

Facility Name & ID Number BOULEVARD CARE CENTER

0032276 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		79	3,189	3,268	8
9	SNF/PED					9
10	ICF	47,697			47,697	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,697	79	3,189	50,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.08%

D. How many bed-hold days during this year were paid by the Department? 1,195 (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 3,189

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **BOULEVARD CARE CENTER** # **0032276** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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	194,593	23,065	13,889	231,547		231,547		231,547		1
2	Food Purchase		229,109		229,109	(22,174)	206,935	(294)	206,641		2
3	Housekeeping	153,980	38,392		192,372		192,372		192,372		3
4	Laundry	57,583	13,094		70,677		70,677		70,677		4
5	Heat and Other Utilities			149,810	149,810		149,810	11	149,821		5
6	Maintenance	92,474	28,671	35,132	156,277		156,277	7,457	163,734		6
7	Other (specify):*			21,455	21,455		21,455	63	21,518		7
8	TOTAL General Services	498,630	332,331	220,286	1,051,247	(22,174)	1,029,073	7,237	1,036,310		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,681,551	76,661	2,160	1,760,372		1,760,372	46,484	1,806,856		10
10a	Therapy	83,755	18,321	27,203	129,279		129,279	8,549	137,828		10a
11	Activities	70,748	7,168	2,258	80,174		80,174		80,174		11
12	Social Services	27,608			27,608		27,608		27,608		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,863,662	102,150	43,621	2,009,433		2,009,433	55,033	2,064,466		16
	C. General Administration										
17	Administrative	145,445		150,000	295,445		295,445	(51,996)	243,449		17
18	Directors Fees										18
19	Professional Services			153,973	153,973		153,973	(85,039)	68,934		19
20	Dues, Fees, Subscriptions & Promotions			10,174	10,174		10,174	(629)	9,545		20
21	Clerical & General Office Expenses	80,119	15,977	98,296	194,392		194,392	16,301	210,693		21
22	Employee Benefits & Payroll Taxes			434,290	434,290	22,174	456,464		456,464		22
23	Inservice Training & Education							1,607	1,607		23
24	Travel and Seminar			2,781	2,781		2,781	2,377	5,158		24
25	Other Admin. Staff Transportation			626	626		626	9,281	9,907		25
26	Insurance-Prop.Liab.Malpractice			236,345	236,345		236,345	2,002	238,347		26
27	Other (specify):*			50,000	50,000		50,000	16,254	66,254		27
28	TOTAL General Administration	225,564	15,977	1,136,485	1,378,026	22,174	1,400,200	(89,842)	1,310,358		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,587,856	450,458	1,400,392	4,438,706		4,438,706	(27,572)	4,411,134		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	13,239
	REPAIRS & MAINTENANCE	650
		0
		13,889
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	57,655
	ELECTRICITY	57,084
	WATER	23,716
	CABLE TV - LOBBY	11,355
		0
		149,810
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,793
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,379
	ELEVATOR MAINTENANCE & REPAIR	6,129
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,400
	FIRE SERVICE	8,431
		0
		0
		0
		0
		35,132
7	OTHER	
	SCAVENGER	21,455
	SECURITY SERVICE	0
		0
		0
		21,455
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

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	720
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		2,160
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	13,392
	SPEECH THERAPY SERVICES	54
	OCCUPATIONAL THERAPY SERVICES	2,957
	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
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		27,203
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,258
		0
		2,258
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		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	150,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,111
	ADMINISTRATIVE CONSULTANTS XIX C	93,000
	PROFESSIONAL FEES XIX C	45,862
		0
		153,973
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,832
	EMPLOYEE WANT ADS XIX F	2,205
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,150
	LICENSES & PERMITS XIX F	2,987
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		10,174
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,632
	OUTSIDE CLERICAL SERVICES	55,800
	PENALTIES / OVERDRAFT CHARGES VI 18	23,734
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	70
	TELEPHONE	14,465
	MESSENGER SERVICE	2,795
	OTHER - COSTS REBILLED SALARIES	(200)
		98,296

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	193,671
	UNEMPLOYMENT COMPENSATION XIX D	63,811
	WORKERS COMPENSATION INSURANC XIX D	59,231
	HOSPITALIZATION INSURANCE XIX D	85,105
	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	26,956
	CHICAGO HEAD TAX XIX D	4,016
		0
		434,290
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,781
	TRAVEL XIX G	0
		2,781
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	626
		626
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	236,345
		236,345
27	OTHER	
	BAD DEBTS VI 24	50,000
		50,000

GRAND TOTAL COLUMN 3 OTHER

1,400,392

**BOULEVARD CARE CENTER
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	229,109
LESS SALES TAX	<u>(294)</u>
NET FOOD	228,815

TOTAL PATIENT CENSUS	50,965
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	152,895

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	16,425

PATIENT MEALS	152,895
ADD EMPLOYEE MEALS	<u>16,425</u>
TOTAL MEALS/YEAR	169,320

NET FOOD	228,815
DIVIDE TOTAL MEALS/YEAR	<u>169,320</u>

COST PER MEAL	1.35
TIME EMPLOYEE MEALS	<u>16,425</u>
EMPLOYEE MEAL RECLASSIFICATION	22,174

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

#0032276

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			48,054	48,054		48,054	133,709	181,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,344	26,344		26,344	400,031	426,375			32
33	Real Estate Taxes			182,106	182,106		182,106	6,425	188,531			33
34	Rent-Facility & Grounds			513,548	513,548		513,548	(513,548)				34
35	Rent-Equipment & Vehicles			56,910	56,910		56,910	(33,151)	23,759			35
36	Other (specify):*											36
37	TOTAL Ownership			826,962	826,962		826,962	(6,534)	820,428			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,219	234,453	377,672		377,672	24,606	402,278			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		143,219	319,316	462,535		462,535	24,606	487,141			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,587,856	593,677	2,546,670	5,728,203		5,728,203	(9,500)	5,718,703			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,152	30		9
10	Interest and Other Investment Income	(21)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	2		13
14	Non-Care Related Interest	(919)	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	(23,734)	21		18
19	Entertainment		20		19
20	Contributions		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	(50,000)	27		24
25	Fund Raising, Advertising and Promotional	(3,832)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,648)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,148		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,148		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,500)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	0	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(294)	0	0	0	0	0	0	0	0	0	0	(294)	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	11	0	0	0	0	0	0	0	0	0	11	5
6	Maintenance	0	7,457	0	0	0	0	0	0	0	0	0	7,457	6
7	Other (specify):*	0	0	63	0	0	0	0	0	0	0	0	63	7
8	TOTAL General Services	(294)	7,468	63	0	0	0	0	0	0	0	0	7,237	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	46,484	0	0	0	0	0	0	0	0	46,484	10
10a	Therapy	0	0	5,694	2,855	0	0	0	0	0	0	0	8,549	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	0	52,178	2,855	0	55,033	16						
	C. General Administration													
17	Administrative	0	(150,000)	98,004	0	0	0	0	0	0	0	0	(51,996)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(93,000)	7,961	0	0	0	0	0	0	0	0	(85,039)	19
20	Fees, Subscriptions & Promotions	(3,832)	0	3,203	0	0	0	0	0	0	0	0	(629)	20
21	Clerical & General Office Expenses	(23,734)	(55,800)	95,835	0	0	0	0	0	0	0	0	16,301	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	1,607	0	0	0	0	0	0	0	0	1,607	23
24	Travel and Seminar	0	0	2,377	0	0	0	0	0	0	0	0	2,377	24
25	Other Admin. Staff Transportation	0	0	9,281	0	0	0	0	0	0	0	0	9,281	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,002	0	0	0	0	0	0	0	0	2,002	26
27	Other (specify):*	(50,000)	0	66,254	0	0	0	0	0	0	0	0	16,254	27
28	TOTAL General Administration	(77,566)	(298,800)	286,524	0	0	0	0	0	0	0	0	(89,842)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,860)	(291,332)	338,765	2,855	0	(27,572)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOULEVARD CARE CENTER# 0032276

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	8,152	0	14,085	111,472	0	0	0	0	0	0	0	133,709	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(940)	0	46,008	354,963	0	0	0	0	0	0	0	400,031	32
33	Real Estate Taxes	0	0	6,425	0	0	0	0	0	0	0	0	6,425	33
34	Rent-Facility & Grounds	0	0	0	(513,548)	0	0	0	0	0	0	0	(513,548)	34
35	Rent-Equipment & Vehicles	0	0	9,444	(42,595)	0	0	0	0	0	0	0	(33,151)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,212	0	75,962	(89,708)	0	(6,534)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	24,606	0	0	0	0	0	0	0	24,606	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	24,606	0	24,606	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(70,648)	(291,332)	414,727	(62,247)	0	(9,500)	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
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				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	17	MANAGEMENT FEES	\$ 150,000	CAREPLUS MANAGEMENT, INC.		\$	(150,000)	1	
2	V	19	ADMIN. CONSULT. FEES	93,000	" "			(93,000)	2	
3	V	21	CLERICAL FEES	55,800	" "			(55,800)	3	
4	V								4	
5	V								5	
6	V								6	
7	V								7	
8	V								8	
9	V								9	
10	V								10	
11	V	5	UTILITIES		CAREPLUS MANAGEMENT, INC.			11	11	
12	V	6	MAINT AND REPAIR		" "			1,339	1,339	
13	V	6	MAINTENANCE SALARIES		" "			6,118	6,118	
14	Total			\$ 298,800			\$	7,468	\$ * (291,332)	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.		\$ 63	\$	63	15
16	V	10 NURSING SALARIES		" "		46,484		46,484	16
17	V	10A THERAPY SALARIES		" "		4,326		4,326	17
18	V	17 ADMIN. SALARIES		" "		98,004		98,004	18
19	V	19 PROFESSIONAL FEES		" "		7,961		7,961	19
20	V	20 ADVERTISING		" "		3,203		3,203	20
21	V	21 TOTAL OFFICE		" "		24,507		24,507	21
22	V	21 CLERICAL SALARIES		" "		71,328		71,328	22
23	V	23 SEMINARS		" "		1,607		1,607	23
24	V	24 TRAVEL		" "		2,377		2,377	24
25	V	25 TRANSPORTATION		" "		9,281		9,281	25
26	V	26 INSURANCE		" "		2,002		2,002	26
27	V	27 EMPLOYEE BENEFITS		" "		66,254		66,254	27
28	V	30 DEPRECIATION (SL)		" "		14,085		14,085	28
29	V	33 REAL ESTATE TAX		" "		6,425		6,425	29
30	V	32 INTEREST		" "		41,299		41,299	30
31	V	32 INTEREST-TAG 18 PPTY-MTG		" "		4,365		4,365	31
32	V	32 INTEREST-CP REHAB-EQ LOAN		" "		344		344	32
33	V	35 EQUIPMENT RENT		" "		9,444		9,444	33
34	V	10A REHAB SUPPLIES		" "		1,368		1,368	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 414,727	\$ *	414,727	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	\$ 27,202	CAREPLUS REHABILITATIVE SERVICES		\$ 30,057	\$ 2,855	15
16	V	39 ANCILLARY THERAPY	234,452			259,058	24,606	16
17	V	35 EQUIPMENT RENTAL	42,595				(42,595)	17
18	V	30 SL DEPRECIATION				7,726	7,726	18
19	V	32 INTEREST				4,715	4,715	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	513,548	BOULEVARD PROPERTY, LLC			(513,548)	26
27	V	30 SL DEPRECIATION				103,746	103,746	27
28	V	32 INTEREST				350,248	350,248	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		\$ 817,797			\$ 755,550	\$ * (62,247)	39

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

Facility Name & ID Number

BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 I. RAY	PRESIDENT	ADMINISTRAT	40.32	SEE	60	6.90	SALARY	18,865	17-7	2
3			FINANCE		ATTACHED						3
4			BANKING		SCHEDULE						4
5	JAKOB BAKST	DIR OPERATIONS	FINANCE	1.61		60	6.90	SALARY	18,865	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 37,730		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: **01/01/2007**

Ending: **2/31/2007**

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	5	UTILITIES	CENSUS DAYS	445,767	11	\$ 100	\$ 50,965	\$ 11	1	
2	6	MAINT & REPAIRS	CENSUS DAYS	445,767	11	11,715	50,965	1,339	2	
3	6	MAINTENANCE SALARIES	CENSUS DAYS	445,767	11	53,507	50,965	6,118	3	
4	7	SECURITY	CENSUS DAYS	445,767	11	548	50,965	63	4	
5	10	NURSING SALARIES	CENSUS DAYS	445,767	11	406,577	406,577	50,965	46,484	5
6	10A	THERAPY SALARIES	CENSUS DAYS	445,767	11	37,834	37,834	50,965	4,326	6
7	17	ADMIN. SALARIES	CENSUS DAYS	445,767	11	857,197	857,197	50,965	98,004	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	445,767	11	69,630	50,965	7,961	8	
9	20	ADVERTISING	CENSUS DAYS	445,767	11	28,013	50,965	3,203	9	
10	21	TOTAL OFFICE	CENSUS DAYS	445,767	11	214,347	50,965	24,507	10	
11	21	CLERICAL SALARIES	CENSUS DAYS	445,767	11	623,871	623,871	50,965	71,328	11
12	23	SEMINARS	CENSUS DAYS	445,767	11	14,052	50,965	1,607	12	
13	24	TRAVEL	CENSUS DAYS	445,767	11	20,788	50,965	2,377	13	
14	25	TRANSPORTATION	CENSUS DAYS	445,767	11	81,177	50,965	9,281	14	
15	26	INSURANCE	CENSUS DAYS	445,767	11	17,511	50,965	2,002	15	
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	445,767	11	579,494	50,965	66,254	16	
17	30	DEPRECIATION (SL)	CENSUS DAYS	445,767	11	123,201	50,965	14,085	17	
18	33	REAL ESTATE TAX	CENSUS DAYS	445,767	11	56,199	50,965	6,425	18	
19	32	INTEREST	CENSUS DAYS	445,767	11	361,224	50,965	41,299	19	
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	445,767	11	38,177	50,965	4,365	20	
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	445,767	11	3,007	50,965	344	21	
22	35	EQUIPMENT RENT	CENSUS DAYS	445,767	11	82,599	50,965	9,444	22	
23	10A	REHAB SUPPLIES		445,767	11	11,963	50,965	1,368	23	
24									24	
25	TOTALS				\$ 3,692,731	\$ 1,978,986		\$ 422,195	25	

Facility Name & ID Number

BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		12/95	4,657,452	3,694,754	01/08	0.0888	338,838	2						
3	LOAN COST		X	LOAN COSTS	W/O OVER 12 YEARS		116,756	31,130			9,011	3						
4	CIB BANK		X	CAPITAL IMPROVEMENT	\$4,052.62	01/04	360,000	5,247	01/09	PRIME+	2,399	4						
5	CARAPLUS MANAGEMENT ALLOCATION										46,008	5						
Working Capital																		
6	CAREPLUS MANAGEMENT	X		WORKING CAPITAL	DEMAND	04/95	450,000			PRIME+	19,934	6						
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCING							5,491	7						
8	CAREPLUS REHAB ALLOCATION:EQUIPMENT LOANS										4,715	8						
9	TOTAL Facility Related						\$ 5,584,208	\$ 3,731,131			\$ 426,396	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							919	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 919	14						
15	TOTALS (line 9+line14)						\$ 5,584,208	\$ 3,731,131			\$ 427,315	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 2006 report.		\$	194,411	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.)		\$	187,322	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,089)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	189,195	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.		\$	182,106	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	161,290	8
	2003	186,405	9
	2004	190,546	10
	2005	192,486	11
	2006	187,322	12

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 2006 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 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 2006 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 2006.

(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>55,568.46</u>	\$ <u>55,568.46</u>
2. <u>17-34-119-002-0000</u>	<u>NURSING HOME</u>	\$ <u>9,365.82</u>	\$ <u>9,365.82</u>
3. <u>17-34-119-003-0000</u>	<u>NURSING HOME</u>	\$ <u>92,719.15</u>	\$ <u>92,719.15</u>
4. <u>17-34-119-004-0000</u>	<u>NURSING HOME</u>	\$ <u>9,051.57</u>	\$ <u>9,051.57</u>
5. <u>17-34-119-005-0000</u>	<u>NURSING HOME</u>	\$ <u>10,308.52</u>	\$ <u>10,308.52</u>
6. <u>17-34-119-006-0000</u>	<u>NURSING HOME</u>	\$ <u>10,308.52</u>	\$ <u>10,308.52</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>187,322.04</u>	\$ <u>187,322.04</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number BOULEVARD CARE CENTER

0032276

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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:

01/01/2007 Ending: 12/31/2007

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	155	1995	1971	\$ 4,046,250	\$ 103,746	39	\$ 103,746	\$	\$ 1,335,871	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LIGHT FIXTURES		1987	3,077		20	68	68	3,077	9
10	LEASEHOLD IMPROVEMENTS		1987	1,159	37	15		(37)	1,159	10
11	FIRE ALARM SERVICE		1988	10,046	319	20	502	183	9,914	11
12	ROOFING		1989	2,000	63	20	100	37	1,942	12
13	SEWER REPAIR		1989	3,250		15			3,250	13
14	ROOFING & AWNING		1990	7,780	247	20	389	142	6,905	14
15	LEASEHOLD IMPROVEMENTS		1991	16,578	482	20	829	347	13,638	15
16	LEASEHOLD IMPROVEMENTS		1992	1,800	60	15	60		1,800	16
17	LEASEHOLD IMPROVEMENTS		1992	19,702	625	31.5	625		9,683	17
18	LEASEHOLD IMPROVEMENTS		1993	25,871	736	31.5	821	85	11,820	18
19	LEASEHOLD IMPROVEMENTS		1994	8,666	222	39	222		2,905	19
20	LEASEHOLD IMPROVEMENTS		1994	4,690		20	235	235	3,172	20
21	ROOF REPAIRS		1995	1,500	38	39	38		490	21
22	ELEVATOR REPAIR / DOOR		1995	5,575	143	39	143		1,722	22
23	LANDSCAPING / FENCE REPAIR		1995	5,195	346	15	346		4,332	23
24	SUMP PUMP		1996	2,840	73	39	73		855	24
25	WALK-IN FREEZER REPAIR		1996	3,187	81	39	81		942	25
26	ROOF REPAIRS		1996	8,735	224	39	224		2,548	26
27	SECURITY SYSTEM		1996	1,035	27	39	27		298	27
28	ELEVATOR REPAIR		1997	6,017	154	39	154		1,647	28
29	WINDOWS		1997	1,170	30	39	30		319	29
30	CARPETING		1998	2,187	56	39	56		544	30
31	FIRE DAMPERS		1998	8,240	212	39	212		1,939	31
32	SEWER REPAIRS		1998	2,704	69	39	69		635	32
33	IRON FENCE		1998	4,684	312	15	312		2,964	33
34	INSTALL PIPE		1999	6,043	155	39	155		1,363	34
35	FLOORING-RESIDENT BATHROOMS		2000	23,773	865	27.5	865		6,737	35
36	ALARM SYSTEM		2000	94,362	3,431	27.5	3,431		26,734	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:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 16,730	37
38	AWNING	2000	2,700	98	27.5	98		698	38
39	INSTALL NEW ROOF SYSTEM	2000	49,600	1,804	27.5	1,804		12,850	39
40	REPAIR SMALL & LARGE PASSENGER ELEVATORS	2001	5,786	210	27.5	210		1,427	40
41	INSTALL NEW STEAM TABLE	2001	4,147	151	27.5	151		1,025	41
42	EJECTOR PUMP	2001	2,878	105	27.5	105		704	42
43	INTERIOR ENTRANCE-INSTALL ALUMINUM DOOR	2001	2,748	100	27.5	100		654	43
44	RESIDENT ROOMS-CLOSETS	2001	20,078	730	27.5	730		4,715	44
45	EXISTING SPRINKLER SYSTEM-PLACARD	2001	3,600	131	27.5	131		835	45
46	INSTALL CHAIN FENCE	2001	1,400	83	15	93	10	731	46
47	FIRE ALARM REPAIR	2001	6,392	232	27.5	232		1,440	47
48	REPLACEMENT CARPET FOR 5 OFFICES	2001	3,294		20	165	165	1,155	48
49	REPLACEMENT OF WINDOW	2001	2,880	105	27.5	105		643	49
50	INSTALL BASEBOARD COVERS, WALK-IN COOLER	2001	3,314		20	166	166	1,162	50
51	NEW WALL, FLOORING-ELEVATORS	2001	4,506		20	225	225	1,575	51
52	FLOORING-1ST, 2ND, 3RD FL CORR/DAYROOM/NURSES ST	2002	49,673	1,806	27.5	1,806		10,618	52
53	NEW WINDOW TREATMENTS, DRAPERY PANELS	2002	6,807	274	20	340	66	2,040	53
54	2ND & 3RD FLOOR-WOOD BASEBOARD	2002	3,367	135	20	168	33	1,008	54
55	WALLCOVERING-LOBBY 1ST, 2ND & 3RD FLOOR	2002	31,043	1,129	27.5	1,129		5,974	55
56	INSTALL NEW SUSPENDED CEILING & LIGHTING	2002	46,843	1,703	27.5	1,703		8,728	56
57	ELECTRICAL WORK-1ST, 2ND AND 3RD FLOOR	2002	9,105	331	27.5	331		1,669	57
58	ELEVATOR-INSTALL OF CONTROLLER, CAR & HALL ST.	2003	99,988	3,636	27.5	3,636		18,029	58
59	REMODELING OF SHOWER & TUB ROOMS	2003	35,363	1,286	27.5	1,286		6,269	59
60	2ND&3RD FL -HANDRAILS&BUMPERS/1ST FL NURSE STA	2003	63,426	2,306	27.5	2,306		9,722	60
61	SOCIAL SERVICES-INSTALL NEW STEEL FRAME	2003	2,469	90	27.5	90		416	61
62	ELECTRICAL WORK FOR ELEVATOR	2003	5,562	202	27.5	202		935	62
63	REMODELING OF THE SHOWER, TUB, RESIDENT ROOMS	2004	109,477	3,981	27.5	3,981		15,095	63
64	REPAIR MASONRY ABOVE TOP FLOOR WINDOWS	2004	7,600	276	27.5	276		932	64
65	REPLACE MAIN ENTRANCE	2005	1,500	55	27.5	55		165	65
66	NEW LANDSCAPING	2006	9,600	640	15	640		1,067	66
67	INSTALL EXHAUST FANS	2006	5,500	200	27.5	200		292	67
68	INSTALL EMERGENCY LIGHTS	2006	3,067	112	27.5	112		163	68
69	INSTALL NEW TRANSFER SWITCH IN PLACE OF OLD	2007	5,463	91	27.5	91		91	69
70	TOTAL (lines 4 thru 69)		\$ 5,001,877	\$ 137,103		\$ 138,828	\$ 1,725	\$ 1,588,762	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:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,001,877	\$ 137,103		\$ 138,828	\$ 1,725	\$ 1,588,762	1
2	REROOFED PROPERTY USING SINGLE PLY BITUMEN	2007	2,500	19	27.5	19		19	2
3									3
4									4
5									5
6									6
7									7
8	RELATED PARTY ALLOCATION:								8
9	CAREPLUS REHAB								9
10	ROOF EXHAUST VENTILATOR	2003	950	24	39		(24)		10
11	MOTORS, ROOF VENTILATOR	2003	836	21	39		(21)		11
12	WALK-IN COOLER EVAPORATOR	2003	1,422	37	39		(37)		12
13	RECIRCULATING PUMP MOTOR	2003	576	14	39		(14)		13
14									14
15	CAREPLUS MGMT								15
16	BUILDING-TAG-18 PROPERTIES		59,443	1,835	39	1,835			16
17	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	23,353	1,086	39	1,086			17
18	BUILDING IMPROVEMENTS-CAREPLUS MGMT			7	39	7			18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,090,957	\$ 140,146		\$ 141,775	\$ 1,629	\$ 1,588,781	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:

01/01/2007

Ending:

12/31/2007

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	\$ 225,323	\$ 13,444	\$ 20,892	\$ 7,448	5-15	\$ 147,409	71
72	Current Year Purchases	6,170	1,234	309	(925)	10	309	72
73	Fully Depreciated Assets	119,970					119,970	73
74	RELATED PARTY SL DEPRECIATION		18,787	18,787				74
75	TOTALS	\$ 351,463	\$ 33,465	\$ 39,988	\$ 6,523		\$ 267,688	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)	\$ 5,542,420	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,611	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,763	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,152	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,856,469	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: \$ **\$56,910** 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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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	\$		\$ 51,902	\$		\$ 51,902	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			297			297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			182,254			182,254	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				141,904		141,904	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MEDICAL SUPPLIES	39-2					1,315		1,315	13
14	TOTAL			\$		\$ 234,453	\$ 143,219		\$ 377,672	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: **01/01/2007**Ending: **12/31/2007****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2007**

(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	\$ 496	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,419,635		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,438		6
7	Other Prepaid Expenses	46,058		7
8	Accounts Receivable (owners or related parties)	390,898		8
9	Other(specify): <u>Real Estate Tax Escrow</u>	250,171		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,208,696	\$	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	950,360		15
16	Equipment, at Historical Cost	351,463		16
17	Accumulated Depreciation (book methods)	(577,179)		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>REPLACEMENT RESERVE</u>	(7,417)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 717,227	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,925,923	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,110,831	\$	26
27	Officer's Accounts Payable	129,421		27
28	Accounts Payable-Patient Deposits	14,252		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,088		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,188		31
32	Accrued Real Estate Taxes(Sch.IX-B)	189,195		32
33	Accrued Interest Payable	4,053		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)	\$ 1,645,028	\$	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)	\$ 1,645,028	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,280,895	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,925,923	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,575,686	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,575,692	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	705,203	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)	\$ 705,203	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)	\$ 2,280,895	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	\$ 6,415,609	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,415,609	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	17,776	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 17,776	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***	21	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21	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)	\$ 6,433,406	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,051,247	31
32	Health Care	2,009,433	32
33	General Administration	1,378,026	33
	B. Capital Expense		
34	Ownership	826,962	34
	C. Ancillary Expense		
35	Special Cost Centers	377,672	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,728,203	40
41	Income before Income Taxes (line 30 minus line 40)**	705,203	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 705,203	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: **01/01/2007**

Ending:

12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,087	2,190	\$ 73,090	\$ 33.37	1
2	Assistant Director of Nursing	2,103	2,162	56,310	26.05	2
3	Registered Nurses	2,656	2,784	70,935	25.48	3
4	Licensed Practical Nurses	28,884	31,645	678,368	21.44	4
5	CNAs & Orderlies	62,328	69,002	668,193	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,604	6,389	83,755	13.11	8
9	Activity Director	2,115	2,280	26,840	11.77	9
10	Activity Assistants	5,251	5,579	43,908	7.87	10
11	Social Service Workers	1,805	1,941	27,608	14.22	11
12	Dietician					12
13	Food Service Supervisor	2,014	2,164	36,420	16.83	13
14	Head Cook	4,060	4,491	40,446	9.01	14
15	Cook Helpers/Assistants	13,187	14,358	117,727	8.20	15
16	Dishwashers					16
17	Maintenance Workers	8,167	9,163	92,474	10.09	17
18	Housekeepers	15,297	16,896	153,980	9.11	18
19	Laundry	5,337	5,972	57,583	9.64	19
20	Administrator	2,221	2,382	87,985	36.94	20
21	Assistant Administrator	1,648	1,880	57,460	30.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,084	5,742	80,119	13.95	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	1,828	1,941	20,468	10.55	31
32	Other Health Care(specify)	5,421	5,975	114,187	19.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,097	194,936	\$ 2,587,856 *	\$ 13.28	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	\$ 13,239	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	720	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	F	0	10a-3	43
44	Activity Consultant	E	2,258	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,457		49

C. CONTRACT NURSES

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

Facility Name & ID Number **BOULEVARD CARE CENTER**# **0032276**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****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? YES
If YES, give association name and amount. IL ASSOCIATION OF HEALTHCARE \$1,085
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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. \$ 0 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. \$ 22,174 Has any meal income been offset against related costs? N/A 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees