

Facility Name & ID Number Fairview Nursing Plaza Inc.

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>114</u>	Intermediate (ICF)	<u>114</u>	<u>41,724</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>77,958</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
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>20,438</u>	<u>421</u>	<u>2,626</u>	<u>23,485</u>	8
9	SNF/PED					9
10	ICF	<u>45,719</u>	<u>942</u>	<u>2,559</u>	<u>49,220</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,157</u>	<u>1,363</u>	<u>5,185</u>	<u>72,705</u>	14

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 2,626

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	278,463	55,402	43,702	377,567		377,567	(17,908)	359,659		1
2	Food Purchase		364,102		364,102	(20,112)	343,990	(68)	343,922		2
3	Housekeeping	234,762	56,645		291,407		291,407		291,407		3
4	Laundry	108,674	18,389		127,063		127,063		127,063		4
5	Heat and Other Utilities			175,939	175,939		175,939	(27,145)	148,794		5
6	Maintenance	59,873	55,006	195,772	310,651		310,651	(26,496)	284,155		6
7	Other (specify):*							6,346	6,346		7
8	TOTAL General Services	681,772	549,544	415,413	1,646,729	(20,112)	1,626,617	(65,271)	1,561,346		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,357,964	165,699	253,159	2,776,822		2,776,822	(28,250)	2,748,572		10
10a	Therapy	96,421	1,647	30,556	128,624		128,624	(11,935)	116,689		10a
11	Activities	137,889	16,232	2,652	156,773		156,773		156,773		11
12	Social Services	274,066	3,023	3,472	280,561		280,561		280,561		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,100	6,100		15
16	TOTAL Health Care and Programs	2,866,340	186,601	297,039	3,349,980		3,349,980	(34,085)	3,315,895		16
	C. General Administration										
17	Administrative	71,586		328,825	400,411		400,411	(214,117)	186,294		17
18	Directors Fees										18
19	Professional Services			199,673	199,673		199,673	(129,286)	70,387		19
20	Dues, Fees, Subscriptions & Promotions			41,244	41,244		41,244	(19,033)	22,211		20
21	Clerical & General Office Expenses	195,577	22,418	397,666	615,661		615,661	(206,221)	409,440		21
22	Employee Benefits & Payroll Taxes			619,854	619,854	20,112	639,966		639,966		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,224	6,224		6,224	1,012	7,236		24
25	Other Admin. Staff Transportation			11,614	11,614		11,614	10,495	22,109		25
26	Insurance-Prop.Liab.Malpractice			148,673	148,673		148,673	1,733	150,406		26
27	Other (specify):*							51,490	51,490		27
28	TOTAL General Administration	267,163	22,418	1,753,773	2,043,354	20,112	2,063,466	(503,928)	1,559,538		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,815,275	758,563	2,466,225	7,040,063		7,040,063	(603,284)	6,436,779		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Fairview Nursing Plaza Inc.

#0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

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			121,737	121,737		121,737	431,506	553,243			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,870	124,870		124,870	438,560	563,430			32
33	Real Estate Taxes							130,592	130,592			33
34	Rent-Facility & Grounds			1,090,000	1,090,000		1,090,000	(1,090,000)				34
35	Rent-Equipment & Vehicles			6,583	6,583		6,583	6,696	13,279			35
36	Other (specify):*											36
37	TOTAL Ownership			1,343,190	1,343,190		1,343,190	(82,646)	1,260,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,209	451,632	576,841		576,841		576,841			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			543,654	543,654		543,654		543,654			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		125,209	995,286	1,120,495		1,120,495		1,120,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,815,275	883,772	4,804,701	9,503,748		9,503,748	(685,930)	8,817,818			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

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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	(29,731)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	89,918	30		9
10	Interest and Other Investment Income	(624)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(315,955)	21		24
25	Fund Raising, Advertising and Promotional	(8,438)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(419)	20		28
29	Other-Attach Schedule	(48,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (315,712)		\$	30

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)	(370,218)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (370,218)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (685,930)		37

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

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

		1	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 Inc.

ID# 0037655

Report Period Beginning: 01/01/12

Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (6,167)	21	1
2	Theft & Damage	(1,166)	21	2
3				3
4	Capitalized R&M	(2,727)	06	4
5	Non-Allowable Legal	(8,401)	19	5
6	Additional Seminar	315	24	6
7	Additional R&M	(9,805)	06	7
8				8
9	COPE Dues	(8,687)	20	9
10	Non Allowable Expense	(5,749)	21	10
11	Non Allowable Professional fees	(429)	19	11
12	Building Company Amortization	(2,084)	36	12
13	Building Company Fees	(275)	20	13
14	Building Company Office Expense	(36)	21	14
15	Building Company Professional Fees	(3,183)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,395)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza Inc.# 0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

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				(17,908)								(17,908)	1
2	Food Purchase	(68)											(68)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(29,731)			2,586								(27,145)	5
6	Maintenance	(12,532)		(16,101)	2,137								(26,496)	6
7	Other (specify):*			741	5,605								6,346	7
8	TOTAL General Services	(42,331)		(15,360)	(7,580)								(65,271)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(36,708)	8,458								(28,250)	10
10a	Therapy				(11,935)								(11,935)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,854	3,246								6,100	15
16	TOTAL Health Care and Programs			(33,854)	(231)								(34,085)	16
	C. General Administration													
17	Administrative			(299,914)	85,797								(214,117)	17
18	Directors Fees													18
19	Professional Services	(12,013)	3,183	(136,921)	16,465								(129,286)	19
20	Fees, Subscriptions & Promotions	(19,819)	275	511									(19,033)	20
21	Clerical & General Office Expenses	(329,073)	36	122,737	79								(206,221)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	315		697									1,012	24
25	Other Admin. Staff Transportation			10,495									10,495	25
26	Insurance-Prop.Liab.Malpractice			1,597	136								1,733	26
27	Other (specify):*			32,782	18,708								51,490	27
28	TOTAL General Administration	(360,591)	3,494	(268,016)	121,185								(503,928)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(402,922)	3,494	(317,230)	113,374								(603,284)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12 Ending:

12/31/12

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	89,918	331,714		9,874								431,506	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(624)	440,669	(8,778)	7,293								438,560	32
33	Real Estate Taxes		126,687		3,905								130,592	33
34	Rent-Facility & Grounds		(1,090,000)										(1,090,000)	34
35	Rent-Equipment & Vehicles			6,696									6,696	35
36	Other (specify):*	(2,084)	2,084											36
37	TOTAL Ownership	87,210	(188,846)	(2,082)	21,072								(82,646)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(315,712)	(185,352)	(319,312)	134,446								(685,930)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,090,000	Fairview Nursing Property, LLC	100.00%	\$	\$ (1,090,000)	1
2	V	32 Interest Income	107	Fairview Nursing Property, LLC	100.00%		(107)	2
3	V	36 Amortization		Fairview Nursing Property, LLC	100.00%	2,084	2,084	3
4	V	30 Depreciation		Fairview Nursing Property, LLC	100.00%	331,714	331,714	4
5	V	20 Fees		Fairview Nursing Property, LLC	100.00%	275	275	5
6	V	32 Interest Expense		Fairview Nursing Property, LLC	100.00%	440,776	440,776	6
7	V	21 Office Expense		Fairview Nursing Property, LLC	100.00%	36	36	7
8	V	33 RE Tax Expense		Fairview Nursing Property, LLC	100.00%	126,687	126,687	8
9	V	19 Professional Fees		Fairview Nursing Property, LLC	100.00%	3,183	3,183	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,090,107			\$ 904,755	\$ * (185,352)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 9,459	\$ (16,101)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	741	741
17	V	10 NURSING	53,676	S.I.R. MANAGEMENT, INC.	100.00%	16,968	(36,708)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,854	2,854
19	V	19 PROFESSIONAL FEES	151,020	S.I.R. MANAGEMENT, INC.	100.00%	13,860	(137,160)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	511	511
21	V	21 CLERICAL & GENERAL	51,120	S.I.R. MANAGEMENT, INC.	100.00%	64,720	13,600
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	697	697
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,495	10,495
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,597	1,597
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	11,452	11,452
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,778)	(8,778)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,696	6,696
28	V						
29	V	17 ADMINISTRATIVE	328,825	S.I.R. MANAGEMENT, INC.	100.00%	28,911	(299,914)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	239	239
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	109,137	109,137
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,330	21,330
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 610,201			\$ 290,889	\$ * (319,312)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,652	\$ (17,908)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,298	1,298	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,458	8,458	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,423	1,423	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	85,797	85,797	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,404	16,404	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,708	18,708	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,004	S.I.R. MANAGEMENT, INC.	100.00%	11,069	(11,935)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,823	1,823	25
26	V								26
27	V	6	MAINTENANCE SALARIES	22,149	S.I.R. MANAGEMENT, INC.	100.00%	23,685	1,536	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,307	4,307	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,586	2,586	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	601	601	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	61	61	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	79	79	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	136	136	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,874	9,874	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,293	7,293	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,905	3,905	37
38	V								38
39	Total		\$ 70,713				\$ 205,159	\$ * 134,446	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 117,764	\$ 117,764	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	117,764	CCS Employee Benefits Group	100.00%		(117,764)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 117,764			\$ 117,764	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$ 6,342	Long Term Care Laboratory, LLC	100.00%	\$ 6,342	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,342			\$ 6,342	\$ *	39

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

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: 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.

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.

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.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES TRUST	2.242%	ALBANY CARE INC	EVANSTON	FAIRVIEW NURSING PROPERT	LINCOLNWOOD	BUILDING CO.	1
2	KATHRYN VALES TRUST	2.242%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST DTD 09/01/2004	14.200%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CELESTE GIANNINI TRUST DTD 3/13/00 K	14.200%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	DANIEL ROTHNER TRUST	2.242%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	GLENDA STRICKLAND	0.897%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	HARVEY SCOTT	4.484%	GREENWOOD CARE, INC.	EVANSTON				7
8	JULIANA BARRISH TRUST DATED 1/26/93	14.200%	MAPLEWOOD CARE, INC.	ELGIN				8
9	KIMBERLY RICHMAN TRUST	2.691%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	LOUISE BERGTHOLD	2.691%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	MARK SOLOMON	6.726%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	MELISSA ROTHNER TRUST	2.242%	WILSON CARE, INC.	CHICAGO				12
13	MICHAEL R GIANNINI TRUST DTD 3/13/00	14.200%						13
14	NATHAN & SHIRLEY ROTHNER FAMILY	11.361%						14
15	RACHEL ROTHNER TRUST	2.242%						15
16	THOMAS WINTER	0.897%						16
17	WILLIAM ROTHNER TRUST	2.242%						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Tom Winter	Shareholder	Administrative	0.90%	See Attached	5.11	8.52%	Alloc. Salary	\$ 17,047	17-7	1
2	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	5.11	8.52%	Alloc. Salary	17,047	17-7	2
3	Michael Giannini	Relative	Administrative	0.00%	See Attached	2.98	7.45%	Alloc. Salary	14,319	17-7	3
4	Bryan Barrish	Relative	Administrative	0.00%	See Attached	3.41	7.58%	Alloc. Salary	17,047	17-7	4
5	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	3.14	7.85%	Alloc. Salary	3,971	21-7	5
6	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.26	8.52%	Alloc. Salary	10,308	17-7	6
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.26	8.52%	Alloc. Salary	7,652	1-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.78	1.95%	Alloc. Salary	1,429	22-7	8
9	David Winter	Relative	Clerical	0.00%	See Attached	0.55	8.46%	Alloc. Salary	289	21-7	9
10	Matthew Winter	Relative	Clerical	0.00%	See Attached	0.14	8.75%	Alloc. Salary	74	21-7	10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect amounts anticipated to be considered										11
12	allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 89,183		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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 Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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		\$	\$		\$ 117,764	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 117,764	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Long Term Care Laboratory, LLC

Street Address

2458 Elmhurst Road

City / State / Zip Code

Elk Grove Village, IL 60007

Phone Number

(630)422-7800

Fax Number

(847)422-1360

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	Ancillary	Direct Allocation		\$	\$		\$ 6,342	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 6,342	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

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

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 Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$				\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	Shareholder Loans		X			\$	\$ 515,000			\$	8							
9	Alloc. - S.I.R. Management		X								7,293							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$				\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	123,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	125,592		2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,592		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	130,592		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	99,849			8
	2008	106,335			9
	2009	111,565			10
	2010	117,084			11
	2011	121,687			12
2012 Accrued Taxes = \$121,787 x 1.05 = \$128,000					
Allocation SIR Management = \$3,905					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza Inc. COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>12-28-203-004</u>	<u>Long-Term Care Property</u>	\$ <u>121,686.62</u>	\$ <u>121,686.62</u>
2.	<u>See Attached</u>	<u>See Attached</u>	\$ <u>101,165.17</u>	\$ <u>6,754.60</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>222,851.79</u></u>	\$ <u><u>128,441.22</u></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? YES NO

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

C. Tax Bills

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

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655 Report Period Beginning:

01/01/12 Ending:

12/31/12

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 (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

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213	2008	1977	\$ 7,695,500	\$ 138,975	35	\$ 320,960	\$ 181,985	\$ 1,457,483	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1992	55,434		20	1,164	1,164	55,422	9
10	Various		1993	68,424		20	3,408	3,408	66,219	10
11	Various		1994	44,837		20	2,242	2,242	42,268	11
12	Various		1995	14,482		20	724	724	12,366	12
13	Various		1996	9,472		20	374	374	8,175	13
14	Various		1997	28,011		20	1,401	1,401	21,999	14
15	Various		1998	23,867		20	949	949	17,968	15
16	Various		1999	46,683		20	2,334	2,334	31,539	16
17	Various		2000	24,848		20	1,042	1,042	16,884	17
18	Various		2001	32,547		20	1,827	1,827	21,114	18
19	Various		2002	39,114		20	2,426	2,426	38,621	19
20	Various		2003	31,242		20	1,562	1,562	15,016	20
21	Various		2004	164,618		20	9,349	9,349	81,426	21
22	Various		2005	111,099		20	7,162	7,162	52,642	22
23	Various		2006	45,816		20	2,291	2,291	15,715	23
24	Various		2007	39,926		20	1,996	1,996	11,533	24
25	Various		2008	25,639		20	1,512	1,512	7,042	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 Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		315,986	117,526		12,184	(105,342)	114,200	67
68		166,422	5,200		6,348	1,148	75,564	68
69			121,737			(121,737)		69
70		\$ 8,983,966	\$ 383,438		\$ 381,255	\$ (2,183)	\$ 2,163,195	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,143,954	\$ 383,438		\$ 444,848	\$ 61,410	\$ 2,260,371	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roofing	2008	172,737	5,758	30	5,758		27,830	9
10	Lighting	2008	18,134	907	20	907		4,382	10
11	Rooftop HVAC	2008	35,086	1,754	20	1,754		8,479	11
12	Painting	2008	56,311	16,689	10	1,669	(15,020)	64,251	12
13	Parking Lot Work	2008	25,518	1,276	20	1,276		5,636	13
14	Handrails	2008	8,200	820	10	820		3,622	14
15	Additional Depreciation			90,322			(90,322)		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 315,986	\$ 117,526		\$ 12,184	\$ (105,342)	\$ 114,200	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	SIR Properties - SIR Management	2009	21,314		35	550	550	1,673	3
4	SIR Properties - SIR Management	1993	38,592	1,225	35	1,103	(122)	21,501	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	9,784	274	20	488	214	9,673	9
10	Alloc. - S.I.R. Management	1994	31		20			31	10
11	Alloc. - S.I.R. Management	1995	224		20	11	11	195	11
12	Alloc. - S.I.R. Management	1997	15,034	337	20	738	401	11,855	12
13	Alloc. - S.I.R. Management	1999	1,182		20	59	59	783	13
14	Alloc. - S.I.R. Management	1999	11,917		20			11,917	14
15	Alloc. - S.I.R. Management	2000	1,396		20	70	70	875	15
16	Alloc. - S.I.R. Management	2007	4,484	306	20	224	(82)	1,165	16
17	Alloc. - S.I.R. Management	2008	12,359	1,181	20	779	(402)	3,774	17
18	Alloc. - S.I.R. Management	2009	30,709	281	20	1,535	1,254	4,982	18
19	Alloc. - S.I.R. Management	2011	760	76	20	76		106	19
20	Alloc. - S.I.R. Management	2012	2,431	51	20	51		51	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,364	1,258	20	10	(1,248)	10	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,329		20	78	78	183	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,317	145	20	116	(29)	440	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	676	54	20	34	(20)	203	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	153		20	8	8	81	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	4,890		20	245	245	3,301	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,337		20	117	117	1,694	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	145		20	7	7	120	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	368	9	20	18	9	340	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	626	3	20	31	28	611	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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)		\$ 166,422	\$ 5,200		\$ 6,348	\$ 1,148	\$ 75,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,327,612	\$ 79,294	\$ 66,816	\$ (12,478)	10	\$ 358,791	71
72	Current Year Purchases	303,786	172	41,127	40,955	10	41,127	72
73	Fully Depreciated Assets	331,016				10	331,016	73
74								74
75	TOTALS	\$ 1,962,414	\$ 79,466	\$ 107,943	\$ 28,477		\$ 730,934	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CHEVY VAN	1996	\$ 11,516	\$	\$	\$	5	\$ 11,516	76
77		CHEVY EXPRESS VAN	2005	31,352				5	31,352	77
78		Allocated from SIR Management	2011	2,997	424	455	31	5	1,048	78
79										79
80	TOTALS			\$ 45,865	\$ 424	\$ 455	\$ 31		\$ 43,916	80

E. Summary of Care-Related Assets

	1 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)	\$ 12,152,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 463,328	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 553,246	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 89,918	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,035,221	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 13,279 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2013 \$ _____

13. _____/2014 \$ _____

14. _____/2015 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	178,292	\$		\$	178,292	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				96,641				96,641	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				175,923				175,923	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					96,754			96,754	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						776	28,455			29,231	13
14	TOTAL			\$		\$	451,632	\$	125,209	\$	576,841	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning: 01/01/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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	\$ 8,557	\$ 57,890	1
2	Cash-Patient Deposits	66,455	66,455	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,838,513	1,838,513	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,276	45,276	6
7	Other Prepaid Expenses	4,150	4,150	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,962,951	\$ 2,012,284	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		7,695,500	14
15	Leasehold Improvements, at Historical Cost	1,458,838	1,885,399	15
16	Equipment, at Historical Cost	1,544,816	1,622,265	16
17	Accumulated Depreciation (book methods)	(1,259,100)	(2,631,108)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		10,416	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	179,869	179,869	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,924,423	\$ 8,762,341	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,887,374	\$ 10,774,625	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 411,568	\$ 411,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,455	66,455	28
29	Short-Term Notes Payable	1,915,000	1,915,000	29
30	Accrued Salaries Payable	365,158	365,158	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,171	37,171	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,000	32
33	Accrued Interest Payable		7,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	255,405	255,405	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,050,757	\$ 3,186,160	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	487,383	487,383	39
40	Mortgage Payable		7,718,719	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 487,383	\$ 8,206,102	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,538,140	\$ 11,392,262	46
47	TOTAL EQUITY(page 18, line 24)	\$ 349,234	\$ (617,637)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,887,374	\$ 10,774,625	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 318,484	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 318,483	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	30,751	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 30,751	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 349,234	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza Inc.

0037655

Report Period Beginning: 01/01/12

Ending:

12/31/12

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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,981,797	1
2	Discounts and Allowances for all Levels	(898,485)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,083,312	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,035,495	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,035,495	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,916	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,849	19
20	Radiology and X-Ray	142	20
21	Other Medical Services	60,999	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,906	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 624	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	254,162	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 254,162	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,534,499	30

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

3		4	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 7,101,050	44
45	Private Pay - Net Inpatient Revenue	197,196	45
46	Medicare - Net Inpatient Revenue	483,275	46
47	Other-(specify) Hospice	257,267	47
48	Other-(specify) Insurance/Prior Period Revenues	44,524	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,083,312	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,084	2,237	\$ 93,165	\$ 41.65	1
2	Assistant Director of Nursing	1,890	2,069	62,175	30.05	2
3	Registered Nurses	10,524	11,115	315,620	28.40	3
4	Licensed Practical Nurses	24,146	25,688	637,921	24.83	4
5	CNAs & Orderlies	84,207	89,647	1,095,482	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,096	6,243	96,421	15.44	8
9	Activity Director	1,763	2,095	34,103	16.28	9
10	Activity Assistants	11,661	13,352	103,786	7.77	10
11	Social Service Workers	18,428	19,987	274,066	13.71	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,184	41,857	19.17	13
14	Head Cook	5,205	6,082	62,587	10.29	14
15	Cook Helpers/Assistants	17,376	18,644	174,019	9.33	15
16	Dishwashers					16
17	Maintenance Workers	4,329	4,673	59,873	12.81	17
18	Housekeepers	21,529	23,473	234,762	10.00	18
19	Laundry	11,434	12,261	108,674	8.86	19
20	Administrator	1,712	2,041	71,586	35.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,203	13,633	195,577	14.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,975	6,518	153,601	23.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	241,477	261,942	\$ 3,815,275 *	\$ 14.57	34

* 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	\$ 43,702	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	1,800	10-03	37
38	Nurse Consultant	Monthly	52,398	10-03	38
39	Pharmacist Consultant	Monthly	14,102	10-03	39
40	Physical Therapy Consultant	41	2,126	10a-03	40
41	Occupational Therapy Consultant	28	1,661	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	468	2,487	10a-03	43
44	Activity Consultant	55	2,652	11-03	44
45	Social Service Consultant	64	3,472	12-03	45
46	Other(specify)				46
47	Psychiatric Med Dir	Monthly	4,500	10-03	47
48	Specialized Rehab	Monthly	24,282	10a-03	48
49	TOTAL (lines 35 - 48)	656	\$ 160,382		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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0037655

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XIX. SUPPORT SCHEDULES

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

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$7,201
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,991 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 543,654
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,112 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT