



Facility Name & ID Number Warren Barr Pavilion

# 0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 \_\_\_\_\_

	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	271	Skilled (SNF)	271	99,186	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	271	TOTALS	271	99,186	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	17,848	26,069	20,652	64,569	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,848	26,069	20,652	64,569	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.10%

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 12/1/2002

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

YES  Date 12/1/2002 NO

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

YES  NO  If YES, enter number of beds certified 271 and days of care provided 18,143

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	574,961	70,571		645,532		645,532	13,496	659,028		1
2	Food Purchase		458,272		458,272		458,272	(3,616)	454,656		2
3	Housekeeping			501,710	501,710		501,710		501,710		3
4	Laundry			334,182	334,182		334,182	(13,646)	320,536		4
5	Heat and Other Utilities			522,225	522,225		522,225		522,225		5
6	Maintenance	173,911	815	313,009	487,735		487,735		487,735		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	748,872	529,658	1,671,126	2,949,656		2,949,656	(3,766)	2,945,890		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			58,200	58,200		58,200		58,200		9
10	Nursing and Medical Records	4,959,772	391,126	137,340	5,488,238		5,488,238	73,152	5,561,390		10
10a	Therapy										10a
11	Activities	195,944	2,890		198,834		198,834		198,834		11
12	Social Services	137,340			137,340		137,340		137,340		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							18,914	18,914		15
16	<b>TOTAL Health Care and Programs</b>	5,293,056	394,016	195,540	5,882,612		5,882,612	92,066	5,974,678		16
	<b>C. General Administration</b>										
17	Administrative	165,615		895,739	1,061,354		1,061,354	(435,007)	626,347		17
18	Directors Fees										18
19	Professional Services			140,965	140,965		140,965		140,965		19
20	Dues, Fees, Subscriptions & Promotions			42,329	42,329		42,329		42,329		20
21	Clerical & General Office Expenses	257,345	56,453	383,578	697,376		697,376	(356,317)	341,059		21
22	Employee Benefits & Payroll Taxes			1,292,166	1,292,166		1,292,166		1,292,166		22
23	Inservice Training & Education			140	140		140		140		23
24	Travel and Seminar			9,229	9,229		9,229		9,229		24
25	Other Admin. Staff Transportation			139	139		139		139		25
26	Insurance-Prop.Liab.Malpractice			533,450	533,450		533,450		533,450		26
27	Other (specify):*							82,124	82,124		27
28	<b>TOTAL General Administration</b>	422,960	56,453	3,297,735	3,777,148		3,777,148	(709,200)	3,067,948		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,464,888	980,127	5,164,401	12,609,416		12,609,416	(620,900)	11,988,516		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 Warren Barr Pavilion #0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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
	<b>D. Ownership</b>										
30	Depreciation			133,416	133,416	133,416	537,198	670,614			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			9,350	9,350	9,350	364,825	374,175			32
33	Real Estate Taxes			504,000	504,000	504,000		504,000			33
34	Rent-Facility & Grounds			546,808	546,808	546,808	(489,166)	57,642			34
35	Rent-Equipment & Vehicles			63,890	63,890	63,890	12,010	75,900			35
36	Other (specify):*						23,269	23,269			36
37	<b>TOTAL Ownership</b>			1,257,464	1,257,464	1,257,464	448,136	1,705,600			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		1,083,662	1,782,159	2,865,821	2,865,821	29,576	2,895,397			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			148,779	148,779	148,779		148,779			42
43	Other (specify):*	211,704		20,168	231,872	231,872	(231,872)				43
44	<b>TOTAL Special Cost Centers</b>	211,704	1,083,662	1,951,106	3,246,472	3,246,472	(202,296)	3,044,176			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	6,676,592	2,063,789	8,372,971	17,113,352	17,113,352	(375,060)	16,738,292			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(3,195)	02		4
5	Telephone, TV & Radio in Resident Rooms	(13,681)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(13,646)	4		8
9	Non-Straightline Depreciation	(100,433)	30		9
10	Interest and Other Investment Income	(1,046)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(421)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(287,279)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,389)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(481,643)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (903,733)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	528,673		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 528,673		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (375,060)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

## Warren Barr Pavilion

ID# 0046003

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Parking Revenue	\$ (33,822)	32	1
2	Space Rental	(26,800)	32	2
3	Hospice Unit	(136,182)	32	3
4	Miscellaneous Income	(2,263)	21	4
5	Marketing Expenses	(231,872)	43	5
6	Building Company - Amortization	(23,269)	21	6
7	Uniforms	(62)	21	7
8	Non-Allowable Expenses	(27,078)	21	8
9	Bank Fees	(296)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	<b>Total</b>	(481,643)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	13,496	0	0	0	0	0	0	0	0	13,496	1
2	Food Purchase	(3,616)	0	0	0	0	0	0	0	0	0	0	(3,616)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(13,646)	0	0	0	0	0	0	0	0	0	0	(13,646)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(17,262)</b>	<b>0</b>	<b>13,496</b>	<b>0</b>	<b>(3,766)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	73,152	0	0	0	0	0	0	0	0	73,152	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	18,914	0	0	0	0	0	0	0	0	18,914	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>92,066</b>	<b>0</b>	<b>92,066</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	(435,007)	0	0	0	0	0	0	0	0	(435,007)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(356,317)	0	0	0	0	0	0	0	0	0	0	(356,317)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	82,124	0	0	0	0	0	0	0	0	82,124	27
28	<b>TOTAL General Administration</b>	<b>(356,317)</b>	<b>0</b>	<b>(352,883)</b>	<b>0</b>	<b>(709,200)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(373,579)</b>	<b>0</b>	<b>(247,321)</b>	<b>0</b>	<b>(620,900)</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(100,433)	617,115	20,516	0	0	0	0	0	0	0	0	537,198	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(197,850)	557,863	4,811	0	0	0	0	0	0	0	0	364,825	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(540,000)	50,834	0	0	0	0	0	0	0	0	(489,166)	34
35	Rent-Equipment & Vehicles	0	0	12,010	0	0	0	0	0	0	0	0	12,010	35
36	Other (specify):*	0	23,269	0	0	0	0	0	0	0	0	0	23,269	36
37	<b>TOTAL Ownership</b>	<b>(298,283)</b>	<b>658,247</b>	<b>88,171</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>448,136</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	29,576	0	0	0	0	0	0	0	29,576	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(231,872)	0	0	0	0	0	0	0	0	0	0	(231,872)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(231,872)</b>	<b>0</b>	<b>0</b>	<b>29,576</b>	<b>0</b>	<b>(202,296)</b>	<b>44</b>						
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(903,733)</b>	<b>658,247</b>	<b>(159,150)</b>	<b>29,576</b>	<b>0</b>	<b>(375,060)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Evergreen Healthcare Realty	100	See Attached		See Attached		
See Attached List Of Evergreen HC Realty Owners				Evergreen Healthcare Realty, LLC		Bldg. Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 540,000	Evergreen Healthcare Realty, LLC	100.00%	\$	\$ (540,000)	1
2	V	32 Interest		Evergreen Healthcare Realty, LLC	100.00%	557,863	557,863	2
3	V	30 Depreciation		Evergreen Healthcare Realty, LLC	100.00%	617,115	617,115	3
4	V	36 Amortization		Evergreen Healthcare Realty, LLC	100.00%	23,269	23,269	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 540,000			\$ 1,198,247	\$ * 658,247	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	17 Management Fees	\$ 895,739	Boulevard Healthcare Mangement, LLC		\$	(895,739)	15
16	V	10 Nursing & Rehabilitation		Boulevard Healthcare Mangement, LLC		73,152	73,152	16
17	V	15 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		18,914	18,914	17
18	V	01 Dietary		Boulevard Healthcare Mangement, LLC		13,496	13,496	18
19	V	17 Administrative & General		Boulevard Healthcare Mangement, LLC		460,732	460,732	19
20	V	27 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		82,124	82,124	20
21	V	30 Depreciation		Boulevard Healthcare Mangement, LLC		20,516	20,516	21
22	V	34 Building Rent		Boulevard Healthcare Mangement, LLC		50,834	50,834	22
23	V	35 Equipment Rent		Boulevard Healthcare Mangement, LLC		12,010	12,010	23
24	V	32 Interest Expense		Boulevard Healthcare Mangement, LLC		4,811	4,811	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		\$ 895,739			\$ 736,589	\$ * (159,150)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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 REHAB	\$ 1,782,159	ADVANCED THERAPY & REHAB, LLC		\$ 1,811,735	\$ 29,576	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			\$ 1,782,159			\$ 1,811,735	\$ * 29,576	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Warren Barr Pavilion

# 0046003

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 Warren Barr Pavilion

# 0046003

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 Boulevard Healthcare Management, LLC  
 Street Address 6400 Shafer Ct., Suite 600  
 City / State / Zip Code Rosemont, IL 60018-4914  
 Phone Number ( 847) 720-8700  
 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	10	Nursing & Rehabilitation	Patient Days/Direct	237,313	5	\$ 268,857	\$ 268,857	64,569	\$ 73,152	1
2	15	Payroll Taxes, Fringes, Staffe Dev	Patient Days/Direct	237,313	5	69,515	64,569	64,569	18,914	2
3	1	Dietary	Patient Days/Direct	237,313	5	49,604	49,604	64,569	13,496	3
4	17	Administartive & General	Patient Days/Direct	237,313	5	1,693,345	1,117,770	64,569	460,732	4
5	27	Payroll Taxes, Fringes, Staffe Dev	Patient Days/Direct	237,313	5	301,832	64,569	64,569	82,124	5
6	30	Depreciation	Patient Days/Direct	237,313	5	75,405	64,569	64,569	20,516	6
7	34	Building Rent	Patient Days/Direct	237,313	5	186,831	64,569	64,569	50,834	7
8	35	Equipment Rental	Patient Days/Direct	237,313	5	44,140	64,569	64,569	12,010	8
9	32	Interest Expense	Patient Days/Direct	237,313	5	17,682	64,569	64,569	4,811	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					\$ 2,707,211	\$ 1,436,231		\$ 736,589	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Advanced Therapy and Rehab, LLC  
 Street Address 6400 Shafer Ct., Suite 600  
 City / State / Zip Code Rosemont, IL 60018-4914  
 Phone Number ( 847) 720-8700  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	ANCILLARY REHAB	DIRECT ALLOCATION		\$	\$		\$ 2,646,324	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				\$	\$		\$ 2,646,324	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	LaSalle Bank - Mortgage		X	Mortgage			\$	\$ 10,216,577			\$ 557,863	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
<b>Working Capital</b>																	
6	LaSalle Bank		X	Line Of Credit				1,045,000			9,350	6					
7												7					
8	See Supplemental Schedule											8					
9	<b>TOTAL Facility Related</b>						\$	\$ 11,261,577			\$ 567,213	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(1,046)	10					
11	Allocated From Boulevard	X									4,811	11					
12	Parking/Rent Income	X									(60,622)	12					
13	See Supplemental Schedule										(136,182)	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (193,039)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 11,261,577			\$ 374,175	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      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 Warren Barr Pavilion # 0045146 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

## 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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>				<b>0.00</b>		<b>0</b>	<b>0</b>			<b>0</b>					
	<b>Working Capital</b>															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>				<b>0.00</b>		<b>0</b>	<b>0</b>			<b>0</b>					
	<b>B. Non-Facility Related*</b>															
15	<b>Hospice Income</b>		<b>X</b>				\$	\$			\$ <b>(136,182)</b>					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>				<b>0.00</b>		<b>0</b>	<b>0</b>			<b>(206,512)</b>					

\* 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2007 report.		\$ <b>575,484</b>	<b>1</b>																													
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.)		\$ <b>539,693</b>	<b>2</b>																													
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(35,791)</b>	<b>3</b>																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>539,791</b>	<b>4</b>																													
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>																													
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>504,000</b>	<b>7</b>																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td><b>612,712</b></td><td><b>8</b></td></tr> <tr><td>2004</td><td><b>608,080</b></td><td><b>9</b></td></tr> <tr><td>2005</td><td><b>554,834</b></td><td><b>10</b></td></tr> <tr><td>2006</td><td><b>505,395</b></td><td><b>11</b></td></tr> <tr><td>2007</td><td><b>539,693</b></td><td><b>12</b></td></tr> </table>	2003	<b>612,712</b>	<b>8</b>	2004	<b>608,080</b>	<b>9</b>	2005	<b>554,834</b>	<b>10</b>	2006	<b>505,395</b>	<b>11</b>	2007	<b>539,693</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6 \$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td><b>16</b></td></tr> </table>	<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007 \$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>
2003	<b>612,712</b>	<b>8</b>																														
2004	<b>608,080</b>	<b>9</b>																														
2005	<b>554,834</b>	<b>10</b>																														
2006	<b>505,395</b>	<b>11</b>																														
2007	<b>539,693</b>	<b>12</b>																														
<b>FOR BHF USE ONLY</b>																																
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007 \$	<b>13</b>																														
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>																														
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>																														
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>																														

**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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Barr Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046003

CONTACT PERSON REGARDING THIS REPORT Boris Kushnir

TELEPHONE 614-222-9045 FAX #: 248-233-8813

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-04-423-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>539,693.00</u>	\$ <u>539,693.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>539,693.00</u>	\$ <u>539,693.00</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 X NO

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

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Barr Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046003

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

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

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

# 0046003 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 130,152 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 9

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).

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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: 260,519 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: 23,269 4. Dates Incurred: 2002

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	<u>Facility</u>		<u>2002</u>	<u>\$ 2,500,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 2,500,000</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	271		2002	1975	\$ 10,110,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various		2002		3,081		20	26	26	154	9
10	Various		2003		431,785		20	17,648	17,648	105,891	10
11	Planter Box		2004		1,425						11
12	HVAC Chiller		2005		188,750						12
13											13
14	Boulevard Healthcare Management		2002		5,840						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

\*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 Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67					617,115	440,159	(176,956)	2,872,757	67
68					152	292	140	4,997	68
69					50,349		(50,349)		69
70		\$ 10,740,881	\$ 667,616		\$ 458,125	\$ (209,491)	\$ 2,983,799	70	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 10,740,881	\$ 667,616		\$ 458,125	\$ (209,491)	\$ 2,983,799	1
2	Install Fire Pump/Controller	2004	29,425		20	1,471	1,471	7,355	2
3	Wander Guard System	2004	5,651		20	283	283	1,415	3
4	Electrical Work	2004	10,252		20	513	513	2,565	4
5	Elevator Renovation	2004	88,475		20	4,424	4,424	22,120	5
6	Wanderguard	2004	1,740		20	87	87	435	6
7	Phone System Installation	2004	5,990		20	300	300	2,696	7
8	Phone System Installation	2004	900		20	45	45	405	8
9	Repair Leak	2004	630		20	32	32	284	9
10	Replace Locks Medication Room	2004	552		20	28	28	249	10
11	Soy Solve/Dry Wall	2004	742		20	37	37	334	11
12	Repair Walk In Freezer	2004	542		20	27	27	244	12
13	Soy Solve/Dry Wall	2004	740		20	37	37	333	13
14	Fire Sprinkler	2004	1,330		20	67	67	599	14
15	Entry Lever Lock	2004	598		20	30	30	269	15
16	Labor On Cooling Tower Pump	2004	1,526		20	76	76	686	16
17	Storeroom Lever Lock	2004	500		20	25	25	225	17
18	Soy Solve/Dry Wall	2004	514		20	26	26	232	18
19	Soy Solve/Dry Wall	2004	595		20	30	30	268	19
20	Elevator Repair/Maintenance	2004	560		20	28	28	252	20
21	Soy Solve/Dry Wall	2004	631		20	32	32	284	21
22	Elevator Repair/Maintenance	2004	614		20	31	31	277	22
23	7Th Fl Ice Room Counter Top Replacement	2004	537		20	27	27	242	23
24	Soy Solve/Kitchen Swer Treatment	2004	507		20	25	25	228	24
25	Repairs On Front Entrance Sliding Door	2004	1,217		20	61	61	548	25
26	Window Handles	2004	1,680		20	84	84	756	26
27	Emergency Valve Replacement	2004	2,933		20	147	147	1,320	27
28	Taco Seal Kit, Taco Suction Cover O-Ring Lip Oil	2004	533		20	27	27	240	28
29	Fire Sprinkler	2004	830		20	42	42	374	29
30	Resident Room Doors	2005	5,981		20	299	299	1,196	30
31	Furnish & Install Windows	2005	2,900		20	145	145	580	31
32	Garage Door	2005	11,900		20	595	595	2,380	32
33	Heater Air Handler	2005	6,550		20	328	328	1,311	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,928,956	\$ 667,616		\$ 467,529	\$ (200,087)	\$ 3,034,496	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 10,928,956	\$ 667,616		\$ 467,529	\$ (200,087)	\$ 3,034,496	1
2	Security Upgrade	2005	3,600		20	180	180	720	2
3	Hot Water Heater Repair	2005	3,083		20	154	154	616	3
4	Sewer Repair	2005	5,270		20	264	264	1,055	4
5	Computer Wiring	2005	6,264		20	313	313	1,252	5
6	Air Handling Unit	2005	2,160		20	108	108	432	6
7	Decorating	2005	2,175		20	109	109	436	7
8	Hot Water System Repair	2005	2,017		20	101	101	404	8
9	Interior Design Fees	2005	1,853		20	93	93	371	9
10	Kitchen Repair	2005	2,000		20	100	100	400	10
11	Plumbing / Heating	2005	1,560		20	78	78	312	11
12	Wonder Guard Service	2005	3,526		20	176	176	705	12
13	Computer Wiring	2005	1,762		20	88	88	352	13
14	Capitalized Professional Fees	2006	48,156		20	2,408	2,408	9,631	14
15	Flooring, Wallpaper, Shades, Drywall, Lighting, Curtains	2006	161,508		20	8,075	8,075	14,805	15
16	Tie In Kitchen System To Fire Alarm	2006	5,960		20	298	298	1,093	16
17	Lobby Remodel	2006	41,085		20	2,054	2,054	8,217	17
18	16'X73" Ideal Steel Rolling Door	2006	3,150		20	158	158	788	18
19	3 Walk In Freezers	2007	20,790		20	1,040	1,040	1,906	19
20	Kitchen Door	2007	1,651		20	83	83	152	20
21	Replace And New Wood Doors	2007	4,596		20	230	230	422	21
22	Boiler	2007	4,328		20	216	216	432	22
23	Smoke Seal For Doors	2007	3,768		20	188	188	376	23
24	Vinyl Tiles & Materials - 9th Fl Renovations	2008	1,934		20	97	97	97	24
25	Cubical Curtains & Tracks	2008	635		20	32	32	32	25
26	Carpet Installation	2008	9,800		20	82	82	82	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,271,587	\$ 667,616		\$ 484,252	\$ (183,364)	\$ 3,079,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,659,123	\$ 28,226	\$ 103,641	\$ 75,415	10	\$ 657,123	71
72	Current Year Purchases	71,510	93	7,609	7,516	10	7,788	72
73	Fully Depreciated Assets	172,051				10	242,108	73
74								74
75	TOTALS	\$ 1,902,684	\$ 28,319	\$ 111,250	\$ 82,931		\$ 907,019	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 15,674,271	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 695,935	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 595,502	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (100,433)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,986,602	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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	<u>Allocated From Boulevard</u>				<u>50,834</u>			5
6	<u>Storage Rental</u>				<u>6,808</u>			6
7	<b>TOTAL</b>				\$ <u>57,642</u>			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.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 75,900

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$		\$ 708,099	\$		\$ 708,099	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			161,013			161,013	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			913,047			913,047	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				828,326		828,326	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						255,336		255,336	13
14	TOTAL			\$		\$ 1,782,159	\$ 1,083,662		\$ 2,865,821	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 Warren Barr Pavilion# 0046003Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 320,240	\$ 420,603	1
2	Cash-Patient Deposits	51,877	51,877	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,521,862	2,521,862	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,318	60,318	6
7	Other Prepaid Expenses	20,439	20,439	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	610,769	408,258	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,585,505	\$ 3,483,357	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,500,000	13
14	Buildings, at Historical Cost		10,110,000	14
15	Leasehold Improvements, at Historical Cost	776,098	777,523	15
16	Equipment, at Historical Cost	720,622	1,827,382	16
17	Accumulated Depreciation (book methods)	(711,696)	(4,458,954)	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):	112,595	124,230	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 897,619	\$ 10,880,181	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,483,124	\$ 14,363,538	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 634,076	\$ 638,357	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,877	51,877	28
29	Short-Term Notes Payable	1,045,000	1,045,000	29
30	Accrued Salaries Payable	327,036	327,036	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	539,791	539,791	32
33	Accrued Interest Payable		34,938	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	1,287,743	398,643	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,885,523	\$ 3,035,642	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,216,577	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 10,216,577	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,885,523	\$ 13,252,219	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 597,601	\$ 1,111,319	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,483,124	\$ 14,363,538	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (212,556)	1
2	Restatements (describe):		2
3	<b>Rounding</b>	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (212,554)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	810,155	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 810,155</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 597,601</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0046003Report Period Beginning: 01/01/2008Ending: 12/31/2008**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,032,678	1
2	Discounts and Allowances for all Levels	(6,853,483)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,179,195	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,310,305	6
7	Oxygen	5,258	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 6,315,563	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,749	13
14	Non-Patient Meals	3,195	14
15	Telephone, Television and Radio	13,681	15
16	Rental of Facility Space	199,066	16
17	Sale of Drugs	734,228	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	179,725	19
20	Radiology and X-Ray	43,369	20
21	Other Medical Services	228,066	21
22	Laundry	13,646	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,423,725	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,046	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,046	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	3,978	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,978	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 17,923,507	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,949,656	31
32	Health Care	5,882,612	32
33	General Administration	3,777,148	33
<b>B. Capital Expense</b>			
34	Ownership	1,257,464	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,097,693	35
36	Provider Participation Fee	148,779	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 17,113,352	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	810,155	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 810,155	43

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

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

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

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

Facility Name & ID Number Warren Barr Pavilion

# 0046003

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,290	2,534	\$ 124,865	\$ 49.28	1
2	Assistant Director of Nursing	4,161	4,623	164,982	35.69	2
3	Registered Nurses	56,038	62,265	1,572,344	25.25	3
4	Licensed Practical Nurses	37,816	42,018	1,034,147	24.61	4
5	CNAs & Orderlies	155,727	173,031	2,026,487	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,041	5,601	100,328	17.91	9
10	Activity Assistants	8,346	9,273	95,616	10.31	10
11	Social Service Workers	5,727	6,338	137,340	21.67	11
12	Dietician	3,517	3,726	84,795	22.76	12
13	Food Service Supervisor	3,932	4,296	86,462	20.13	13
14	Head Cook	6,180	6,698	84,521	12.62	14
15	Cook Helpers/Assistants	28,676	31,096	319,183	10.26	15
16	Dishwashers					16
17	Maintenance Workers	8,385	9,097	173,911	19.12	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,992	2,152	117,322	54.52	20
21	Assistant Administrator	1,096	1,192	48,293	40.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,942	19,769	257,345	13.02	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	1,948	2,136	36,947	17.30	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	7,291	7,962	211,704	26.59	33
34	TOTAL (lines 1 - 33)	356,104	393,805	\$ 6,676,592 *	\$ 16.95	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		\$		35
36	Medical Director	Monthly	58,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	28,287	10-03	38
39	Pharmacist Consultant	140	8,391	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	165	9,091	10-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	\$ 103,969		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	78	\$ 4,629	10-03	50
51	Licensed Practical Nurses	98	4,539	10-03	51
52	Certified Nurse Assistants/Aides	3,021	82,403	10-03	52
53	TOTAL (lines 50 - 52)	3,197	\$ 91,571		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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 &amp; ID Number Warren Barr Pavilion

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 122,268 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. \$ 148,779  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Plante & Moran, PLLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT