

Facility Name & ID Number Warren Barr Pavilion

0046003 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,761	22,547	21,592	58,900	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,761	22,547	21,592	58,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.55%

D. How many bed-hold days during this year were paid by the Department?

0 (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 12/01/02

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

YES Date 12/01/02 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 17,978

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: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	249,154	30,372	588,627	868,153	868,153		868,153			1
2	Food Purchase		208,627		208,627	208,627	(7)	208,620			2
3	Housekeeping			423,956	423,956	423,956		423,956			3
4	Laundry			289,304	289,304	289,304		289,304			4
5	Heat and Other Utilities			416,489	416,489	416,489		416,489			5
6	Maintenance	136,559	52,138	237,430	426,127	426,127	2,968	429,095			6
7	Other (specify):*										7
8	TOTAL General Services	385,713	291,137	1,955,806	2,632,656	2,632,656	2,961	2,635,617			8
	B. Health Care and Programs										
9	Medical Director			59,400	59,400	59,400		59,400			9
10	Nursing and Medical Records	4,925,347	391,015	26,288	5,342,650	5,342,650	66,928	5,409,578			10
10a	Therapy										10a
11	Activities	193,309	4,803	646	198,758	198,758		198,758			11
12	Social Services	147,484			147,484	147,484		147,484			12
13	CNA Training										13
14	Program Transportation			20,701	20,701	20,701		20,701			14
15	Other (specify):*						14,166	14,166			15
16	TOTAL Health Care and Programs	5,266,140	395,818	107,035	5,768,993	5,768,993	81,094	5,850,087			16
	C. General Administration										
17	Administrative	160,656		826,800	987,456	987,456	(294,952)	692,504			17
18	Directors Fees										18
19	Professional Services			100,913	100,913	100,913		100,913			19
20	Dues, Fees, Subscriptions & Promotions			78,011	78,011	78,011	(48,309)	29,702			20
21	Clerical & General Office Expenses	242,134	39,185	677,261	958,580	958,580	(609,102)	349,478			21
22	Employee Benefits & Payroll Taxes			1,161,706	1,161,706	1,161,706		1,161,706			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,179	1,179	1,179		1,179			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			337,506	337,506	337,506		337,506			26
27	Other (specify):*						93,275	93,275			27
28	TOTAL General Administration	402,790	39,185	3,183,376	3,625,351	3,625,351	(859,088)	2,766,263			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,054,643	726,140	5,246,217	12,027,000	12,027,000	(775,033)	11,251,967			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:

01/01/10

Ending:

12/31/10

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			145,600	145,600		145,600	629,725	775,325			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,476	3,476		3,476	405,289	408,765			32
33	Real Estate Taxes			678,049	678,049		678,049	(128,337)	549,712			33
34	Rent-Facility & Grounds			546,933	546,933		546,933	(481,506)	65,427			34
35	Rent-Equipment & Vehicles			43,652	43,652		43,652	9,551	53,203			35
36	Other (specify):*											36
37	TOTAL Ownership			1,417,710	1,417,710		1,417,710	434,722	1,852,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		840,817	1,873,302	2,714,119		2,714,119	62,804	2,776,923			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,373	148,373		148,373		148,373			42
43	Other (specify):* Supplemental	239,164		10,736	249,900		249,900	(249,900)				43
44	TOTAL Special Cost Centers	239,164	840,817	2,032,411	3,112,392		3,112,392	(187,096)	2,925,296			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,293,807	1,566,957	8,696,338	16,557,102		16,557,102	(527,407)	16,029,695			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

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 4 Supplemental Schedule

Description	Amount	Allowable
Line 43 - Salary		
Marketing	239,164	-
	<u>239,164</u>	
Line 43 - Other		
Marketing Mileage Reimbursement	10,736	-
	<u>10,736</u>	

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	(7)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,760)	21		5
6	Rented Facility Space	(24,497)	32		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,221)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,328)	21		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	(594,014)	21		24
25	Fund Raising, Advertising and Promotional	(48,309)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(421,506)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,099,642)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	572,235		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 572,235		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (527,407)		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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Warren Barr Pavilion

ID# 0046003

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Parking Fees	\$ (6,000)	21	1
2	Parking Revenue	(31,155)	32	2
3	Marketing Expenses	(249,900)	43	3
4	Real Estate Tax Expense	(128,337)	33	4
5				5
6				6
7	Warren Barr Pavilion Realty, LLC - Office	(307)	21	7
8	Warren Barr Pavilion Realty, LLC - Amortization	(5,807)	36	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	(421,506)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7)	0	0	0	0	0	0	0	0	0	0	(7)	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	2,968	0	0	0	0	0	0	0	0	2,968	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7)	0	2,968	0	2,961	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	66,928	0	0	0	0	0	0	0	0	66,928	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	14,166	0	0	0	0	0	0	0	0	14,166	15
16	TOTAL Health Care and Programs	0	0	81,094	0	81,094	16							
	C. General Administration													
17	Administrative	0	0	(294,952)	0	0	0	0	0	0	0	0	(294,952)	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	(48,309)	0	0	0	0	0	0	0	0	0	0	(48,309)	20
21	Clerical & General Office Expenses	(609,409)	307	0	0	0	0	0	0	0	0	0	(609,102)	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	93,275	0	0	0	0	0	0	0	0	93,275	27
28	TOTAL General Administration	(657,718)	307	(201,677)	0	(859,088)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(657,725)	307	(117,615)	0	(775,033)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/10 Ending:

12/31/10

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	0	617,115	12,610	0	0	0	0	0	0	0	0	629,725	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,873)	463,162	0	0	0	0	0	0	0	0	0	405,289	32
33	Real Estate Taxes	(128,337)	0	0	0	0	0	0	0	0	0	0	(128,337)	33
34	Rent-Facility & Grounds	0	(540,000)	58,494	0	0	0	0	0	0	0	0	(481,506)	34
35	Rent-Equipment & Vehicles	0	0	9,551	0	0	0	0	0	0	0	0	9,551	35
36	Other (specify):*	(5,807)	5,807	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(192,017)	546,084	80,655	0	0	0	0	0	0	0	0	434,722	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	62,804	0	0	0	0	0	0	0	62,804	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):*	(249,900)	0	0	0	0	0	0	0	0	0	0	(249,900)	43
44	TOTAL Special Cost Centers	(249,900)	0	0	62,804	0	(187,096)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,099,642)	546,391	(36,960)	62,804	0	(527,407)	45						

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Supplemental Schedule		See Supplemental Schedule		See Supp. Schedule		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 540,000	Warren Barr Pavilion Realty, LLC	100.00%	\$	\$ (540,000)	1
2	V	21 Office		Warren Barr Pavilion Realty, LLC	100.00%	307	307	2
3	V	30 Depreciation		Warren Barr Pavilion Realty, LLC	100.00%	617,115	617,115	3
4	V	32 Interest		Warren Barr Pavilion Realty, LLC	100.00%	463,162	463,162	4
5	V	36 Amortization		Warren Barr Pavilion Realty, LLC	100.00%	5,807	5,807	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			\$ 1,086,391	\$ * 546,391	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 6 Supplemental Schedule - Related Party

Warren Barr Pavilion Realty, LLC	Building Company
Boulevard Healthcare Management, LLC	Management Company
Advanced Therapy and Rehab, LLC	Therapy Company
Evergreen Health Care Center, LLC	Nursing Home
Ridgewood Health Care Center, LLC	Nursing Home
Westlake Health Care Center, LLC	Nursing Home

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 Fee	\$ 826,800	Boulevard Healthcare Management, LLC	100.00%	\$	\$ (826,800)
16	V	6 Maintenance & Minor Equipment		Boulevard Healthcare Management, LLC	100.00%	2,968	2,968
17	V	10 Nursing & Rehabilitation		Boulevard Healthcare Management, LLC	100.00%	66,928	66,928
18	V	15 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	14,166	14,166
19	V	17 Administrative and General		Boulevard Healthcare Management, LLC	100.00%	531,848	531,848
20	V	27 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	93,275	93,275
21	V	30 Depreciation		Boulevard Healthcare Management, LLC	100.00%	12,610	12,610
22	V	34 Building Rent		Boulevard Healthcare Management, LLC	100.00%	58,494	58,494
23	V	35 Equipment Rent		Boulevard Healthcare Management, LLC	100.00%	9,551	9,551
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		\$ 826,800			\$ 789,840	\$ * (36,960)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Services	\$ 1,647,152	Advanced Therapy & Rehab, LLC	100.00%	\$ 1,709,956	\$ 62,804	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			\$ 1,647,152			\$ 1,709,956	\$ * 62,804	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:

01/01/10

Ending:

12/31/10

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:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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:

01/01/10

Ending: 12/31/10

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 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 (847) 720 - 8701

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maint. & Minor Equipment	Census	188,127	4	\$ 9,480	\$ 58,900	\$ 2,968	1	
2	10	Nursing & Rehabilitation	Census	188,127	4	213,767	213,767	58,900	66,928	2
3	15	Payroll Taxes, Fringes, Staff	Census	188,127	4	45,247	58,900	14,166	3	
4	17	Administrative and General	Census	188,127	4	1,698,727	1,256,428	58,900	531,848	4
5	27	Payroll Taxes, Fringes, Staff	Census	188,127	4	297,920	58,900	93,275	5	
6	30	Depreciation	Census	188,127	4	40,276	58,900	12,610	6	
7	34	Building Rent	Census	188,127	4	186,831	58,900	58,494	7	
8	35	Equipment Rental	Census	188,127	4	30,506	58,900	9,551	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					\$ 2,522,754	\$ 1,470,195	\$ 789,840	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 (847) 720 - 8701

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 Services	Billing	4,725,493	4	\$ 4,905,671	\$ 3,567,091	1,647,152	\$ 1,709,956	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					\$ 4,905,671	\$ 3,567,091		\$ 1,709,956	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10

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		X	Mortgage			\$	\$ 8,505,818		\$ 463,162	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	FIC		X	Line of Credit				\$ 20,000		\$ 3,476	6								
7											7								
8											8								
9	TOTAL Facility Related						\$	\$ 8,525,818		\$ 466,638	9								
B. Non-Facility Related*																			
10	Interest Income		X							\$ (2,221)	10								
11	Parking / Rental Income		X							\$ (55,652)	11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (57,873)	14								
15	TOTALS (line 9+line14)						\$	\$ 8,525,818		\$ 408,765	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 bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	572,683	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.)		\$	532,318	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(40,365)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	590,077	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.		\$	549,712	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	554,834	8
	2006	505,395	9
	2007	539,693	10
	2008	545,108	11
	2009	532,318	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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:

01/01/10

Ending:

12/31/10

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Barr Pavilion# 0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10**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	271		2002	1975	\$ 10,110,000	\$ 505,500	20	\$ 505,500		\$ 4,086,125	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	The building costs above and leasehold improvements listed										
10	below are captured on Warren Barr Pavilion Realty, LLC										
11											11
12	Various		2004		1,425	807	10	807		890	12
13	Various		2005		188,750	12,583	15	12,583		67,111	13
14											14
15											15
16	The following leasehold improvement cost listed below are										
17	captured on Boulevard Healthcare Magement, LLC.										
18											18
19	Various		2002		6,719	672	10	672		6,179	19
20											20
21											21
22	The leasehold improvements listed below are captured on										
23	the books of Warren Barr Pavilion:										
24											24
25	Various		2002		3,081	308	10	308		2,491	25
26	Various		2003		431,785	28,856	7 - 20	28,856		275,887	26
27	Various		2004		160,741	8,546	7 - 20	8,546		58,380	27
28	Various		2005		62,601	1,800	10 - 20	1,800		1,800	28
29	Various		2006		259,859	18,225	10 - 20	18,225		83,672	29
30	Walk in Freezers (3)		2007		20,790	4,158	5	4,158		15,593	30
31	Kitchen Door		2007		1,651	330	5	330		1,211	31
32	Doors - Wood		2007		4,596	460	10	460		1,609	32
33	Boiler		2007		4,328	433	10	433		1,516	33
34	Doors - Smoke Seal		2007		3,768	377	10	377		1,320	34
35	Vinyl Tile and Materials		2008		1,934	193	10	193		580	35
36	Cubicle Curtains and Tracks		2008		635	63	10	63		190	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:

01/01/10

Ending:

12/31/10

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 Carpet Installation	2008	\$ 9,800	\$ 980	10	\$ 980	\$	\$ 2,205	37
38 Water Heater System	2009	152,320	15,232	10	15,232		29,195	38
39 Masonry Repair	2009	9,540	954	10	954		1,670	39
40 CI Pipe Repair	2009	6,049	605	10	605		807	40
41 Boiler Fan Repair	2009	40,140	4,014	10	4,014		4,572	41
42 Trough Collector	2010	7,641	700	10	700		700	42
43 Front Door	2010	6,100	508	10	508		508	43
44 Board Replacement (Security Doors and Badges)	2010	2,825	212	10	212		212	44
45 8th Floor Renovations (Paint, Cubicle Curtains, Electrical, Cornices, Shades, Signs, Wallmount Plates)	2010	34,692	4,626	5	4,626		4,626	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)		\$ 11,531,770	\$ 611,142		\$ 611,142	\$	\$ 4,649,048	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:

01/01/10

Ending:

12/31/10

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	\$ 559,370	\$ 45,693	\$ 45,693	\$	5	\$ 503,614	71
72	Current Year Purchases	57,994	7,663	7,663		5	7,663	72
73	Fully Depreciated Assets							73
74	See Supplemental Schedule	1,214,587	110,827	110,827		5 - 10	1,100,006	74
75	TOTALS	\$ 1,831,951	\$ 164,183	\$ 164,183	\$		\$ 1,611,283	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)	\$ 15,863,721	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 775,325	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 775,325	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,260,331	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

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Warren Barr Pavilion Realty, LLC			
Prior	918,010	98,889	827,362
Current	-	-	-
Total	918,010	98,889	827,362
Boulevard Healthcare Management, LLC			
Prior	291,939	11,215	271,922
Current	4,638	722	722
Total	296,577	11,938	272,644
Total	1,214,587	110,827	1,100,006

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	Storage				6,933			5
6	Alloc. Blvd				58,494			6
7	TOTAL				\$ 65,427			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: \$ 53,203 Description: Copier - \$41,436, Dishwash Machine - \$2,216, Alloc. - Boulevard, LLC - \$9,551

(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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 654,463	\$	\$	654,463	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			192,202		192,202		2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			803,013		803,013		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				792,975	792,975		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Supplemental</u>	39 - 02					47,842	47,842		12
13	Other (specify): <u>See Supplemental</u>	39 - 03				223,624		223,624		13
14	TOTAL			\$		\$ 1,873,302	\$ 840,817	\$	2,714,119	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

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen	30,777	
IV Therapy Drugs and Supplies	4,325	
Medical Supplies	12,740	
Complex Medical Equipment		65,620
Lab		19,931
Radiology		23,145
Specialty Beds		93,831
Other Consolidated Billing Services		21,097
	<hr/> <hr/>	<hr/> <hr/>
	47,842	223,624

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning: 01/01/10

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 182,166	\$ 250,675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,524,013	1,524,013	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,302	57,302	6
7	Other Prepaid Expenses	25,214	25,214	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Supplementary Schedule</u>	963,803	409,790	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,752,498	\$ 2,266,994	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	1,000,713	1,002,138	15
16	Equipment, at Historical Cost	841,527	1,948,287	16
17	Accumulated Depreciation (book methods)	(1,000,020)	(5,981,508)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Supplementary Schedule</u>	24,902	33,613	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 867,122	\$ 9,612,530	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,619,620	\$ 11,879,524	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 960,225	\$ 960,225	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	20,000	269,669	29
30	Accrued Salaries Payable	273,319	273,319	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,155	7,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,077	590,077	32
33	Accrued Interest Payable		40,399	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Supplementary Schedule</u>	328,611	328,611	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,179,387	\$ 2,469,455	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,505,818	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)	\$	\$ 8,505,818	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,179,387	\$ 10,975,273	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,440,233	\$ 904,251	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,619,620	\$ 11,879,524	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Intercompany System Receivables	298,128	408,864
Due to Warren Barr Pavilion Realty, LLC	664,749	-
Security Deposit	926	926
	<u>963,803</u>	<u>409,790</u>
Line 23 - Other Long Term Assets		
Construction in Progress	24,902	24,902
Finance Fees (Net of Amortization)		8,711
	<u>24,902</u>	<u>33,613</u>
Line 36 - Other Current Liabilities		
Intercompany System Payable	328,611	328,611
	<u>328,611</u>	<u>328,611</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,488,270	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,488,270	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(17,831)	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)	\$ (48,037)	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)	\$ 1,440,233	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,350,125	1
2	Discounts and Allowances for all Levels	(7,287,030)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,063,095	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,186,075	6
7	Oxygen	10,815	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,196,890	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	4,944	13
14	Non-Patient Meals	7	14
15	Telephone, Television and Radio	6,760	15
16	Rental of Facility Space	24,497	16
17	Sale of Drugs	681,192	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	170,689	19
20	Radiology and X-Ray	47,251	20
21	Other Medical Services	297,639	21
22	Laundry	9,452	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,242,431	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,221	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,221	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Supplementary Schedule</u>	34,634	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,634	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,539,271	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,632,656	31
32	Health Care	5,768,993	32
33	General Administration	3,625,351	33
B. Capital Expense			
34	Ownership	1,417,710	34
C. Ancillary Expense			
35	Special Cost Centers	2,964,019	35
36	Provider Participation Fee	148,373	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,557,102	40
41	Income before Income Taxes (line 30 minus line 40)**	(17,831)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (17,831)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Vending Commission	3,004	
Parking Revenue	31,155	ADJ - Page 5
Returned Check Fees	475	
	<u>34,634</u>	

Facility Name & ID Number Warren Barr Pavilion

0046003

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	5,496	7,061	\$ 255,876	\$ 36.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	46,900	59,380	1,922,858	32.38	3
4	Licensed Practical Nurses	28,617	38,661	915,483	23.68	4
5	CNAs & Orderlies	117,800	129,170	1,663,756	12.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,952	5,465	98,563	18.04	9
10	Activity Assistants	7,181	7,985	94,746	11.87	10
11	Social Service Workers	5,007	5,398	147,484	27.32	11
12	Dietician					12
13	Food Service Supervisor	901	982	26,667	27.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,827	16,395	222,487	13.57	15
16	Dishwashers					16
17	Maintenance Workers	5,603	6,160	136,559	22.17	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,000	2,080	117,307	56.40	20
21	Assistant Administrator	1,000	1,040	43,349	41.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,076	15,643	242,134	15.48	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	1,611	1,818	35,517	19.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supplemental</u>	14,556	15,026	371,021	24.69	33
34	TOTAL (lines 1 - 33)	270,527	312,264	\$ 6,293,807 *	\$ 20.16	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	59,400	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,263	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	17,025	10 - 03	42
43	Speech Therapy Consultant			43
44	Activity Consultant	646	11 - 03	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 86,334		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Line 33 - Other Salary			
Unit Secretary	4,000	4,160	89,674
Central Supply	2,000	2,080	42,183
Marketing (Adjusted Out Page 5)	8,556	8,786	239,164
	<u>14,556</u>	<u>15,026</u>	<u>371,021</u>

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	
Ken Kolich	Administrator	0	\$ 117,307	Workers' Compensation Insurance	\$ 138,495	IDPH License Fee	\$	
Katherine Cao	Asst. Admin.	0	43,349	Unemployment Compensation Insurance	119,665	Advertising: Employee Recruitment	3,831	
				FICA Taxes	469,488	Health Care Worker Background Check	1,120	
				Employee Health Insurance	353,494	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	5,990	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	758	
				Pension Expense	60,731	Licenses	18,003	
				Dental / Vision Insurance	2,847	Advertising and Marketing	48,309	
				Life Insurance	4,622			
				Disability / Accident Insurance	7,162			
				Employee Welfare	5,202			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,656	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,161,706		
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
Boulevard Healthcare Management, LLC			\$ 826,800				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 826,800				In-State Travel	107
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount					
Plante & Moran, PLLC	Accounting / Audit		\$ 52,908				1,072	
Gould & Ratner, LLP	Legal		4,756					
Klafter & Burke	Legal		6,799					
Louis A. Reiff	Legal		935					
Pretzel & Stouffer, Chartered	Legal		7,526					
Ungaretti & Harris	Legal		296					
Vedder, Price, Kaufman & Kamm	Legal		1,845					
ADP, Inc.	Payroll Processing		5,582					
Paycom	Payroll Processing		6,224					
Security Insurance	Insurance Broker		6,167					
Surequest Systems	Data Processing		520					
Other Professional Services	Other Professional		7,355					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 100,913				TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 29,702	
							\$ 1,179	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

**Warren Barr Pavilion
Medicaid Cost Report
01/01/10 - 12/31/10**

Page 21 Supplemental Schedule

Vendor	Amount	Allowable
Gould & Ratner, LLP	525	525
Gould & Ratner, LLP	204	204
Gould & Ratner, LLP	333	333
Gould & Ratner, LLP	1,673	1,673
Gould & Ratner, LLP	629	629
Gould & Ratner, LLP	405	405
Gould & Ratner, LLP	987	987
Klafter & Burke	6,799	6,799
Louis A. Reiff	935	935
Ungaretti & Harris	296	296
Vedder, Price, Kaufman & Kamm	403	403
Vedder, Price, Kaufman & Kamm	1,442	1,442
Pretzel & Stouffer, Chartered	75	75
Pretzel & Stouffer, Chartered	934	934
Pretzel & Stouffer, Chartered	100	100
Pretzel & Stouffer, Chartered	75	75
Pretzel & Stouffer, Chartered	251	251
Pretzel & Stouffer, Chartered	200	200
Pretzel & Stouffer, Chartered	587	587
Pretzel & Stouffer, Chartered	225	225
Pretzel & Stouffer, Chartered	50	50
Pretzel & Stouffer, Chartered	175	175
Pretzel & Stouffer, Chartered	375	375
Pretzel & Stouffer, Chartered	200	200
Pretzel & Stouffer, Chartered	306	306
Pretzel & Stouffer, Chartered	1,060	1,060
Pretzel & Stouffer, Chartered	101	101
Pretzel & Stouffer, Chartered	168	168
Pretzel & Stouffer, Chartered	275	275
Pretzel & Stouffer, Chartered	1,840	1,840
Pretzel & Stouffer, Chartered	175	175
Pretzel & Stouffer, Chartered	100	100
Pretzel & Stouffer, Chartered	255	255
	<u>22,158</u>	<u>22,158</u>

Facility Name & ID Number Warren Barr Pavilion

Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

