

Facility Name & ID Number Fairview Nursing Plaza

0037655 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,976</u>	<u>201</u>	<u>2,165</u>	<u>23,342</u>	8
9	SNF/PED					9
10	ICF	<u>46,922</u>	<u>449</u>	<u>1,607</u>	<u>48,978</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,898</u>	<u>650</u>	<u>3,772</u>	<u>72,320</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.02%

D. How many bed-hold days during this year were paid by the Department? None (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 09/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/1991 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 2,165

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	290,821	61,463	43,749	396,033		396,033	(17,518)	378,515	1	
2	Food Purchase		390,909		390,909	(21,718)	369,192	(35)	369,156	2	
3	Housekeeping	255,957	47,889		303,846		303,846		303,846	3	
4	Laundry	106,154	21,677		127,831		127,831		127,831	4	
5	Heat and Other Utilities			178,947	178,947		178,947	(26,848)	152,099	5	
6	Maintenance	51,991	67,640	247,856	367,487		367,487	1,104	368,591	6	
7	Other (specify):*							9,944	9,944	7	
8	TOTAL General Services	704,923	589,578	470,552	1,765,053	(21,718)	1,743,336	(33,353)	1,709,982	8	
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200	9	
10	Nursing and Medical Records	2,569,544	187,994	178,439	2,935,977		2,935,977	(44,836)	2,891,141	10	
10a	Therapy	108,761		32,104	140,865		140,865	(10,025)	130,840	10a	
11	Activities	138,549	14,927	2,256	155,732		155,732		155,732	11	
12	Social Services	282,636	7,326	1,050	291,012		291,012		291,012	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*							4,228	4,228	15	
16	TOTAL Health Care and Programs	3,099,490	210,247	221,049	3,530,786		3,530,786	(50,633)	3,480,153	16	
	C. General Administration										
17	Administrative	61,544		102,240	163,784		163,784	21,663	185,447	17	
18	Directors Fees									18	
19	Professional Services			201,309	201,309	(135)	201,174	(118,482)	82,692	19	
20	Dues, Fees, Subscriptions & Promotions			48,659	48,659		48,659	(18,486)	30,173	20	
21	Clerical & General Office Expenses	158,439	25,388	280,202	464,029		464,029	(86,045)	377,985	21	
22	Employee Benefits & Payroll Taxes			561,572	561,572	21,718	583,290		583,290	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			5,727	5,727		5,727	1,036	6,763	24	
25	Other Admin. Staff Transportation			7,943	7,943		7,943	10,519	18,462	25	
26	Insurance-Prop.Liab.Malpractice			144,801	144,801		144,801	2,128	146,929	26	
27	Other (specify):*							44,327	44,327	27	
28	TOTAL General Administration	219,983	25,388	1,352,453	1,597,824	21,583	1,619,407	(143,340)	1,476,067	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,024,396	825,213	2,044,054	6,893,663	(135)	6,893,528	(227,326)	6,666,202	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Fairview Nursing Plaza

#0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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			141,991	141,991		141,991	549,874	691,865			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			107,316	107,316		107,316	399,752	507,068			32
33	Real Estate Taxes					135	135	125,266	125,401			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(900,000)				34
35	Rent-Equipment & Vehicles			6,428	6,428		6,428	6,616	13,044			35
36	Other (specify):*											36
37	TOTAL Ownership			1,155,735	1,155,735	135	1,155,870	181,508	1,337,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,501	293,190	435,691		435,691		435,691			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			540,917	540,917		540,917		540,917			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		142,501	834,107	976,608		976,608		976,608			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,024,396	967,714	4,033,896	9,026,006		9,026,006	(45,818)	8,980,188			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(29,163)	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	211,175	30		9
10	Interest and Other Investment Income	(1,187)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,900)	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	(200,817)	21		24
25	Fund Raising, Advertising and Promotional	(7,459)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(326)	20		28
29	Other-Attach Schedule	(58,998)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (88,710)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	42,892		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 42,892		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (45,818)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Collection Fees	\$ (7,860)	19	1
2	Bank Fees	(6,415)	21	2
3	Theft & Damage	(2,296)	21	3
4	Additional R&M	18,966	06	4
5	Capitalized R&M	(12,182)	06	5
6	Miscellaneous Income	(52)	21	6
7	Non Allowable Legal	(3,139)	19	7
8	Bldg Co. - Amortization	(2,500)	36	8
9	Bldg Co. - Fees	(250)	20	9
10	Bldg Co. - Office Expense	(44)	21	10
11	Bldg Co. - Professional Fees	(23,616)	19	11
12	COPE Dues	(9,298)	20	12
13	PPA - Contract Nursing	(10,312)	10	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(58,998)	49

Fairview Nursing Plaza

ID# 0037655

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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				(17,518)								(17,518)	1
2	Food Purchase	(35)											(35)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(29,163)			2,315								(26,848)	5
6	Maintenance	6,784		(14,830)	9,150								1,104	6
7	Other (specify):*			666	9,278								9,944	7
8	TOTAL General Services	(22,414)		(14,164)	3,225								(33,353)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,312)		(43,318)	8,794								(44,836)	10
10a	Therapy				(10,025)								(10,025)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,355	2,873								4,228	15
16	TOTAL Health Care and Programs	(10,312)		(41,963)	1,642								(50,633)	16
	C. General Administration													
17	Administrative			(72,465)	94,128								21,663	17
18	Directors Fees													18
19	Professional Services	(34,615)	23,616	(124,511)	17,028								(118,482)	19
20	Fees, Subscriptions & Promotions	(19,233)	250	497									(18,486)	20
21	Clerical & General Office Expenses	(209,624)	44	123,456	79								(86,045)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,036									1,036	24
25	Other Admin. Staff Transportation			10,519									10,519	25
26	Insurance-Prop.Liab.Malpractice			1,964	164								2,128	26
27	Other (specify):*			25,621	18,706								44,327	27
28	TOTAL General Administration	(263,472)	23,910	(33,883)	130,105								(143,340)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(296,198)	23,910	(90,010)	134,972								(227,326)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	211,175	331,714		6,985								549,874	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,187)	411,627	(17,959)	7,271								399,752	32
33	Real Estate Taxes		118,564		6,702								125,266	33
34	Rent-Facility & Grounds		(900,000)										(900,000)	34
35	Rent-Equipment & Vehicles			6,616									6,616	35
36	Other (specify):*	(2,500)	2,500											36
37	TOTAL Ownership	207,488	(35,595)	(11,343)	20,958								181,508	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)	(88,710)	(11,685)	(101,353)	155,930								(45,818)	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	\$ 900,000	Fairview Nursing Property, LLC	100.00%	\$	\$ (900,000)	1
2	V	32 Interest Income	121	Fairview Nursing Property, LLC	100.00%		(121)	2
3	V	36 Amortization		Fairview Nursing Property, LLC	100.00%	2,500	2,500	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%	250	250	5
6	V	32 Interest Expense		Fairview Nursing Property, LLC	100.00%	411,748	411,748	6
7	V	21 Office Expense		Fairview Nursing Property, LLC	100.00%	44	44	7
8	V	33 RE Tax Expense	7,736	Fairview Nursing Property, LLC	100.00%	126,300	118,564	8
9	V	19 Professional Fees		Fairview Nursing Property, LLC	100.00%	23,616	23,616	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 907,857			\$ 896,172	\$ * (11,685)	14

* 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	6 REPAIRS AND MAINT.	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 10,730	\$ (14,830)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	666	666
17	V	10 NURSING	53,676	S.I.R. MANAGEMENT, INC.	100.00%	10,358	(43,318)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,355	1,355
19	V	19 PROFESSIONAL FEES	145,908	S.I.R. MANAGEMENT, INC.	100.00%	16,919	(128,989)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	497	497
21	V	21 CLERICAL & GENERAL	51,120	S.I.R. MANAGEMENT, INC.	100.00%	59,209	8,089
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,036	1,036
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,519	10,519
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,964	1,964
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,322	8,322
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,959)	(17,959)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,616	6,616
28	V						
29	V	17 ADMINISTRATIVE	102,240	S.I.R. MANAGEMENT, INC.	100.00%	29,775	(72,465)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	4,478	4,478
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	115,367	115,367
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,299	17,299
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 378,504			\$ 277,151	\$ * (101,353)

* 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	1	DIETARY SALARIES	\$ 25,560	S.I.R. MANAGEMENT, INC.	100.00%	\$ 8,042	\$ (17,518)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,058	1,058	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,794	8,794	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,145	1,145	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	94,128	94,128	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,961	16,961	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,706	18,706	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,004	S.I.R. MANAGEMENT, INC.	100.00%	12,979	(10,025)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,728	1,728	25
26	V								26
27	V	6	MAINTENANCE SALARIES	46,920	S.I.R. MANAGEMENT, INC.	100.00%	55,205	8,285	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	8,220	8,220	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,315	2,315	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	865	865	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	67	67	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%	164	164	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,985	6,985	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,271	7,271	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,702	6,702	37
38	V								38
39	Total		\$ 95,484				\$ 251,414	\$ * 155,930	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	39 Ancillary	\$ 6,842	Long Term Care Laboratory, LLC	100.00%	\$ 6,842	\$	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		\$ 6,842			\$ 6,842	\$ *	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.

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: 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: 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: 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		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

* 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

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				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%	WESLEY HEALTHCARE & REHABILITATION CENTER	AUBURN, IN				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 # 0037655 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	5.27	8.78%	Alloc. Salary	\$ 17,558	17-7	1	
2	Louise Bergthold	Shareholder	Administrative	2.69%	See Attached	5.27	8.78%	Alloc. Salary	17,558	17-7	2	
3	Michael Giannini	Relative	Administrative	0.00%	See Attached	3.07	7.68%	Alloc. Salary	14,691	17-7	3	
4	Bryan Barrish	Relative	Administrative	0.00%	See Attached	3.51	7.80%	Alloc. Salary	17,558	17-7	4	
5	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	4.39	8.78%	Alloc. Salary	4,424	21-7	5	
6	Sarah Barrish	Relative	Administrative	0.00%	See Attached	3.95	8.78%	Alloc. Salary	8,356	17-7	6	
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.39	8.78%	Alloc. Salary	8,042	1-7	7	
8	Matthew Winter	Relative	Clerical	0.00%	See Attached	0.54	8.85%	Alloc. Salary	278	21-7	8	
9	Mark Solomon	Shareholder	Administrative	6.73%	See Attached	0.88	2.20%	Alloc. Salary	3,372	17-7	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 91,837		13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	823,778	14	\$ 122,226	\$ 54,106	72,320	\$ 10,730	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581	72,320	666	2	
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	72,320	10,358	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435	72,320	1,355	4	
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	72,320	16,919	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665	72,320	497	6	
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	72,320	59,209	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805	72,320	1,036	8	
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815	72,320	10,519	9	
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368	72,320	1,964	10	
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799	72,320	8,322	11	
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)	72,320	(17,959)	12	
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364	72,320	6,616	13	
14									14	
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	72,320	29,775	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011	72,320	4,478	16	
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	72,320	115,367	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046	72,320	17,299	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,156,964	\$ 2,409,562		\$ 277,151	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	823,778	14	\$ 91,605	\$ 91,605	72,320	\$ 8,042	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049	72,320	72,320	1,058	2
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	72,320	8,794	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047	72,320	72,320	1,145	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	72,320	94,128	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200	72,320	72,320	16,961	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069	72,320	72,320	18,706	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	23,004	12,979	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	293,544	14	22,047	23,004	23,004	1,728	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	46,920	55,205	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242	46,920	46,920	8,220	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365	1,131	1,131	2,315	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845	1,131	1,131	865	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768	1,131	1,131	67	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896	1,131	1,131	79	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870	1,131	1,131	164	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536	1,131	1,131	6,985	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793	1,131	1,131	7,271	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319	1,131	1,131	6,702	23
24										24
25	TOTALS					\$ 2,672,494	\$ 1,874,448	\$	251,414	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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		\$	\$		\$ 6,842	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				\$	\$		\$ 6,842	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	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		Wells Fargo		X	Note Payable			\$		\$ 471,150			\$ 22,975	1					
2		Centrue Bank		X	Mortgage Payable					6,981,547			379,185	2					
3														3					
4														4					
5														5					
		Working Capital																	
6		Shareholder Loans		X						600,000			35,629	6					
7		Lake Forest Bank		X	Line of Credit					1,260,000			48,713	7					
8		See Supplemental Schedule								395,180			39,834	8					
9		TOTAL Facility Related						\$		\$ 9,707,877			\$ 526,335	9					
		B. Non-Facility Related*																	
10		Interest Income		X									(1,187)	10					
11		Interest Income - Bldg Co.		X									(121)	11					
12		Alloc. - S.I.R. Management		X									(17,959)	12					
13														13					
14		TOTAL Non-Facility Related						\$		\$			\$ (19,267)	14					
15		TOTALS (line 9+line14)						\$		\$ 9,707,877			\$ 507,068	15					

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

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

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

Facility Name & ID Number

Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Centrue Bank		X	Notes Payable - Bldg Co.		\$	\$ 395,180			\$ 32,563	8							
9	Alloc. - S.I.R. Management		X							7,271	9							
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 2012 report.		\$	<u>128,000</u>	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.)		\$	<u>126,966</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,034)</u>	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>126,300</u>	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.)		\$	<u>135</u>	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.		\$	<u>125,401</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>106,335</u>	8	FOR BHF USE ONLY	
	2009	<u>111,565</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	<u>117,084</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>121,687</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>120,264</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2013 Accrual = \$120,264 x 1.05 = \$126,300 (Rounded)					
Allocated from SIR Management : \$6,702					

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Nursing Plaza COUNTY Winnebago
 FACILITY IDPH LICENSE NUMBER 0037655
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-28-203-004</u>	<u>Long Term Care Property</u>	\$ <u>120,263.68</u>	\$ <u>120,263.68</u>
2. <u>See Attached</u>	<u>Allocated from SIR Management</u>	\$ <u>106,516.99</u>	\$ <u>7,325.67</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>226,780.67</u></u>	\$ <u><u>127,589.35</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? X 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

Facility Name & ID Number Fairview Nursing Plaza

0037655 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	\$ 1,778,443	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1992	55,434		20			55,422	9
10	Various		1993	68,424		20	2,089	2,089	68,308	10
11	Various		1994	44,837		20	2,242	2,242	44,510	11
12	Various		1995	14,482		20	724	724	13,090	12
13	Various		1996	9,472		20	374	374	8,548	13
14	Various		1997	28,011		20	1,401	1,401	23,400	14
15	Various		1998	23,867		20	949	949	18,917	15
16	Various		1999	46,683		20	2,334	2,334	33,873	16
17	Various		2000	24,848		20	1,042	1,042	17,927	17
18	Various		2001	32,547		20	1,627	1,627	20,341	18
19	Various		2002	39,114		20	112	112	38,733	19
20	Various		2003	31,242		20	1,562	1,562	16,579	20
21	Various		2004	164,618		20	9,349	9,349	90,775	21
22	Various		2005	111,099		20	7,162	7,162	59,804	22
23	Various		2006	45,816		20	2,291	2,291	18,006	23
24	Various		2007	39,926		20	1,996	1,996	13,529	24
25	Various		2008	25,639		20	1,512	1,512	8,554	25
26	Various		2009	35,550		20	2,677	2,677	12,166	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		27,204	(90,322)	119,401	67
68		171,064	4,423		6,216	1,793	83,789	68
69			141,991			(141,991)		69
70		\$ 9,024,158	\$ 402,915		\$ 393,824	\$ (9,091)	\$ 2,544,113	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 9,024,158	\$ 402,915		\$ 393,824	\$ (9,091)	\$ 2,544,113	1
2	Security Camera	2010	6,100		20	871	871	2,760	2
3	Radiator Guards	2010	5,558		20	1,112	1,112	4,446	3
4	Water Heater	2010	12,628		20	2,526	2,526	9,050	4
5	Window Treatments	2010	10,008		20	2,002	2,002	7,006	5
6	Sewer Pipe	2010	9,800		20	1,960	1,960	7,677	6
7	Straight Cubicle Track	2010	2,941		20	294	294	980	7
8	Excavation	2010	3,100		20	310	310	956	8
9	Roofing	2011	7,695		20	385	385	1,058	9
10	Masterlock System	2011	4,890		20	245	245	693	10
11	Fire Alarm Panel	2011	4,430		20	222	222	609	11
12	Resident Room Doors	2011	7,102		20	355	355	917	12
13	Elevator Panels	2011	3,800		20	190	190	491	13
14	Hallway Room Signs	2011	7,901		20	790	790	2,041	14
15	Ceiling Grid And Lighting	2011	41,636		20	2,082	2,082	5,378	15
16	Drywall Repair/Patch	2011	14,060		20	703	703	1,816	16
17	Window Treatments	2011	11,128		20	556	556	1,484	17
18	Flooring	2011	27,953		20	1,398	1,398	3,727	18
19	Wall-Base	2011	9,932		20	1,986	1,986	4,800	19
20	Handrails, Crashrails, Corner Guards	2011	76,093		20	3,805	3,805	8,878	20
21	Resident Room Doors	2011	4,929		20	246	246	555	21
22	Room 501 Ceiling, Doors	2011	3,315		20	332	332	774	22
23	Chair Rail: Dining And Activities	2011	8,594		20	430	430	931	23
24	Corner Guards	2011	4,301		20	215	215	466	24
25	Generator Work	2011	19,600		20	980	980	2,123	25
26	Water Heater	2011	4,208		20	210	210	526	26
27	Hvac Work	2011	4,774		20	955	955	1,989	27
28	Painting	2011	110,575		20	5,529	5,529	11,979	28
29	Drywall Repair	2011	3,800		20	190	190	475	29
30	Electrical Breaker	2011	2,928		20	146	146	378	30
31	Elevator Adjustment	2011	2,726		20	136	136	341	31
32	Remodel Bathroom; Metal Stairs And Rails	2011	4,978		20	498	498	1,037	32
33	Replaced Toilet And Sink, Repaired Pipes, Installed Towel And Gr	2011	3,665		20	367	367	764	33
34	TOTAL (lines 1 thru 33)		\$ 9,469,306	\$ 402,915		\$ 425,848	\$ 22,933	\$ 2,631,216	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 9,469,306	\$ 402,915		\$ 425,848	\$ 22,933	\$ 2,631,216	1
2	Flooring On 1St Floor	2011	67,137		20	6,714	6,714	13,987	2
3	Drained Sprinkler System, Replaced Sprinkler Heads, And Install	2012	5,441		20	544	544	1,088	3
4	Metal Stair Rails	2012	3,650		20	365	365	730	4
5	Tear Out Old Bathroom-New Painting, Plumbing,Electrical,Dry W	2012	4,978		20	498	498	996	5
6	Bathroom Tile Upgrade	2012	3,228		20	323	323	619	6
7	Tear Out Old Bathroom-New Tile, Dry Wall, Fixtures,Painting	2012	3,665		20	367	367	702	7
8	Flooring-1St Floor	2012	9,192		20	460	460	843	8
9	Flooring-1St Floor Rooms	2012	150,217		20	7,511	7,511	13,770	9
10	Built-In Closet Cabinetry	2012	95,790		20	9,579	9,579	15,965	10
11	Privacy Curtains	2012	17,105		20	1,711	1,711	2,423	11
12	Wall Base In Hallways, Flooring At 2Nd Floor Nurses Station	2012	4,558		20	912	912	1,140	12
13	Electrical Work	2012	4,260		20	426	426	533	13
14	Room Signs	2012	6,063		20	1,213	1,213	1,516	14
15	First Floor Karndean Wood Look Hallway Tile	2012	135,854		20	27,171	27,171	33,964	15
16	Nurses Station - 1St Floor	2012	13,000		20	1,300	1,300	1,625	16
17	Nurses Station - 2Nd Floor	2012	13,000		20	1,300	1,300	1,625	17
18	Roofing (Contract+Extras)	2012	38,869		20	3,887	3,887	4,859	18
19	Air Conditioning Units	2012	26,167		20	1,308	1,308	1,417	19
20	Water Heater	2012	4,778		20	239	239	259	20
21	Draperies - 1St Floor	2012	69,610		20	3,481	3,481	4,351	21
22	Hvac Unit #8 Repair	2012	2,727		20	136	136	193	22
23	Outdoor Sign	2013	3,275		20	109	109	109	23
24	Custom Cabinetry - Offices	2013	27,720		20	1,386	1,386	1,386	24
25	Backflow Device - Fire System	2013	6,794		20	311	311	311	25
26	Water Heater	2013	12,995		20	541	541	541	26
27	Windows	2013	3,690		20	154	154	154	27
28	Water Heater	2013	10,242		20	512	512	512	28
29	Roof-Top Hvac Units	2013	30,285		20	1,262	1,262	1,262	29
30	Elevator Motor Replacement	2013	8,478		20	212	212	212	30
31	Roof Work For Hvac Install	2013	2,662		20	67	67	67	31
32	Heat & Cooling Unit (2)	2013	30,098		20	752	752	752	32
33	Door Protector	2013	6,498		20	325	325	325	33
34	TOTAL (lines 1 thru 33)		\$ 10,291,333	\$ 402,915		\$ 500,921	\$ 98,006	\$ 2,739,450	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building 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	Totals from Page 12C, Carried Forward		\$ 10,291,333	\$ 402,915		\$ 500,921	\$ 98,006	\$ 2,739,450	1
2	Sprinkler Heads In 1St Fl Storage Rm, 1St Fl Dining Rm, 2Nd Fl E	2013	2,541		20	127	127	127	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)		\$ 10,293,874	\$ 402,915		\$ 501,048	\$ 98,133	\$ 2,739,577	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 10,293,874	\$ 402,915		\$ 501,048	\$ 98,133	\$ 2,739,577		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)	\$ 10,293,874	\$ 402,915		\$ 501,048	\$ 98,133	\$ 2,739,577		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	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	20	5,758		34,548	9
10	Lighting	2008	18,134	907	20	907		5,442	10
11	Rooftop HVAC	2008	35,086	1,754	20	1,754		10,524	11
12	Painting	2008	56,311	16,689	20	16,689		56,311	12
13	Parking Lot Work	2008	25,518	1,276	20	1,276		7,656	13
14	Handrails	2008	8,200	820	20	820		4,920	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

0037655

Report Period Beginning:

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Ending:

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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		\$ 27,204	\$ (90,322)	\$ 119,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	21,954		20	563	563	2,275	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	39,752	1,262	20	1,136	(126)	23,283	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	10,078	281	20	86	(195)	10,078	9
10	Alloc. - S.I.R. Management	1994	31		20			31	10
11	Alloc. - S.I.R. Management	1995	230		20	12	12	212	11
12	Alloc. - S.I.R. Management	1997	15,486	347	20	755	408	12,962	12
13	Alloc. - S.I.R. Management	1999	1,218		20	61	61	867	13
14	Alloc. - S.I.R. Management	1999	11,917		20			11,917	14
15	Alloc. - S.I.R. Management	2000	1,438		20	72	72	973	15
16	Alloc. - S.I.R. Management	2007	4,619	315	20	231	(84)	1,431	16
17	Alloc. - S.I.R. Management	2008	12,730	1,216	20	802	(414)	4,690	17
18	Alloc. - S.I.R. Management	2009	31,632	289	20	1,582	1,293	6,713	18
19	Alloc. - S.I.R. Management	2011	783	78	20	78		189	19
20	Alloc. - S.I.R. Management	2012	2,504	125	20	125		177	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,435	335	20	17	(318)	20	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,399		20	120	120	400	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,387	107	20	119	12	573	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	696	55	20	35	(20)	244	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	157		20	8	8	91	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,037		20	252	252	3,652	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,407		20	120	120	1,866	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	150		20	7	7	131	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	379	10	20	19	9	369	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	645	3	20	16	13	645	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 171,064	\$ 4,423		\$ 6,216	\$ 1,793	\$ 83,789	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 1,632,999	\$ 77,451	\$ 183,450	\$ 105,999	10	\$ 867,012	71
72	Current Year Purchases	83,082		6,969	6,969	10	6,969	72
73	Fully Depreciated Assets	332,610		27	27	10	332,610	73
74								74
75	TOTALS	\$ 2,048,691	\$ 77,451	\$ 190,447	\$ 112,996		\$ 1,206,591	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	2013	3,087	323	369	46	5	1,449	78
79										79
80	TOTALS			\$ 45,955	\$ 323	\$ 369	\$ 46		\$ 44,317	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)	\$ 12,388,519	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 480,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 691,864	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 211,175	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,990,486	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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 13,045 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	103,917	\$		\$	103,917	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				86,048				86,048	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				103,225				103,225	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					78,757			78,757	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Supplemental							63,744			63,744	13
14	TOTAL			\$		\$	293,190	\$	142,501	\$	435,691	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Fairview Nursing Plaza**

0037655

Report Period Beginning: **01/01/13**

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/13** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 85,062	\$ 137,344	1
2	Cash-Patient Deposits	52,165	52,165	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,144,269	1,144,269	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,306	41,306	6
7	Other Prepaid Expenses	2,158	2,158	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,324,960	\$ 1,377,242	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	1,591,802	2,018,363	15
16	Equipment, at Historical Cost	1,646,994	1,724,443	16
17	Accumulated Depreciation (book methods)	(1,401,091)	(3,104,813)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	195,387	203,303	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,033,092	\$ 8,536,796	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,358,052	\$ 9,914,038	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 438,708	\$ 438,708	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,165	52,165	28
29	Short-Term Notes Payable	1,860,000	1,860,000	29
30	Accrued Salaries Payable	371,816	371,816	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,711	36,711	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,300	32
33	Accrued Interest Payable		8,145	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	102,091	102,091	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,861,491	\$ 2,995,936	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	471,150	471,150	39
40	Mortgage Payable		7,376,727	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 471,150	\$ 7,847,877	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,332,641	\$ 10,843,813	46
47	TOTAL EQUITY(page 18, line 24)	\$ 25,411	\$ (929,775)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,358,052	\$ 9,914,038	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 349,234	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 349,234	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(323,823)	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)	\$ (323,823)	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)	\$ 25,411	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,450,692	1
2	Discounts and Allowances for all Levels	(1,143,475)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,307,217	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,107,077	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,107,077	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,547	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,336	19
20	Radiology and X-Ray	864	20
21	Other Medical Services	42,593	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 132,340	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,187	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,187	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	154,362	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 154,362	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,702,183	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,765,053	31
32	Health Care	3,530,786	32
33	General Administration	1,597,824	33
B. Capital Expense			
34	Ownership	1,155,735	34
C. Ancillary Expense			
35	Special Cost Centers	435,691	35
36	Provider Participation Fee	540,917	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,026,006	40
41	Income before Income Taxes (line 30 minus line 40)**	(323,823)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (323,823)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,090,272	44
45	Private Pay - Net Inpatient Revenue	98,550	45
46	Medicare - Net Inpatient Revenue	(42,502)	46
47	Other-(specify) Hospice	163,145	47
48	Other-(specify) Insurance	(2,248)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,307,217	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

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,939	2,102	\$ 88,669	\$ 42.18	1
2	Assistant Director of Nursing	2,097	2,279	68,790	30.18	2
3	Registered Nurses	8,273	8,797	247,937	28.18	3
4	Licensed Practical Nurses	29,469	32,009	797,425	24.91	4
5	CNAs & Orderlies	94,479	102,702	1,211,705	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,627	6,341	108,761	17.15	8
9	Activity Director	1,600	1,916	32,720	17.08	9
10	Activity Assistants	13,562	14,019	105,829	7.55	10
11	Social Service Workers	18,416	19,915	282,636	14.19	11
12	Dietician					12
13	Food Service Supervisor	3,627	3,917	60,586	15.47	13
14	Head Cook	5,518	5,946	62,909	10.58	14
15	Cook Helpers/Assistants	16,294	18,050	167,326	9.27	15
16	Dishwashers					16
17	Maintenance Workers	3,884	4,129	51,991	12.59	17
18	Housekeepers	23,623	25,603	255,957	10.00	18
19	Laundry	10,361	11,143	106,154	9.53	19
20	Administrator	1,799	1,889	61,544	32.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,427	10,016	158,439	15.82	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	5,804	6,455	155,018	24.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,799	277,228	\$ 4,024,396 *	\$ 14.52	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	\$ 43,749	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	1,816	10-03	37
38	Nurse Consultant	Monthly	53,676	10-03	38
39	Pharmacist Consultant	Monthly	14,281	10-03	39
40	Physical Therapy Consultant	46	2,400	10a-03	40
41	Occupational Therapy Consultant	47	2,776	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	78	3,924	10a-03	43
44	Activity Consultant	47	2,256	11-03	44
45	Social Service Consultant	19	1,050	12-03	45
46	Other(specify)				46
47	Psychiatric Med Dir	Monthly	6,000	10-03	47
48	Specialized Rehab	Monthly	23,004	10a-03	48
49	TOTAL (lines 35 - 48)	237	\$ 162,132		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,472	\$ 81,132	10-03	50
51	Licensed Practical Nurses	336	21,534	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,808	\$ 102,666		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	
Marla Murphy	Administrator	0	\$ 61,544	Workers' Compensation Insurance	\$ 41,321	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	134,396	Advertising: Employee Recruitment	11,602	
				FICA Taxes	300,217	Health Care Worker Background Check		
				Employee Health Insurance	72,134	(Indicate # of checks performed 302)	3,016	
				Employee Meals	21,718	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	9,481	
				401K Contribution	3,375	Licenses & Permits	3,585	
				Other Employee Benefits	10,129	Allocated from SIR Management	497	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 61,544					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SIR Management - Dir. Of Admin. Services			\$ 51,120				Out-of-State Travel	\$
SIR Management - Ancillary Admin Services			51,120				In-State Travel	
							Seminar Expense	5,727
							Allocated from SIR Management	1,036
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 102,240				Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	\$ 6,763
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,305					
Plante & Moran	Accounting		5,325					
SIR Management	Accounting		36,000					
SIR Management	Bookkeeping		84,348					
SIR Management	Admin Legal Services		25,560					
Personnel Planners	Unemployment Consult		2,618					
Pinnacle Consulting	Customer Satisfaction		3,755					
E-Health Data	Computer Services		3,300					
Legat Architects	Architects		2,765					
Achieve Accreditation	Accreditation		10,220					
Honkamp & Krueger	WOTC Consultant		1,237					
See Supplemental Schedule			11,875					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 201,309					

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fairview Nursing Plaza

0037655

Report Period Beginning:

01/01/13

Ending:

12/31/13

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. IL Council on LTC: \$16,997
- (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. \$ 1,980 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. \$ 540,917
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 21,718 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? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.