

Facility Name & ID Number Warren Barr Pavilion

0046003 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	98,915	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	98,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	17,199	23,745	20,751	61,695	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,199	23,745	20,751	61,695	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.37%

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 18,572

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	578,736	66,420		645,156		645,156		645,156		1
2	Food Purchase		407,340		407,340		407,340	(711)	406,629		2
3	Housekeeping		488,616		488,616		488,616		488,616		3
4	Laundry		324,119		324,119		324,119		324,119		4
5	Heat and Other Utilities			396,282	396,282		396,282		396,282		5
6	Maintenance	176,117	105	307,415	483,637		483,637		483,637		6
7	Other (specify):*										7
8	TOTAL General Services	754,853	1,286,599	703,697	2,745,149		2,745,149	(711)	2,744,438		8
	B. Health Care and Programs										
9	Medical Director			59,400	59,400		59,400		59,400		9
10	Nursing and Medical Records	4,678,232	389,798	35,269	5,103,299		5,103,299	73,460	5,176,759		10
10a	Therapy										10a
11	Activities	194,049	3,563		197,612		197,612		197,612		11
12	Social Services	138,312			138,312		138,312		138,312		12
13	CNA Training										13
14	Program Transportation			5,820	5,820		5,820		5,820		14
15	Other (specify):*							14,384	14,384		15
16	TOTAL Health Care and Programs	5,010,593	393,361	100,488	5,504,442		5,504,442	87,844	5,592,286		16
	C. General Administration										
17	Administrative	210,766		859,705	1,070,471		1,070,471	(301,417)	769,054		17
18	Directors Fees										18
19	Professional Services			138,972	138,972		138,972		138,972		19
20	Dues, Fees, Subscriptions & Promotions			32,577	32,577		32,577		32,577		20
21	Clerical & General Office Expenses	334,327	43,931	245,204	623,463		623,463	(176,141)	447,322		21
22	Employee Benefits & Payroll Taxes			1,221,805	1,221,805		1,221,805		1,221,805		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,284	11,284		11,284		11,284		24
25	Other Admin. Staff Transportation			132	132		132		132		25
26	Insurance-Prop.Liab.Malpractice			376,774	376,774		376,774		376,774		26
27	Other (specify):*							77,931	77,931		27
28	TOTAL General Administration	545,093	43,931	2,886,455	3,475,479		3,475,479	(399,627)	3,075,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,310,539	1,723,891	3,690,640	11,725,070		11,725,070	(312,494)	11,412,576		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:

01/01/2009

Ending:

12/31/2009

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			142,725	142,725		142,725	617,007	759,732			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							329,565	329,565			32
33	Real Estate Taxes			578,000	578,000		578,000		578,000			33
34	Rent-Facility & Grounds			546,566	546,566		546,566	(481,157)	65,409			34
35	Rent-Equipment & Vehicles			56,040	56,040		56,040	11,410	67,450			35
36	Other (specify):*											36
37	TOTAL Ownership			1,323,331	1,323,331		1,323,331	476,825	1,800,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,075,419	1,751,785	2,827,204		2,827,204	24,100	2,851,304			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,375	148,375		148,375		148,375			42
43	Other (specify):*	228,846		36,685	265,531		265,531	(265,531)				43
44	TOTAL Special Cost Centers	228,846	1,075,419	1,936,844	3,241,109		3,241,109	(241,431)	2,999,678			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,539,385	2,799,310	6,950,815	16,289,511		16,289,511	(77,100)	16,212,411			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,977)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(711)	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	(173,323)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,818)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(332,027)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (523,856)		\$	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)	446,756		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 446,756		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (77,100)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Warren Barr PavilionID# 0046003Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Parking Revenue	\$ (48,082)	32	1
2	Space Rental	(3,567)	32	2
3	Marketing Expense	(265,531)	43	3
4	Building Company - Amortization	(14,538)	36	4
5	Non-Allowable	(309)	21	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				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	(332,027)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(711)	0	0	0	0	0	0	0	0	0	0	(711)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL General Services	(711)	0	0	0	0	0	0	0	0	0	0	(711)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	73,460	0	0	0	0	0	0	0	0	73,460	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	14,384	0	0	0	0	0	0	0	0	14,384	15
16	TOTAL Health Care and Programs	0	0	87,844	0	87,844	16							
	C. General Administration													
17	Administrative	0	0	(301,417)	0	0	0	0	0	0	0	0	(301,417)	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	(176,450)	309	0	0	0	0	0	0	0	0	0	(176,141)	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	77,931	0	0	0	0	0	0	0	0	77,931	27
28	TOTAL General Administration	(176,450)	309	(223,486)	0	(399,627)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,161)	309	(135,642)	0	(312,494)	29							

STATE OF ILLINOIS

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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	(14,977)	617,115	14,869	0	0	0	0	0	0	0	0	617,007	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,649)	381,142	72	0	0	0	0	0	0	0	0	329,565	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)	58,843	0	0	0	0	0	0	0	0	(481,157)	34
35	Rent-Equipment & Vehicles	0	0	11,410	0	0	0	0	0	0	0	0	11,410	35
36	Other (specify):*	(14,538)	14,538	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(81,164)	472,795	85,194	0	0	0	0	0	0	0	0	476,825	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	24,100	0	0	0	0	0	0	0	24,100	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):*	(265,531)	0	0	0	0	0	0	0	0	0	0	(265,531)	43
44	TOTAL Special Cost Centers	(265,531)	0	0	24,100	0	(241,431)	44						
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(523,856)	473,104	(50,448)	24,100	0	0	0	0	0	0	0	(77,100)	45

VII. RELATED PARTIES

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

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

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	<u>34 Rent</u>	\$ <u>540,000</u>	<u>Evergreen Healthcare Realty, LLC</u>	<u>100.00%</u>	\$	<u>(540,000)</u>	1
2	V	<u>32 Interest</u>		<u>Evergreen Healthcare Realty, LLC</u>	<u>100.00%</u>	<u>381,142</u>	<u>381,142</u>	2
3	V	<u>30 Depreciation</u>		<u>Evergreen Healthcare Realty, LLC</u>	<u>100.00%</u>	<u>617,115</u>	<u>617,115</u>	3
4	V	<u>36 Amortization</u>		<u>Evergreen Healthcare Realty, LLC</u>	<u>100.00%</u>	<u>14,538</u>	<u>14,538</u>	4
5	V	<u>21 Miscellaneous</u>		<u>Evergreen Healthcare Realty, LLC</u>	<u>100.00%</u>	<u>309</u>	<u>309</u>	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			\$ 1,013,104	\$ * 473,104	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 859,705	Boulevard Healthcare Mangement, LLC		\$	\$ (859,705)
16	V	10 Nursing & Rehabilitation		Boulevard Healthcare Mangement, LLC		73,460	73,460
17	V	15 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		14,384	14,384
18	V	17 Administrative & General		Boulevard Healthcare Mangement, LLC		558,288	558,288
19	V	27 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		77,931	77,931
20	V	30 Depreciation		Boulevard Healthcare Mangement, LLC		14,869	14,869
21	V	34 Building Rent		Boulevard Healthcare Mangement, LLC		58,843	58,843
22	V	35 Equipment Rent		Boulevard Healthcare Mangement, LLC		11,410	11,410
23	V	32 Interest Expense		Boulevard Healthcare Mangement, LLC		72	72
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		\$ 859,705			\$ 809,257	\$ * (50,448)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 ANCILLARY REHAB	\$ 1,751,785	ADVANCED THERAPY & REHAB, LLC		\$ 1,775,885	\$ 24,100	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		\$ 1,751,785			\$ 1,775,885	\$ * 24,100	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: 01/01/2009 Ending: 12/31/2009

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:

01/01/2009

Ending: 2/31/2009

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	195,885	4	\$ 233,239	\$ 268,857	61,695	\$ 73,460	1
2	15	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	195,885	4	45,672		61,695	14,385	2
3	17	Administrative & General	Patient Days/Direct	195,885	4	1,772,594	1,263,621	61,695	558,288	3
4	27	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	195,885	4	247,436		61,695	77,931	4
5	30	Depreciation	Patient Days/Direct	195,885	4	47,209		61,695	14,869	5
6	34	Building Rent	Patient Days/Direct	195,885	4	186,831		61,695	58,843	6
7	35	Equipment Rent	Patient Days/Direct	195,885	4	36,229		61,695	11,411	7
8	32	Interest Expense	Patient Days/Direct	195,885	4	228		61,695	72	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					\$ 2,569,438	\$ 1,532,478		\$ 809,259	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	ANCILLARY REHAB	DIRECT ALLOCATION		\$	\$		\$ 1,775,885	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				\$	\$		\$ 1,775,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America - Mortgage		X	Mortgage			\$	8,755,487		\$	364,372	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	FIC		X	Line Of Credit				164,202			16,770	6							
7												7							
8												8							
9	TOTAL Facility Related					\$	8,919,689			\$	381,142	9							
B. Non-Facility Related*																			
10	Allocated From Boulevard	X									72	10							
11	Parking/Rent Income	X									(51,649)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related					\$				\$	(51,577)	14							
15	TOTALS (line 9+line14)					\$	8,919,689			\$	329,565	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.)

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

1. Real Estate Tax accrual used on 2008 report.		\$	539,791	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.)		\$	545,108	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,317	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	572,683	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	578,000	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	608,080	8	
	2005	554,834	9	
	2006	505,395	10	
	2007	539,693	11	
	2008	545,108	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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).

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: 14,538 4. Dates Incurred: 2002

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2002</u>	<u>\$ 2,500,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 2,500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		2002	3,081		20	26	26	180
10	Various		2003	431,785		20	17,648	17,648	123,539
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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		10,300,175	518,225		515,009	(3,216)	3,462,616	67
68		6,760	176		338	162	5,335	68
69			142,725			(142,725)		69
70		\$ 10,741,801	\$ 661,126		\$ 533,021	\$ (128,105)	\$ 3,591,670	70

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:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,741,801	\$ 661,126		\$ 533,021	\$ (128,105)	\$ 3,591,670	1
2	Install Fire Pump/Controller	2004	29,425		20	1,471	1,471	8,827	2
3	Wander Guard System	2004	5,651		20	283	283	1,697	3
4	Electrical Work	2004	10,252		20	513	513	3,077	4
5	Elevator Renovation	2004	88,475		20	4,424	4,424	26,544	5
6	Wanderguard	2004	1,740		20	87	87	522	6
7	Phone System Installation	2004	5,990		20	300	300	2,995	7
8	Phone System Installation	2004	900		20	45	45	450	8
9	Repair Leak	2004	630		20	32	32	315	9
10	Replace Locks Medication Room	2004	552		20	28	28	276	10
11	Soy Solve/Dry Wall	2004	742		20	37	37	371	11
12	Repair Walk In Freezer	2004	542		20	27	27	271	12
13	Soy Solve/Dry Wall	2004	740		20	37	37	370	13
14	Fire Sprinkler	2004	1,330		20	67	67	665	14
15	Entry Lever Lock	2004	598		20	30	30	299	15
16	Labor On Cooling Tower Pump	2004	1,526		20	76	76	763	16
17	Storeroom Lever Lock	2004	500		20	25	25	250	17
18	Soy Solve/Dry Wall	2004	514		20	26	26	257	18
19	Soy Solve/Dry Wall	2004	595		20	30	30	298	19
20	Elevator Repair/Maintenance	2004	560		20	28	28	280	20
21	Soy Solve/Dry Wall	2004	631		20	32	32	315	21
22	Elevator Repair/Maintenance	2004	614		20	31	31	307	22
23	7Th Fl Ice Room Counter Top Replacement	2004	537		20	27	27	269	23
24	Soy Solve/Kitchen Swer Treatment	2004	507		20	25	25	254	24
25	Repairs On Front Entrance Sliding Door	2004	1,217		20	61	61	609	25
26	Window Handles	2004	1,680		20	84	84	840	26
27	Emergency Valve Replacement	2004	2,933		20	147	147	1,466	27
28	Taco Seal Kit, Taco Suction Cover O-Ring Lip Oil	2004	533		20	27	27	266	28
29	Fire Sprinkler	2004	830		20	42	42	415	29
30	Resident Room Doors	2005	5,981		20	299	299	1,495	30
31	Furnish & Install Windows	2005	2,900		20	145	145	725	31
32	Garage Door	2005	11,900		20	595	595	2,975	32
33	Heater Air Handler	2005	6,550		20	328	328	1,638	33
34	TOTAL (lines 1 thru 33)		\$ 10,929,876	\$ 661,126		\$ 542,425	\$ (118,702)	\$ 3,651,770	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:

01/01/2009 Ending: 12/31/2009

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 12B, Carried Forward		\$ 10,929,876	\$ 661,126		\$ 542,425	\$ (118,702)	\$ 3,651,770	1
2	Security Upgrade	2005	3,600		20	180	180	900	2
3	Hot Water Heater Repair	2005	3,083		20	154	154	770	3
4	Sewer Repair	2005	5,270		20	264	264	1,318	4
5	Computer Wiring	2005	6,264		20	313	313	1,565	5
6	Air Handling Unit	2005	2,160		20	108	108	540	6
7	Decorating	2005	2,175		20	109	109	545	7
8	Hot Water System Repair	2005	2,017		20	101	101	505	8
9	Interior Design Fees	2005	1,853		20	93	93	463	9
10	Kitchen Repair	2005	2,000		20	100	100	500	10
11	Plumbing / Heating	2005	1,560		20	78	78	390	11
12	Wonder Guard Service	2005	3,526		20	176	176	882	12
13	Computer Wiring	2005	1,762		20	88	88	440	13
14	Capitalized Professional Fees	2006	48,156		20	2,408	2,408	12,039	14
15	Flooring, Wallpaper, Shades, Drywall, Lighting, Curtains	2006	161,508		20	8,075	8,075	22,881	15
16	Tie In Kitchen System To Fire Alarm	2006	5,960		20	298	298	1,391	16
17	Lobby Remodel	2006	41,085		20	2,054	2,054	10,271	17
18	16'X73" Ideal Steel Rolling Door	2006	3,150		20	158	158	945	18
19	3 Walk In Freezers	2007	20,790		20	1,040	1,040	2,945	19
20	Kitchen Door	2007	1,651		20	83	83	234	20
21	Replace And New Wood Doors	2007	4,596		20	230	230	652	21
22	Boiler	2007	4,328		20	216	216	649	22
23	Smoke Seal For Doors	2007	3,768		20	188	188	565	23
24	Vinyl Tiles & Materials - 9th Fl Renovations	2008	1,934		20	97	97	194	24
25	Cubical Curtains & Tracks	2008	635		20	32	32	64	25
26	Carpet Installation	2008	9,800		20	490	490	572	26
27	Domestic Water Heating System	2009	152,320		20	6,347	6,347	6,347	27
28	Masonry Repair (Critical Exam)	2009	9,540		20	318	318	318	28
29	Emergency Repair For Leak In CI Pipe	2009	6,049		20	76	76	76	29
30	Repair Fan In Boiler Fan	2009	4,475		20	56	56	56	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,444,891	\$ 661,126		\$ 566,354	\$ (94,772)	\$ 3,720,785	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	271		2002	1975	\$ 10,110,000	\$ 505,500	20	\$ 505,500	\$ 0	\$ 3,424,509	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Planter Box			2004	1,425	142	20	71	(71)	356	9
10	HVAC Chiller			2005	188,750	12,583	20	9,438	(3,146)	37,751	10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17									0		17
18									0		18
19									0		19
20									0		20
21									0		21
22									0		22
23									0		23
24									0		24
25									0		25
26									0		26
27									0		27
28									0		28
29									0		29
30									0		30
31									0		31
32									0		32
33									0		33
34									0		34
35									0		35
36									0		36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 10,300,175	\$ 518,225		\$ 515,009	\$ (3,216)	\$ 3,462,616	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$ 0	\$	4
5									0		5
6									0		6
7									0		7
8									0		8
	Improvement Type**										
9	Boulevard Healthcare Management		2002		6,760	176	20	338	162	5,335	9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17									0		17
18									0		18
19									0		19
20									0		20
21									0		21
22									0		22
23									0		23
24									0		24
25									0		25
26									0		26
27									0		27
28									0		28
29									0		29
30									0		30
31									0		31
32									0		32
33									0		33
34									0		34
35									0		35
36									0		36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,760	\$ 176		\$ 338	\$ 162	\$ 5,335	70

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:

01/01/2009

Ending:

12/31/2009

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	\$ 1,674,668	\$ 113,425	\$ 190,037	\$ 76,612	10	\$ 1,212,239	71
72	Current Year Purchases	53,361	156	3,339	3,183	10	3,283	72
73	Fully Depreciated Assets	271,154				10	271,154	73
74								74
75	TOTALS	\$ 1,999,183	\$ 113,581	\$ 193,376	\$ 79,795		\$ 1,486,676	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)	\$ 15,944,074	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 774,707	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 759,732	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,977)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,207,461	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	<u>Allocated From Boulevard</u>			<u>58,843</u>			5
6	<u>Storage Rental</u>			<u>6,566</u>			6
7	TOTAL			\$ <u>65,409</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 67,450 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 713,294	\$		\$ 713,294	1
2	Licensed Speech and Language Development Therapist		hrs			274,857			274,857	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			787,734			787,734	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				797,258		797,258	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>						278,161		278,161	13
14	TOTAL			\$		\$ 1,775,885	\$ 1,075,419		\$ 2,851,304	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**# **0046003**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 255,347	\$ 308,665	1
2	Cash-Patient Deposits	42,783	42,783	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,658,959	1,658,958	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,226	63,226	6
7	Other Prepaid Expenses	33,247	33,247	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	86,043	86,043	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,139,605	\$ 2,192,922	10
B. Long-Term Assets				
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	948,482	949,907	15
16	Equipment, at Historical Cost	771,426	1,878,186	16
17	Accumulated Depreciation (book methods)	(854,421)	(5,218,795)	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):	443,428	25,034	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,308,915	\$ 10,244,332	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,448,520	\$ 12,437,254	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 527,580	\$ 527,580	26
27	Officer's Accounts Payable	42,783	42,783	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		329,868	29
30	Accrued Salaries Payable	309,004	309,004	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	572,683	572,683	32
33	Accrued Interest Payable	164,202	207,409	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,980	6,980	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	337,019	259,773	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,960,251	\$ 2,256,080	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,755,487	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)	\$	\$ 8,755,487	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,960,251	\$ 11,011,567	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,488,270	\$ 1,425,687	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,448,520	\$ 12,437,254	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 597,601	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 597,601	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	860,463	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	30,206	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)	\$ 890,669	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)	\$ 1,488,270	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,653,963	1
2	Discounts and Allowances for all Levels	(7,384,914)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,269,048	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,569,290	6
7	Oxygen	509	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,569,799	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	5,494	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,567	16
17	Sale of Drugs	716,308	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	197,519	19
20	Radiology and X-Ray	49,748	20
21	Other Medical Services	290,408	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,263,044	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Parking Revenue</u>	48,082	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,082	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,149,973	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,745,149	31
32	Health Care	5,504,442	32
33	General Administration	3,475,479	33
B. Capital Expense			
34	Ownership	1,323,331	34
C. Ancillary Expense			
35	Special Cost Centers	3,092,735	35
36	Provider Participation Fee	148,375	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,289,511	40
41	Income before Income Taxes (line 30 minus line 40)**	860,463	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 860,463	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:

01/01/2009

Ending:

12/31/2009

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	5,751	7,389	\$ 263,777	\$ 35.70	1
2	Assistant Director of Nursing	12,757	14,418	454,094	31.50	2
3	Registered Nurses	22,843	30,655	983,908	32.10	3
4	Licensed Practical Nurses	31,491	42,544	992,764	23.33	4
5	CNAs & Orderlies	139,821	153,317	1,946,152	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,759	5,252	93,310	17.77	9
10	Activity Assistants	7,752	8,620	100,739	11.69	10
11	Social Service Workers	4,766	5,138	138,312	26.92	11
12	Dietician					12
13	Food Service Supervisor	1,712	1,866	49,943	26.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,760	39,541	528,793	13.37	15
16	Dishwashers					16
17	Maintenance Workers	7,337	8,066	176,117	21.84	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,923	2,121	125,404	59.12	20
21	Assistant Administrator	1,793	2,014	85,362	42.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,725	21,921	334,327	15.25	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	1,728	1,950	37,537	19.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	8,308	8,531	228,846	26.82	33
34	TOTAL (lines 1 - 33)	308,225	353,345	\$ 6,539,385 *	\$ 18.51	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	59,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	6,687	10-03	38
39	Pharmacist Consultant	106	6,367	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	31	1,694	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)	137	\$ 74,148		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	47	\$ 1,368	10-03	50
51	Licensed Practical Nurses	24	1,574	10-03	51
52	Certified Nurse Assistants/Aides	752	17,579	10-03	52
53	TOTAL (lines 50 - 52)	823	\$ 20,521		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Megan Mulherin	Administrator		\$ 125,404	Workers' Compensation Insurance	\$ 95,919	IDPH License Fee	\$	
Katey Dorney	Assistant Administrator		85,362	Unemployment Compensation Insurance	127,516	Advertising: Employee Recruitment	3,700	
				FICA Taxes	498,134	Health Care Worker Background Check		
				Employee Health Insurance	419,339	(Indicate # of checks performed <u>105</u>)	1,050	
				Employee Meals		Patient Background Checks	541 5,410	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	21,659	
				Employee Welfare	4,501	Administrative Subscriptions	758	
				Holiday Party	1,590			
				Employee Disability Insurance	10,413			
				401k Expense	62,669			
				Employee Life Insurance	1,723			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 210,766	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,221,805		\$ 32,577		
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
Management Fees - Boulevard Healthcare Management			\$ 859,705				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 859,705				Seminar Expense	11,284
				TOTAL			Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 11,284
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Legal		\$ 1,044					
Gould & Ratner, LLP	Legal		486					
Pretzel & Stouffer, Chartered	Legal		11,220					
Ungaretti & Harris	Legal		10,986					
Vedder, Price, Kaufman & Kammho	Legal		10,225					
Plante & Moran, PLLC	Accounting		54,155					
ADP, Inc	Data Processing		33,451					
AT&T	Data Processing		17,406					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 138,972					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

