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,005	231,564	337,569		337,569	(2,118)	335,451			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		106,005	348,182	454,187		454,187	(2,118)	452,069			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,407,552	801,263	3,666,221	7,875,036		7,875,036	(489,465)	7,385,571			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		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	(17,824)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,359	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(5,958)	06		18
19	Entertainment				19
20	Contributions	(350)	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	(135,098)	21		24
25	Fund Raising, Advertising and Promotional	(8,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,824)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,309)	20		28
29	Other-Attach Schedule	(73,152)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (208,659)		\$	30

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)	(280,806)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (280,806)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (489,465)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (10)	21	1
2	Theft & Damage	(1,588)	21	2
3	COPE Dues	(5,964)	20	3
4	2010 Seminar Expense	(364)	24	4
5	Additional R & M	1,594	06	5
6	Capitalized R&M	(17,994)	06	6
7	Bank Charges	(5,965)	21	7
8	Non-Allowable Legal	(1,000)	19	8
9				9
10	Building Co:			10
11	Amortization	(30,329)	36	11
12	Office Expense	(60)	21	12
13	Fees	(335)	20	13
14	Professional Fees	(11,137)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,152)		49

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(16,178)								(16,178)	1
2	Food Purchase	(30)											(30)	2
3	Housekeeping					(1,412)							(1,412)	3
4	Laundry					(1,348)							(1,348)	4
5	Heat and Other Utilities				2,460								2,460	5
6	Maintenance	(40,182)		(10,867)	(3,572)	(117)							(54,738)	6
7	Other (specify):*			975	2,782								3,757	7
8	TOTAL General Services	(40,212)		(9,892)	(14,508)	(2,876)							(67,488)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(30,220)	7,819	(6,430)		(2,212)					(31,043)	10
10a	Therapy				(17,172)								(17,172)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,381	2,103								4,484	15
16	TOTAL Health Care and Programs			(27,839)	(7,250)	(6,430)		(2,212)					(43,731)	16
	C. General Administration													
17	Administrative			(447,488)	90,334								(357,154)	17
18	Directors Fees													18
19	Professional Services	(12,137)	11,137	(147,339)	15,828								(132,511)	19
20	Fees, Subscriptions & Promotions	(19,431)	335	307									(18,789)	20
21	Clerical & General Office Expenses	(145,545)	60	100,233	72								(45,180)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(364)		414									50	24
25	Other Admin. Staff Transportation			9,957									9,957	25
26	Insurance-Prop.Liab.Malpractice			1,178	146								1,324	26
27	Other (specify):*			25,737	18,231								43,968	27
28	TOTAL General Administration	(177,477)	11,532	(457,001)	124,611								(498,335)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,689)	11,532	(494,732)	102,853	(9,307)		(2,212)					(609,555)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	39,359	331,713		11,782								382,854	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		571,750	(26,252)	7,705								553,203	32
33	Real Estate Taxes		113,935		7,373								121,308	33
34	Rent-Facility & Grounds		(945,000)										(945,000)	34
35	Rent-Equipment & Vehicles			9,843									9,843	35
36	Other (specify):*	(30,329)	30,329											36
37	TOTAL Ownership	9,030	102,727	(16,409)	26,860								122,208	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,118)					(2,118)	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							(2,118)					(2,118)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(208,659)	114,259	(511,141)	129,713	(9,307)		(4,330)					(489,465)	45

VII. RELATED PARTIES

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

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

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	34 Rental Income	\$ 945,000	Fairview Nursing Property, LLC	100.00%	\$	(945,000)	1
2	V	32 Interest	350	Fairview Nursing Property, LLC	100.00%	572,100	571,750	2
3	V	36 Amortization		Fairview Nursing Property, LLC	100.00%	30,329	30,329	3
4	V	30 Depreciation		Fairview Nursing Property, LLC	100.00%	331,713	331,713	4
5	V	21 Office Expense		Fairview Nursing Property, LLC	100.00%	60	60	5
6	V	20 Fees		Fairview Nursing Property, LLC	100.00%	335	335	6
7	V	19 Professional Fees		Fairview Nursing Property, LLC	100.00%	11,137	11,137	7
8	V	33 Real Estate Tax		Fairview Nursing Property, LLC	100.00%	113,935	113,935	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 945,350			\$ 1,059,609	\$ * 114,259	14

* 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	6 REPAIRS AND MAINT.	\$ 23,004	S.I.R. MANAGEMENT, INC.	100.00%	\$ 12,137	\$ (10,867)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	975	975
17	V	10 NURSING	46,008	S.I.R. MANAGEMENT, INC.	100.00%	15,788	(30,220)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,381	2,381
19	V	19 PROFESSIONAL FEES	150,852	S.I.R. MANAGEMENT, INC.	100.00%	2,642	(148,210)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	307	307
21	V	21 CLERICAL & GENERAL	46,008	S.I.R. MANAGEMENT, INC.	100.00%	36,170	(9,838)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	414	414
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,957	9,957
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,178	1,178
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,631	4,631
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(26,252)	(26,252)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,843	9,843
28	V						
29	V	17 ADMINISTRATIVE	474,589	S.I.R. MANAGEMENT, INC.	100.00%	27,101	(447,488)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	871	871
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	110,071	110,071
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,106	21,106
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 740,461			\$ 229,320	\$ * (511,141)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 23,004	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,826	\$ (16,178)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,055	1,055	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,819	7,819	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,188	1,188	18
19	V	17	ADMIN./LEGAL SALARIES	11,508	S.I.R. MANAGEMENT, INC.	100.00%	101,842	90,334	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,768	15,768	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,231	18,231	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,004	S.I.R. MANAGEMENT, INC.	100.00%	5,832	(17,172)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	915	915	25
26	V								26
27	V	6	MAINTENANCE SALARIES	13,754	S.I.R. MANAGEMENT, INC.	100.00%	9,478	(4,276)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,727	1,727	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,460	2,460	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	704	704	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	60	60	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	72	72	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	146	146	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	11,782	11,782	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,705	7,705	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,373	7,373	37
38	V								38
39	Total		\$ 71,270				\$ 200,983	\$ * 129,713	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:

01/01/09

Ending:

12/31/09

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	15,372	Xcel Supply, LLC	100.00%	13,960	(1,412)	16
17	V	4 Laundry	14,679	Xcel Supply, LLC	100.00%	13,331	(1,348)	17
18	V	6 Repairs & Maintenance	1,269	Xcel Supply, LLC	100.00%	1,153	(117)	18
19	V	10 Nursing	70,024	Xcel Supply, LLC	100.00%	63,594	(6,430)	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		\$ 101,344			\$ 92,037	\$ * (9,307)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 164,752	\$ 164,752
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	164,752	CCS Employee Benefits Group	100.00%		(164,752)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 164,752			\$ 164,752	\$ *

* 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	39 Enterals	\$ 4,935	Care Centers Health Systems, Inc.		\$ 2,817	\$ (2,118)
16	V	10 Infusion Supplies	5,154	Care Centers Health Systems, Inc.		2,942	(2,212)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 10,089			\$ 5,759	\$ * (4,330)

* 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:

01/01/09

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12/31/09

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.

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: 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		
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:

01/01/09

Ending:

12/31/09

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	Bryan Barrish	Shareholder	Administrative	14.20%	See Attached	2.65	6.63%	Alloc. Salary	\$ 17,194	17-7	1
2	Michael Giannini	Shareholder	Administrative	14.20%	See Attached	3.09	7.73%	Alloc. Salary	14,719	17-7	2
3	Eric Rothner	Relative	Administrative	N/A	See Attached	0.62	1.33%	Alloc. Salary	8,817	17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.41	8.82%	Alloc. Salary	4,677	1-7	4
5	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	4.85	8.82%	Alloc. Salary	17,194	17-7	5
6	Tom Winter	Shareholder	Administrative	0.90%	See Attached	5.07	8.45%	Alloc. Salary	16,469	17-7	6
7	Adam Vales	Shareholder	Clerical	2.24%	See Attached	0.96	2.40%	Alloc. Salary	1,728	22-7	7
8	Mark Solomon	Shareholder	Administrative	6.73%	See Attached	3.53	8.83%	Alloc. Salary	8,689	17-7	8
9	Sarah Barrish	Relative	Administrative	N/A	See Attached	3.53	8.83%	Alloc. Salary	8,991	17-7	9
10	Kirsten Barrish	Relative	Clerical	N/A	See Attached	1.50	8.82%	Alloc. Salary	1,192	21-7	10
11											11
12											12
13								TOTAL	\$ 99,670		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	71,083	\$ 12,137	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		71,083	975	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	71,083	15,788	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		71,083	2,381	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	71,083	2,642	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		71,083	307	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	71,083	36,170	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		71,083	414	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		71,083	9,957	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		71,083	1,178	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		71,083	4,631	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		71,083	(26,252)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		71,083	9,843	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	71,083	27,101	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		71,083	871	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	71,083	110,071	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		71,083	21,106	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 229,320	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	806,183	12	\$ 77,418	\$ 77,418	71,083	\$ 6,826	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		71,083	1,055	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	71,083	7,819	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		71,083	1,188	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	71,083	101,842	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		71,083	15,768	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		71,083	18,231	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	23,004	5,832	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		23,004	915	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	13,754	9,478	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		13,754	1,727	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		1,121	2,460	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		1,121	704	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		1,121	60	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		1,121	72	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		1,121	146	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		1,121	11,782	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		1,121	7,705	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		1,121	7,373	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 200,983	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

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Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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					13,960	2
3	4	Laundry	Direct Allocation					13,331	3
4	6	Repairs & Maintenance	Direct Allocation					1,153	4
5	10	Nursing	Direct Allocation					63,594	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				\$	\$		\$	92,037

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 164,752	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				\$	\$		\$ 164,752	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Enterals	Direct Allocation		\$	\$		\$ 2,817	1
2	10	Infusion Supplies	Direct Allocation					2,942	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				\$	\$		\$ 5,759	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Centrue Bank		X	Mortgage Payable			\$	\$ 7,927,353		\$ 512,100	1								
2	GMAC		X	Vehicle	\$591.42			6,349		488	2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Lake Forest Bank		X	Line of Credit				671,092		23,229	6								
7	Centrue Bank		X	Notes Payable- Bldg. Co.				872,500		60,000	7								
8	See Supplemental Schedule									7,705	8								
9	TOTAL Facility Related				\$591.42		\$	\$ 9,477,294		\$ 603,522	9								
B. Non-Facility Related*																			
10	Interest Income- Building Co.		X							(350)	10								
11	Interest Income- S.I.R. Mgmt	X								(26,252)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (26,602)	14								
15	TOTALS (line 9+line14)						\$	\$ 9,477,294		\$ 576,920	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Alloc.- S.I.R. Management	X								7,705	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										7,705	14								
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

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.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: Use, Square Feet, Year Acquired, Cost, 2. Row 3: TOTALS, Square Feet, Year Acquired, Cost, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1992	55,434		20	2,772	2,772	48,715	9
10	Various		1993	68,424		20	3,421	3,421	55,970	10
11	Various		1994	44,837		20	2,242	2,242	35,543	11
12	Various		1995	14,482		20	724	724	10,193	12
13	Various		1996	9,472		20	374	374	7,054	13
14	Various		1997	73,164		20	3,658	3,658	46,208	14
15	Various		1998	23,867		20	948	948	15,120	15
16	Various		1999	46,683		20	2,334	2,334	24,536	16
17	Various		2000	50,948		20	2,347	2,347	25,812	17
18	Various		2001	43,547		20	2,176	2,176	19,352	18
19	Various		2002	39,114		20	3,626	3,626	28,944	19
20	Various		2003	31,242		20	1,562	1,562	10,328	20
21	Various		2004	164,617		20	9,349	9,349	53,381	21
22	Various		2005	126,099		20	7,912	7,912	34,345	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:

01/01/09

Ending:

12/31/09

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	Related Building Company (Pages 12F & 12G)	8,122,061	323,970		348,164	24,194	531,458	67
68	Related Party Allocations (Pages 12H & 12I)	139,848	5,729		4,502	(1,227)	57,754	68
69	Financial Statement Depreciation		69,982			(69,982)		69
70	TOTAL (lines 4 thru 69)	\$ 9,053,839	\$ 399,681		\$ 396,111	\$ (3,570)	\$ 1,004,713	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:

01/01/09

Ending:

12/31/09

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		\$ 9,053,839	\$ 399,681		\$ 396,111	\$ (3,570)	\$ 1,004,713	1
2	Fire Door	2006	5,512		20	276	276	988	2
3	Generator	2006	34,268		20	1,713	1,713	6,711	3
4	Office Remodel	2006	3,000		20	150	150	538	4
5	Hvac	2006	3,036		20	152	152	607	5
6	Hot Water Heater	2007	12,524		20	626	626	1,826	6
7	Flooring	2007	6,872		20	344	344	974	7
8	Wall Papering	2007	7,604		20	380	380	1,077	8
9	Furnace-Motor	2007	2,222		20	111	111	306	9
10	Door Alarm	2007	3,510		20	176	176	468	10
11	Hvac Work	2007	3,896		20	195	195	536	11
12	Roof Repair	2007	3,298		20	165	165	357	12
13	Telephone System	2008	4,601		20	460	460	882	13
14	Cove Base	2008	8,070		20	404	404	740	14
15	Generator Switch	2008	4,034		20	202	202	353	15
16	Hvac Burner	2008	5,673		20	284	284	355	16
17	Door Installation	2008	3,260		20	163	163	177	17
18	Lighting Work	2009	4,274		20	178	178	178	18
19	Water Heater	2009	13,292		20	55	55	55	19
20	Side Walk	2009	7,628		20	381	381	381	20
21	Furnace Burner	2009	5,094		20	255	255	255	21
22	Fire Protection System	2009	2,665		20	133	133	133	22
23	Smoke Dampers	2009	2,607		20	130	130	130	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 9,200,779	\$ 399,681		\$ 403,045	\$ 3,364	\$ 1,022,741	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1977	7,695,500	296,766	35	320,960	24,194	483,849	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roofing	2008	172,737	5,758		5,758		10,556	9
10	Lighting	2008	18,134	907		907		1,662	10
11	Rooftop HVAC	2008	35,086	1,754		1,754		3,216	11
12	Painting	2008	166,886	16,689		16,689		29,205	12
13	Parking Lot Work	2008	25,518	1,276		1,276		1,808	13
14	Handrails	2008	8,200	820		820		1,162	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 8,122,061	\$ 323,970		\$ 348,164	\$ 24,194	\$ 531,458	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	S.I.R. Properties- S.I.R. Management	1993	39,400	1,251	35	1,126	(125)	18,574	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc.- S.I.R.Properties - S.I.R.Management	2009	2,366	1,352	20	95	(1,257)	95	9
10	Alloc.- S.I.R.Properties - S.I.R.Management	2007	690	100	20	34	(66)	103	10
11	Alloc.- S.I.R.Properties - S.I.R.Management	2002	156		20	8	8	59	11
12	Alloc.- S.I.R.Properties - S.I.R.Management	1999	4,993	250	20	250		2,621	12
13	Alloc.- S.I.R.Properties - S.I.R.Management	1998	2,386		20	119	119	1,372	13
14	Alloc.- S.I.R.Properties - S.I.R.Management	1997	148		20	7	7	100	14
15	Alloc.- S.I.R.Properties - S.I.R.Management	1994	375	10	20	19	9	291	15
16	Alloc.- S.I.R.Properties - S.I.R.Management	1993	639	3	20	32	29	527	16
17									17
18	Alloc.- S.I.R. Management	1993	9,989	278	20	495	217	8,419	18
19	Alloc.- S.I.R. Management	1994	31		20			31	19
20	Alloc.- S.I.R. Management	1995	228		20	11	11	165	20
21	Alloc.- S.I.R. Management	1997	15,349	344	20	767	423	9,830	21
22	Alloc.- S.I.R. Management	1999	1,207		20	60	60	618	22
23	Alloc.- S.I.R. Management	1999	11,917		20			11,917	23
24	Alloc.- S.I.R. Management	2000	1,425		20	71	71	680	24
25	Alloc.- S.I.R. Management	2007	4,578	816	20	229	(587)	502	25
26	Alloc.- S.I.R. Management	2008	12,618	1,262	20	795	(467)	1,467	26
27	Alloc.- S.I.R. Management	2009	31,353	63	20	384	321	383	27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 139,848	\$ 5,729		\$ 4,502	\$ (1,227)	\$ 57,754	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 489,174	\$ 13,614	\$ 43,416	\$ 29,802	10	\$ 236,764	71
72	Current Year Purchases	34,631	185	922	737	10	922	72
73	Fully Depreciated Assets	278,933		313	313	10	278,933	73
74								74
75	TOTALS	\$ 802,738	\$ 13,799	\$ 44,651	\$ 30,852		\$ 516,619	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	Facility	CHEVY VAN	1996	\$ 11,516	\$	\$	\$	5	\$ 11,516	76
77	Facility	CHEVY EXPRESS VAN	2005	31,352		5,143	5,143	5	26,852	77
78										78
79										79
80	TOTALS			\$ 42,868	\$	\$ 5,143	\$ 5,143		\$ 38,368	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,046,385	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 413,480	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 452,839	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,359	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,577,728	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 16,638 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 120,023	\$		\$ 120,023	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			307			307	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			111,234			111,234	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				85,277		85,277	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						20,728		20,728	13
14	TOTAL			\$		\$ 231,564	\$ 106,005		\$ 337,569	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: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 8,067	\$ 44,707	1
2	Cash-Patient Deposits	42,485	42,485	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,335,390	1,335,390	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,484	48,484	6
7	Other Prepaid Expenses	895	895	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,435,321	\$ 1,471,961	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		7,695,500	14
15	Leasehold Improvements, at Historical Cost	475,043	673,298	15
16	Equipment, at Historical Cost	1,010,663	1,316,418	16
17	Accumulated Depreciation (book methods)	(997,946)	(1,374,813)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		59,395	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	11,226	11,226	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 498,986	\$ 8,381,024	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,934,307	\$ 9,852,985	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 322,566	\$ 322,567	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,104	50,104	28
29	Short-Term Notes Payable	677,441	677,441	29
30	Accrued Salaries Payable	293,073	293,073	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,087	18,087	31
32	Accrued Real Estate Taxes(Sch.IX-B)		112,000	32
33	Accrued Interest Payable		11,081	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)	\$ 1,361,271	\$ 1,484,353	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,799,853	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,799,853	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,361,271	\$ 10,284,206	46
47	TOTAL EQUITY(page 18, line 24)	\$ 573,036	\$ (431,221)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,934,307	\$ 9,852,985	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 477,807	1
2	Restatements (describe):		2
3	Treasury Stock	20,000	3
4	Rounding	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 497,810	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	195,576	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	(100,350)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Treasury Stock	(20,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 75,226	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)	\$ 573,036	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 7,614,523	1
2	Discounts and Allowances for all Levels	(357,191)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,257,332	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	615,940	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 615,940	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	83,056	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,876	19
20	Radiology and X-Ray	1,755	20
21	Other Medical Services	9,082	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 98,769	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	98,571	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 98,571	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,070,612	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,568,584	31
32	Health Care	3,005,098	32
33	General Administration	1,801,673	33
B. Capital Expense			
34	Ownership	1,045,494	34
C. Ancillary Expense			
35	Special Cost Centers	337,569	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)*	\$ 7,875,036	40
41	Income before Income Taxes (line 30 minus line 40)**	195,576	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 195,576	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:

01/01/09

Ending:

12/31/09

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	2,069	2,198	\$ 72,607	\$ 33.03	1
2	Assistant Director of Nursing	2,093	2,206	63,677	28.87	2
3	Registered Nurses	4,999	5,251	158,697	30.22	3
4	Licensed Practical Nurses	19,030	20,416	501,918	24.58	4
5	CNAs & Orderlies	80,946	86,659	1,061,867	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,734	7,397	128,932	17.43	8
9	Activity Director	1,350	1,591	43,279	27.20	9
10	Activity Assistants	11,728	12,380	99,794	8.06	10
11	Social Service Workers	14,808	16,348	221,732	13.56	11
12	Dietician					12
13	Food Service Supervisor	1,910	2,086	36,733	17.61	13
14	Head Cook	5,807	6,240	59,423	9.52	14
15	Cook Helpers/Assistants	16,453	17,478	159,588	9.13	15
16	Dishwashers					16
17	Maintenance Workers	5,935	6,317	80,822	12.79	17
18	Housekeepers	20,560	22,464	198,090	8.82	18
19	Laundry	11,360	12,659	105,911	8.37	19
20	Administrator	1,957	2,086	98,251	47.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,280	14,127	145,840	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,816	7,293	170,391	23.36	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	227,835	245,196	\$ 3,407,552 *	\$ 13.90	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	\$ 18,000	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant		427	10-03	37
38	Nurse Consultant	Monthly	46,008	10-03	38
39	Pharmacist Consultant	Monthly	4,320	10-03	39
40	Physical Therapy Consultant	173	8,992	10a-03	40
41	Occupational Therapy Consultant	76	4,444	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	31	10a-03	43
44	Activity Consultant	51	2,458	11-03	44
45	Social Service Consultant	66	3,540	12-03	45
46	Other(specify) Dir of Food Service	Monthly	23,004	01-03	46
47	Psychiatric Med. Dir	Monthly	5,500	10-03	47
48	Specialized Rehab Consultant	Monthly	23,004	10a-03	48
49	TOTAL (lines 35 - 48)	367	\$ 146,928		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,181	\$ 51,706	10-03	50
51	Licensed Practical Nurses	4,659	173,996	10-03	51
52	Certified Nurse Assistants/Aides	650	14,931	10-03	52
53	TOTAL (lines 50 - 52)	6,490	\$ 240,633		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N/A
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$14,691
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,946 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 116,618
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,312 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.