

Facility Name & ID Number BOULEVARD CARE CENTER

0032276 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	155	Skilled (SNF)	155	56,575	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	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			4,486	4,486	8	
9	SNF/PED					9	
10	ICF	47,287	815		48,102	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	47,287	815	4,486	52,588	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.95%

D. How many bed-hold days during this year were paid by the Department? 1,077 (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 05/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 21 and days of care provided 4,486

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **BOULEVARD CARE CENTER** # **0032276** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	177,514	23,224	14,003	214,741		214,741		214,741		1
2	Food Purchase		204,307		204,307	(19,217)	185,090	(273)	184,817		2
3	Housekeeping	130,557	26,375		156,932		156,932		156,932		3
4	Laundry	54,325	16,152		70,477		70,477		70,477		4
5	Heat and Other Utilities			132,903	132,903		132,903	55	132,958		5
6	Maintenance	89,809	14,078	42,911	146,798		146,798	7,380	154,178		6
7	Other (specify):*			12,810	12,810		12,810	42	12,852		7
8	TOTAL General Services	452,205	284,136	202,627	938,968	(19,217)	919,751	7,204	926,955		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,382,181	68,894	77,880	1,528,955		1,528,955	(41,933)	1,487,022		10
10a	Therapy	85,362	2,619	100,488	188,469		188,469	(1,345)	187,124		10a
11	Activities	60,879	4,622	12,341	77,842		77,842		77,842		11
12	Social Services	110,856			110,856		110,856		110,856		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,639,278	76,135	197,909	1,913,322		1,913,322	(43,278)	1,870,044		16
	C. General Administration										
17	Administrative	148,140		218,250	366,390		366,390	(40,346)	326,044		17
18	Directors Fees										18
19	Professional Services			236,940	236,940		236,940	(174,489)	62,451		19
20	Dues, Fees, Subscriptions & Promotions			7,685	7,685		7,685	629	8,314		20
21	Clerical & General Office Expenses	128,118	11,097	282,669	421,884		421,884	(165,350)	256,534		21
22	Employee Benefits & Payroll Taxes			355,742	355,742	19,217	374,959		374,959		22
23	Inservice Training & Education							1,430	1,430		23
24	Travel and Seminar			125	125		125	278	403		24
25	Other Admin. Staff Transportation			237	237		237	3,172	3,409		25
26	Insurance-Prop.Liab.Malpractice			214,367	214,367		214,367	1,610	215,977		26
27	Other (specify):*							62,280	62,280		27
28	TOTAL General Administration	276,258	11,097	1,316,015	1,603,370	19,217	1,622,587	(310,786)	1,311,801		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,367,741	371,368	1,716,551	4,455,660		4,455,660	(346,860)	4,108,800		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	13,034
	REPAIRS & MAINTENANCE		969
			0
			14,003
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		62,856
	ELECTRICITY		46,873
	WATER		23,174
	CABLE TV - LOBBY		0
			0
			132,903
6	MAINTENANCE		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		13,707
	ELEVATOR MAINTENANCE & REPAIR		5,209
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		5,400
	FIRE SERVICE		18,595
			0
			0
			0
			42,911
7	OTHER		
	SCAVENGER		12,810
	SECURITY SERVICE		0
			12,810
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,200
			7,200

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,440
	PHARMACY CONSULTANT	XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES	XVIII B __-2	50,000
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	25,000
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			77,880
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		7,884
	SPEECH THERAPY SERVICES		95
	OCCUPATIONAL THERAPY SERVICES		2,672
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	THERAPY CONTRACT SERVICES	XVIII B 43-2	79,037
			100,488
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		10,119
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,222
			0
			12,341
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	218,250
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,205
	ADMINISTRATIVE CONSULTANTS XIX C	168,000
	PROFESSIONAL FEES XIX C	43,735
		0
		236,940
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,970
	EMPLOYEE WANT ADS XIX F	1,000
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,295
	LICENSES & PERMITS XIX F	1,920
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		7,685
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,522
	OUTSIDE CLERICAL SERVICES	93,000
	PENALTIES / OVERDRAFT CHARGES VI 18	29,291
	HOME OFFICE EXPENSE	129,885
	THEFT & DAMAGE LOSS	0
	TELEPHONE	23,971
	MESSENGER SERVICE	0
		0
		282,669

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	178,180
	UNEMPLOYMENT COMPENSATION XIX D	60,261
	WORKERS COMPENSATION INSURANCE XIX D	40,609
	HOSPITALIZATION INSURANCE XIX D	48,819
	EMPLOYEE BENEFITS - OTHER XIX D	1,500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	22,537
	CHICAGO HEAD TAX XIX D	3,836
		355,742
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	125
	TRAVEL XIX G	0
		0
		0
		125
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	237
		237
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	214,367
		214,367
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,716,551

BOULEVARD CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	204,307	PATIENT MEALS	157764
LESS SALES TAX	(273)	ADD EMPLOYEE MEALS	16425
	-----		-----
NET FOOD	204,034	TOTAL MEALS/YEAR	174189
TOTAL PATIENT CENSUS	52,588	NET FOOD	204034
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	174189

TOTAL PATIENT MEALS	157764	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	19217
	-----		=====
TOTAL EMPLOYEE MEALS	16425		

Facility Name & ID Number **BOULEVARD CARE CENTER**

#0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,981	48,981		48,981	137,919	186,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,624	56,624		56,624	434,489	491,113			32
33	Real Estate Taxes			194,729	194,729		194,729		194,729			33
34	Rent-Facility & Grounds			495,451	495,451		495,451	(495,451)				34
35	Rent-Equipment & Vehicles			56,055	56,055		56,055	(35,182)	20,873			35
36	Other (specify):*											36
37	TOTAL Ownership			851,840	851,840		851,840	41,775	893,615			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,699	355,946	483,645		483,645	(36,089)	447,556			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		127,699	440,809	568,508		568,508	(36,089)	532,419			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,367,741	499,067	3,009,200	5,876,008		5,876,008	(341,174)	5,534,834			45

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

Facility Name & ID Number **BOULEVARD CARE CENTER**

0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	OHF 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	7,389	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	(273)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(29,291)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(2,970)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE PAGE 5 A</u>	340			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,305)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(315,869)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (315,869)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (341,174)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BOULEVARD CARE CENTER

ID# 0032276

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 340	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	340	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BOULEVARD CARE CENTER**# **0032276**

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**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)	
1	A. General Services													
	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(273)	0	0	0	0	0	0	0	0	0	0	(273)	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	55	0	0	0	0	0	0	0	0	0	55	5
6	Maintenance	340	7,040	0	0	0	0	0	0	0	0	0	7,380	6
7	Other (specify):*	0	0	42	0	0	0	0	0	0	0	0	42	7
8	TOTAL General Services	67	7,095	42	0	0	0	0	0	0	0	0	7,204	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	(75,000)	33,067	0	0	0	0	0	0	0	0	(41,933)	10
10a	Therapy	0	0	3,164	(4,509)	0	0	0	0	0	0	0	(1,345)	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	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(75,000)	36,231	(4,509)	0	(43,278)	16						
	C. General Administration													
17	Administrative	0	(144,000)	103,654	0	0	0	0	0	0	0	0	(40,346)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(180,000)	5,511	0	0	0	0	0	0	0	0	(174,489)	19
20	Fees, Subscriptions & Promotions	(3,470)	0	4,099	0	0	0	0	0	0	0	0	629	20
21	Clerical & General Office Expenses	(29,291)	(222,885)	86,826	0	0	0	0	0	0	0	0	(165,350)	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	1,430	0	0	0	0	0	0	0	0	1,430	23
24	Travel and Seminar	0	0	278	0	0	0	0	0	0	0	0	278	24
25	Other Admin. Staff Transportation	0	0	3,172	0	0	0	0	0	0	0	0	3,172	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,610	0	0	0	0	0	0	0	0	1,610	26
27	Other (specify):*	0	0	62,280	0	0	0	0	0	0	0	0	62,280	27
28	TOTAL General Administration	(32,761)	(546,885)	268,860	0	0	0	0	0	0	0	0	(310,786)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,694)	(614,790)	305,133	(4,509)	0	(346,860)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,389	0	11,308	119,222	0	0	0	0	0	0	0	137,919	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	53,136	381,353	0	0	0	0	0	0	0	434,489	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(495,451)	0	0	0	0	0	0	0	(495,451)	34
35	Rent-Equipment & Vehicles	0	0	7,413	(42,595)	0	0	0	0	0	0	0	(35,182)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,389	0	71,857	(37,471)	0	41,775	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	(36,089)	0	0	0	0	0	0	0	(36,089)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(36,089)	0	(36,089)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(25,305)	(614,790)	376,990	(78,069)	0	(341,174)	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
				CAREPLUS MGMT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
				BOULEVARD		
				PROPERTY, LLC	NILES	REAL ESTATE

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	21 HOME OFFICE EXPENSE	\$ 129,885	CAREPLUS MANAGEMENT, INC.		\$	\$	(129,885) 1
2	V	10 MEDICARE CONSULT. FEES	50,000	" "				(50,000) 2
3	V	10 PSYCHIATRIC CONS. FEE	25,000	" "				(25,000) 3
4	V	17 MANAGEMENT FEES	144,000	" "				(144,000) 4
5	V	19 ADMIN. CONSULT. FEES	168,000	" "				(168,000) 5
6	V	19 DATA PROCESS FEES	12,000	" "				(12,000) 6
7	V	21 CLERICAL FEES	93,000	" "				(93,000) 7
8	V							
9	V							
10	V							
11	V	5 UTILITIES		CAREPLUS MANAGEMENT, INC.		55	55	55 11
12	V	6 MAINT AND REPAIR		" "		2,620	2,620	2,620 12
13	V	6 MAINTENANCE SALARIES		" "		4,420	4,420	4,420 13
14	Total		\$ 621,885			\$ 7,095	\$ *	(614,790) 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	7 SECURITY	\$	CAREPLUS MGMT. INC.		\$ 42	\$	42	15
16	V	10 NURSING SALARIES		" "		33,067		33,067	16
17	V	10A THERAPY SALARIES		" "		3,164		3,164	17
18	V	17 ADMIN. SALARIES		" "		103,654		103,654	18
19	V	19 PROFESSIONAL FEES		" "		5,511		5,511	19
20	V	20 ADVERTISING		" "		4,099		4,099	20
21	V	21 TOTAL OFFICE		" "		32,406		32,406	21
22	V	21 CLERICAL SALARIES		" "		54,420		54,420	22
23	V	23 SEMINARS		" "		1,430		1,430	23
24	V	24 TRAVEL		" "		278		278	24
25	V	25 TRANSPORTATION		" "		3,172		3,172	25
26	V	26 INSURANCE		" "		1,610		1,610	26
27	V	27 EMPLOYEE BENEFITS		" "		62,280		62,280	27
28	V	30 DEPRECIATION (SL)		" "		11,308		11,308	28
29	V	32 INTEREST		" "		53,136		53,136	29
30	V	35 EQUIPMENT RENT		" "		7,413		7,413	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		\$			\$ 376,990	\$ *	376,990	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A THERAPY SERVICES	\$ 100,488	CAREPLUS REHABILITATIVE SERVICES		\$ 95,979	\$ (4,509)
16	V	39 ANCILLARY THERAPY	355,946			319,857	(36,089)
17	V	35 EQUIPMENT RENTAL	42,595				(42,595)
18	V	30 SL DEPRECIATION				7,726	7,726
19	V	32 INTEREST				4,081	4,081
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V	34 RENT	495,451	BOULEVARD PROPERTY, LLC			(495,451)
27	V	30 SL DEPRECIATION				111,496	111,496
28	V	32 INTEREST				377,272	377,272
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 994,480			\$ 916,411	\$ * (78,069)

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

Facility Name & ID Number

BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	CAREPLUS MGMT ALLOCATION:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMINISTRAT.	40.32	SEE	5.6		SALARY	18,993	17-7	2
3			FINANCE		ATTACHED						3
4			BANKING		SCHEDULE						4
5	JAKOB BAKST	DIR OPERATIONS	FINANCE	1.61		5.6		SALARY	18,893	17-7	5
6											6
7											7
8											8
9	ERIC ROTHNER	HUNTER MGMT	MGMT	32.26				MGMT FEES	74,250	17-3	9
10											10
11											11
12											12
13								TOTAL	\$ 112,136		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

Facility Name & ID Number **BOULEVARD CARE CENTER**

0032276

Report Period Beginning:

01/01/2005

Ending: **2/31/2005**

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 CAREPLUS MANAGEMENT, INC.
 Street Address 8320 SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-1555
 Fax Number (847) 329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	5	UTILITIES	CENSUS DAYS	553,765	13	574	52,588	55	2
3	6	MAINT AND REPAIR	CENSUS DAYS	553,765	13	27,588	52,588	2,620	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	553,765	13	46,540	52,588	4,420	4
5	7	SECURITY	CENSUS DAYS	553,765	13	444	52,588	42	5
6	10	NURSING SALARIES	CENSUS DAYS	553,765	13	348,203	52,588	33,067	6
7	10A	THERAPY SALARIES	CENSUS DAYS	553,765	13	33,317	52,588	3,164	7
8	17	ADMIN. SALARIES	CENSUS DAYS	553,765	13	1,091,504	52,588	103,654	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	553,765	13	58,031	52,588	5,511	9
10	20	ADVERTISING	CENSUS DAYS	553,765	13	43,163	52,588	4,099	10
11	21	TOTAL OFFICE	CENSUS DAYS	553,765	13	341,243	52,588	32,406	11
12	21	CLERICAL SALARIES	CENSUS DAYS	553,765	13	573,059	52,588	54,420	12
13	23	SEMINARS	CENSUS DAYS	553,765	13	15,061	52,588	1,430	13
14	24	TRAVEL	CENSUS DAYS	553,765	13	2,923	52,588	278	14
15	25	TRANSPORTATION	CENSUS DAYS	553,765	13	33,401	52,588	3,172	15
16	26	INSURANCE	CENSUS DAYS	553,765	13	16,951	52,588	1,610	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,765	13	655,825	52,588	62,280	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	553,765	13	119,076	52,588	11,308	18
19	32	INTEREST	CENSUS DAYS	553,765	13	559,538	52,588	53,136	19
20	35	EQUIPMENT RENT	CENSUS DAYS	553,765	13	78,057	52,588	7,413	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,044,498	\$ 2,092,623		\$ 384,085	25

Facility Name & ID Number

BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY:BOULEVARD PROPERTY, LLC						\$	\$			\$	1						
2	PACIFIC MUTUAL		X	MORTGAGE	\$38,703.00	12/95	4,657,452	3,935,178	01/08	0.0888	359,465	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 12 YEARS		116,756	18,741			9,730	3						
4	CIB BANK		X	CAPITAL IMPROVEMENT	\$4,052.62	01/04	360,000	94,817	01/09	PRIME+	8,077	4						
5	CAREPLUS MANAGEMENT ALLOCATION:LOC,ETC										53,136	5						
Working Capital																		
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND	04/95	450,000			PRIME+	52,942	6						
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCING							3,682	7						
8	CAREPLUS REHAB ALLOCATION:EQUIPMENT LOANS										4,081	8						
9	TOTAL Facility Related				\$42,755.62		\$ 5,584,208	\$ 4,048,736			\$ 491,113	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,584,208	\$ 4,048,736			\$ 491,113	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

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

** 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 2004 report.		\$	188,269	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.)		\$	190,546	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,277	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	192,452	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.		\$	194,729	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	155,459	8
	2001	159,502	9
	2002	161,290	10
	2003	186,405	11
	2004	190,546	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOULEVARD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032276

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-34-119-001-0000</u>	<u>NURSING HOME</u>	\$ <u>56,554.35</u>	\$ <u>56,554.35</u>
2. <u>17-34-119-002-0000</u>	<u>NURSING HOME</u>	\$ <u>9,527.01</u>	\$ <u>9,527.01</u>
3. <u>17-34-119-003-0000</u>	<u>NURSING HOME</u>	\$ <u>94,359.32</u>	\$ <u>94,359.32</u>
4. <u>17-34-119-004-0000</u>	<u>NURSING HOME</u>	\$ <u>9,222.24</u>	\$ <u>9,222.24</u>
5. <u>17-34-119-005-0000</u>	<u>NURSING HOME</u>	\$ <u>10,441.57</u>	\$ <u>10,441.57</u>
6. <u>17-34-119-006-0000</u>	<u>NURSING HOME</u>	\$ <u>10,441.57</u>	\$ <u>10,441.57</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>190,546.06</u>	\$ <u>190,546.06</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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>NURSING HOME</u>	<u>51,000</u>	<u>1995</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,000		\$ 100,000	3

Facility Name & ID Number **BOULEVARD CARE CENTER**# **0032276**

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155	1995	1971	\$ 4,046,250	\$ 103,746	39	\$ 103,746	\$	\$ 1,128,379	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LIGHT FIXTURES		1987	3,077		20	154	154	2,855	9
10	LEASEHOLD IMPROVEMENTS		1987	1,159	37	15	(120)	(157)	1,159	10
11	FIRE ALARM SERVICE		1988	10,046	319	20	502	183	8,910	11
12	ROOFING		1989	2,000	63	20	100	37	1,742	12
13	SEWER REPAIR		1989	3,250		15	(23)	(23)	3,250	13
14	ROOFING & AWNING		1990	7,780	247	20	389	142	6,127	14
15	LEASEHOLD IMPROVEMENTS		1991	16,578	575	20	829	254	11,980	15
16	LEASEHOLD IMPROVEMENTS		1992	1,800	120	15	120		1,620	16
17	LEASEHOLD IMPROVEMENTS		1992	19,702	625	31.5	625		8,433	17
18	LEASEHOLD IMPROVEMENTS		1993	25,871	736	31.5	821	85	10,178	18
19	LEASEHOLD IMPROVEMENTS		1994	8,666	222	39	222		2,461	19
20	LEASEHOLD IMPROVEMENTS		1994	4,690		20	235	235	2,702	20
21	ROOF REPAIRS		1995	1,500	38	39	38		414	21
22	ELEVATOR REPAIR / DOOR		1995	5,575	143	39	143		1,436	22
23	LANDSCAPING / FENCE REPAIR		1995	5,195	346	15	346		3,640	23
24	SUMP PUMP		1996	2,840	73	39	73		709	24
25	WALK-IN FREEZER REPAIR		1996	3,187	81	39	81		780	25
26	ROOF REPAIRS		1996	8,735	224	39	224		2,100	26
27	SECURITY SYSTEM		1996	1,035	27	39	27		244	27
28	ELEVATOR REPAIR		1997	6,017	154	39	154		1,339	28
29	WINDOWS		1997	1,170	30	39	30		259	29
30	CARPETING		1998	2,187	56	39	56		432	30
31	FIRE DAMPERS		1998	8,240	212	39	212		1,515	31
32	SEWER REPAIRS		1998	2,704	69	39	69		497	32
33	IRON FENCE		1998	4,684	312	15	312		2,340	33
34	INSTALL PIPE		1999	6,043	155	39	155		1,053	34
35	FLOORING-RESIDENT BATHROOMS		2000	23,773	865	27.5	865		5,007	35
36	ALARM SYSTEM		2000	94,362	3,431	27.5	3,431		19,872	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	
37	SMALL SERVICE ELEVATOR	2000	\$ 64,585	\$ 2,348	27.5	\$ 2,348		\$ 12,034	37
38	AWNING	2000	2,700	98	27.5	98		502	38
39	INSTALL NEW ROOF SYSTEM	2000	49,600	1,804	27.5	1,804		9,242	39
40	REPAIR SMALL & LARGE PASSENGER ELEVATORS	2001	5,786	210	27.5	210		1,007	40
41	INSTALL NEW STEAM TABLE	2001	4,147	151	27.5	151		723	41
42	EJECTOR PUMP	2001	2,878	105	27.5	105		494	42
43	INTERIOR ENTRANCE-INSTALL ALUMINUM DOOR	2001	2,748	100	27.5	100		454	43
44	RESIDENT ROOMS-CLOSETS	2001	20,078	730	27.5	730		3,255	44
45	EXISTING SPRINKLER SYSTEM-PLACARD	2001	3,600	131	27.5	131		573	45
46	INSTALL CHAIN FENCE	2001	1,400	97	15	93	(4)	545	46
47	FIRE ALARM REPAIR	2001	6,392	232	27.5	232		976	47
48	REPLACEMENT CARPET FOR 5 OFFICES	2001	3,294	379	20	165	(214)	825	48
49	REPLACEMENT OF WINDOW	2001	2,880	105	27.5	105		433	49
50	INSTALL BASEBOARD COVERS, WALK-IN COOLER	2001	3,314	382	20	166	(216)	830	50
51	NEW WALL, FLOORING-ELEVATORS	2001	4,506	519	20	225	(294)	1,125	51
52	FLOORING-1ST, 2ND, 3RD FL CORR/DAYROOM/NURSES ST	2002	49,673	1,806	27.5	1,806		7,006	52
53	NEW WINDOW TREATMENTS, DRAPERY PANELS	2002	6,807	549	20	340	(209)	1,360	53
54	2ND & 3RD FLOOR-WOOD BASEBOARD	2002	3,367	272	20	168	(104)	672	54
55	WALLCOVERING-LOBBY 1ST, 2ND & 3RD FLOOR	2002	31,043	1,129	27.5	1,129		3,716	55
56	INSTALL NEW SUSPENDED CEILING & LIGHTING	2002	46,843	1,703	27.5	1,703		5,322	56
57	ELECTRICAL WORK-1ST, 2ND AND 3RD FLOOR	2002	9,105	331	27.5	331		1,007	57
58	ELEVATOR-INSTALL OF CONTROLLER, CAR & HALL ST.	2003	99,988	3,636	27.5	3,636		10,757	58
59	REMODELING OF SHOWER & TUB ROOMS	2003	35,363	1,286	27.5	1,286		3,697	59
60	2ND&3RD FL -HANDRAILS&BUMPERS/1ST FL NURSE STA	2003	63,426	2,306	27.5	2,306		5,110	60
61	SOCIAL SERVICES-INSTALL NEW STEEL FRAME	2003	2,469	90	27.5	90		236	61
62	ELECTRICAL WORK FOR ELEVATOR	2003	5,562	202	27.5	202		531	62
63	REMODELING OF THE SHOWER, TUB, RESIDENT ROOMS	2004	109,477	3,981	27.5	3,981		7,133	63
64	REPAIR MASONRY ABOVE TOP FLOOR WINDOWS	2004	7,600	276	27.5	276		380	64
65	REPLACE MAIN ENTRANCE	2005	1,500	39	27.5	39		55	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,978,247	\$ 137,903		\$ 137,772	\$ (131)	\$ 1,311,433	70

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

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,978,247	\$ 137,903		\$ 137,772	\$ (131)	\$ 1,311,433	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10	RELATED PARTY ALLOCATION:								10
11	CAREPLUS REHAB								11
12	ROOF EXHAUST VENTILATOR	2003	950	24	39	24			12
13	MOTORS, ROOF VENTILATOR	2003	836	21	39	21			13
14	WALK-IN COOLER EVAPORATOR	2003	1,422	37	39	37			14
15	RECIRCULATING PUMP MOTOR	2003	576	14	39	14			15
16									16
17	CAREPLUS MGMT								17
18	BUILDING-TAG-18 PROPERTIES	2004	59,443	1,524	39	1,524			18
19	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	23,353	899	39	899			19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,064,827	\$ 140,422		\$ 140,291	\$ (131)	\$ 1,311,433	34

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

Facility Name & ID Number **BOULEVARD CARE CENTER**

0032276

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	\$ 217,756	\$ 10,357	\$ 21,227	\$ 10,870	5-10	\$ 138,469	71
72	Current Year Purchases	22,336	4,467	1,117	(3,350)	10	1,117	72
73	Fully Depreciated Assets	84,231					84,231	73
74	RELATED PARTY SL DEPRECIATION		24,265	24,265				74
75	TOTALS	\$ 324,323	\$ 39,089	\$ 46,609	\$ 7,520		\$ 223,817	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)	\$ 5,489,150	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,900	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,389	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,535,250	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A-RELATED PARTY**

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **56,055** Description: **SEE SCHEDULE ATTACHED**

(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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 121,010	\$		\$ 121,010	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			999			999	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			212,459			212,459	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				123,973		123,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-3				21,478			21,478	12
13	MEDICAL SUPPLIES Other (specify): RADIOLOGY	39-2 39-2					3,121 605		3,121 605	13
14	TOTAL			\$		\$ 355,946	\$ 127,699		\$ 483,645	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.

Facility Name & ID Number **BOULEVARD CARE CENTER**# **0032276**Report Period Beginning: **01/01/2005**Ending: **12/31/2005****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2005**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (79,724)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>179,915</u>)	1,988,185		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,303		6
7	Other Prepaid Expenses	50,674		7
8	Accounts Receivable (owners or related parties)	143,780		8
9	Other(specify): <u>Real Estate Tax Escrow</u>	226,093		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,425,311	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	924,230		15
16	Equipment, at Historical Cost	324,323		16
17	Accumulated Depreciation (book methods)	(476,896)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(219,551)		21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 552,106	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,977,417	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 579,056	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,752		28
29	Short-Term Notes Payable	710,591		29
30	Accrued Salaries Payable	139,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,125		31
32	Accrued Real Estate Taxes(Sch.IX-B)	192,452		32
33	Accrued Interest Payable	4,469		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,659,390	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,659,390	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,318,027	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,977,417	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 661,603	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(54,079)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 607,524	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	710,503	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 710,503	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)	\$ 1,318,027	24 *

* This must agree with page 17, line 47.

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	\$ 6,586,511	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,586,511	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,586,511	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	938,968	31
32	Health Care	1,913,322	32
33	General Administration	1,603,370	33
	B. Capital Expense		
34	Ownership	851,840	34
	C. Ancillary Expense		
35	Special Cost Centers	483,645	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,876,008	40
41	Income before Income Taxes (line 30 minus line 40)**	710,503	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 710,503	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,984	2,164	\$ 68,456	\$ 31.63	1
2	Assistant Director of Nursing	945	1,078	32,432	30.09	2
3	Registered Nurses	1,341	1,341	32,139	23.97	3
4	Licensed Practical Nurses	29,681	30,577	632,455	20.68	4
5	CNAs & Orderlies	59,441	64,554	595,621	9.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,127	7,981	85,362	10.70	8
9	Activity Director	1,521	1,584	16,102	10.17	9
10	Activity Assistants	5,394	5,624	44,777	7.96	10
11	Social Service Workers	8,321	8,796	110,856	12.60	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,129	34,343	16.13	13
14	Head Cook	6,363	6,967	56,078	8.05	14
15	Cook Helpers/Assistants	11,043	11,699	87,093	7.44	15
16	Dishwashers					16
17	Maintenance Workers	8,542	9,212	89,809	9.75	17
18	Housekeepers	14,569	15,830	130,557	8.25	18
19	Laundry	5,243	5,871	54,325	9.25	19
20	Administrator	3,861	4,094	148,140	36.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,949	7,684	128,118	16.67	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	1,989	2,090	21,078	10.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,354	189,275	\$ 2,367,741 *	\$ 12.51	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	M	\$ 13,034	1-3	35
36	Medical Director	O	7,200	9-3	36
37	Medical Records Consultant	N	1,440	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,222	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	E	25,000	10-3	46
47	<u>UTILIZATION REVIEW FEES</u>	S	50,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 111,136		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	
KEVIN MEALS	ADMIN	0	\$ 80,070	Workers' Compensation Insurance	\$ 40,609	IDPH License Fee	\$	
CYNTHIA STAIN	ADMIN	0	68,070	Unemployment Compensation Insurance	60,261	Advertising: Employee Recruitment	1,000	
				FICA Taxes	178,180	Health Care Worker Background Check	0	
				Employee Health Insurance	48,819	(Indicate # of checks performed)		
				Employee Meals	19,217	MARKETING/ADV/PROMO	2,970	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	500	
				EMPLOYEE BENEFITS - OTHER	1,500	LICENSES & PERMITS	1,920	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	1,295	
				PENSION/PROFIT SHARING PLANS	22,537	MGMT CO ALLOCATION	4,099	
				CHICAGO HEAD TAX	3,836	TRUST/FRANCHISE/CONTRIB/ETC	(500)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,970)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 148,140	TOTAL (agree to Schedule V, line 22, col.8)	\$ 374,959	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,314	
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
CAREPLUS MANAGEMENT, INC MANAGEMENT FEES			\$ 144,000			\$	Out-of-State Travel	\$
HUNTER MANAGEMENT MANAGEMENT FEES			74,250					
							In-State Travel	0
							MGMT CO ALLOCATION	278
							Seminar Expense	125
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 218,250	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 403
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			236,940					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 236,940					

* Attach copy of IMRF notifications

**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								
						FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2002	\$ 2,039	3 YRS	\$ 340	\$ 680	\$ 680	\$ 340						
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 2,039		\$ 340	\$ 680	\$ 680	\$ 340						

Facility Name & ID Number **BOULEVARD CARE CENTER**# **0032276**Report Period Beginning: **01/01/2005**Ending: **12/31/2005****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,863
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,217 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees