

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			59,887	59,887		59,887	128,669	188,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,609	10,609		10,609	581,242	591,851			32
33	Real Estate Taxes			188,275	188,275		188,275	5,467	193,742			33
34	Rent-Facility & Grounds			500,936	500,936		500,936	(500,936)				34
35	Rent-Equipment & Vehicles			16,526	16,526		16,526	7,820	24,346			35
36	Other (specify):* OFFICE RENT			22,200	22,200		22,200	(22,200)				36
37	TOTAL Ownership			798,433	798,433		798,433	200,062	998,495			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,503	287,559	393,062		393,062		393,062			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		105,503	372,423	477,926		477,926		477,926			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,811,529	618,284	2,647,552	6,077,365		6,077,365	170,763	6,248,128			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	9,199	30		9
10	Interest and Other Investment Income	(8,041)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(252)	2		13
14	Non-Care Related Interest	(442)	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	(3,593)	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	(20,000)	27		24
25	Fund Raising, Advertising and Promotional	(28,442)	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)	\$ (51,571)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	222,334		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 222,334		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 170,763		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

BOULEVARD CARE NURSING & REHAB

ID# 0050716

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	DEFERRED MAINTENANCE	\$	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 NURSING & REHAB# 0050716

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(252)	0	0	0	0	0	0	0	0	0	0	(252)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	14,717	0	4	0	0	0	0	0	0	0	14,721	6
7	Other (specify):*	0	100	0	0	0	0	0	0	0	0	0	100	7
8	TOTAL General Services	(252)	14,817	0	4	0	14,569	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	26,263	0	0	0	0	0	0	0	0	0	26,263	10
10a	Therapy	0	6,606	0	0	0	0	0	0	0	0	0	6,606	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	32,869	0	0	0	0	0	0	0	0	0	32,869	16
	C. General Administration													
17	Administrative	0	(125,000)	113,794	0	0	0	0	0	0	0	0	(11,206)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(77,500)	8,726	0	0	0	0	0	0	0	0	(68,774)	19
20	Fees, Subscriptions & Promotions	(28,442)	0	1,915	25	0	0	0	0	0	0	0	(26,502)	20
21	Clerical & General Office Expenses	(3,593)	(46,500)	92,818	(57,670)	0	0	0	0	0	0	0	(14,945)	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	890	221	0	0	0	0	0	0	0	1,111	23
24	Travel and Seminar	0	0	217	8	0	0	0	0	0	0	0	225	24
25	Other Admin. Staff Transportation	0	0	9,538	1,899	0	0	0	0	0	0	0	11,437	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,682	0	0	0	0	0	0	0	0	1,682	26
27	Other (specify):*	(20,000)	0	47,846	2,389	0	0	0	0	0	0	0	30,235	27
28	TOTAL General Administration	(52,035)	(249,000)	277,426	(53,128)	0	(76,737)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,287)	(201,314)	277,426	(53,124)	0	(29,299)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOULEVARD CARE NURSING & REHAB# 0050716

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,199	0	7,998	111,472	0	0	0	0	0	0	0	128,669	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,483)	0	93,339	496,386	0	0	0	0	0	0	0	581,242	32
33	Real Estate Taxes	0	0	5,467	0	0	0	0	0	0	0	0	5,467	33
34	Rent-Facility & Grounds	0	0	0	(500,936)	0	0	0	0	0	0	0	(500,936)	34
35	Rent-Equipment & Vehicles	0	0	7,820	0	0	0	0	0	0	0	0	7,820	35
36	Other (specify):*	0	(22,200)	0	0	0	0	0	0	0	0	0	(22,200)	36
37	TOTAL Ownership	716	(22,200)	114,624	106,922	0	200,062	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	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(51,571)	(223,514)	392,050	53,798	0	0	0	0	0	0	0	170,763	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	EVANSTON	MGMT/CLERICAL
				CAREPLUS REHAB	EVANSTON	THERAPY
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EXTENDED CARE CONSULTING		
					EVANSTON	MGMT/CLERICAL
				BOULEVARD		
				PROPERTY, LLC	EVANSTON	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	\$ 125,000	CAREPLUS MANAGEMENT, INC.		\$	(125,000)	1
2	V	19	ADMIN. CONSULT. FEES	77,500				(77,500)	2
3	V	21	CLERICAL FEES	46,500				(46,500)	3
4	V	36	OFFICE RENT	22,200				(22,200)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V	6	MAINT AND REPAIR			7,843		7,843	9
10	V	6	MAINTENANCE SALARIES			6,874		6,874	10
11	V	7	SCAVENGER & SECURITY			100		100	11
12	V	10	NURSING SALARIES			26,263		26,263	12
13	V	10A	THERAPY SALARIES			6,606		6,606	13
14	Total		\$ 271,200			\$ 47,686	\$ *	(223,514)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. SALARIES	\$	CAREPLUS MGMT. INC.		\$ 113,794	\$ 113,794
16	V	19 PROFESSIONAL FEES				8,726	8,726
17	V	20 ADVERTISING				1,915	1,915
18	V	21 TOTAL OFFICE				18,697	18,697
19	V	21 CLERICAL SALARIES				74,121	74,121
20	V	23 SEMINARS				890	890
21	V	24 TRAVEL				217	217
22	V	25 TRANSPORTATION				9,538	9,538
23	V	26 INSURANCE				1,682	1,682
24	V	27 EMPLOYEE BENEFITS				47,846	47,846
25	V	30 DEPRECIATION (SL)				7,998	7,998
26	V	32 INTEREST				87,556	87,556
27	V	32 INTEREST-TAG 18 PPTY-MTG				5,783	5,783
28	V	33 REAL ESTATE TAX-TAG 18 PPTY				5,467	5,467
29	V	35 EQUIPMENT RENT				7,820	7,820
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 392,050	\$ * 392,050

* 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	30 SL DEPRECIATION	\$	CAREPLUS REHABILITATIVE SERVICES		\$ 7,726	\$ 7,726
16	V						
17	V						
18	V						
19	V						
20	V	21 CLERICAL FEES	7,362	EXTENDED CARE CONSULTING/CLINICAL			(7,362)
21	V	21 HOME OFFICE EXPENSES	51,322				(51,322)
22	V	6 MAINTENANCE & REPAIR				4	4
23	V	20 DUES/LICENSES				25	25
24	V	21 OFFICE EXPENSES				1,014	1,014
25	V	23 SEMINARS				221	221
26	V	24 TRAVEL				8	8
27	V	25 TRANSPORTATION				1,899	1,899
28	V	27 EMPLOYEE BENEFITS				2,389	2,389
29	V						
30	V						
31	V						
32	V	34 RENT	500,936	BOULEVARD PROPERTY, LLC			(500,936)
33	V	30 SL DEPRECIATION				103,746	103,746
34	V	32 INTEREST				496,386	496,386
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 559,620			\$ 613,418	\$ * 53,798

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

Facility Name & ID Number **BOULEVARD CARE NURSING & REHAE** # **0050716** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATION:								\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT		SEE	5.4	13.53	SALARY	26,390	17-7	2
3			FINANCE		ATTACHED						3
4			BANKING		SCHEDULE						4
5	JAKOB BAKST	DIR OPERATIONS	FINANCE			5.4	13.53	SALARY	26,390	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 52,780		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 NURSING & REHAB

0050716

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CAREPLUS MANAGEMENT, INC.
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847) 905-3000
 Fax Number (847) 491-9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT AND REPAIR	CENSUS DAYS	356,012	8	\$ 57,951	\$ 48,181	\$ 7,843	1
2	6	MAINTENANCE SALARIES	CENSUS DAYS	356,012	8	50,792	48,181	6,874	2
3	7	SCAVENGER & SECURITY	CENSUS DAYS	356,012	8	738	48,181	100	3
4	10	NURSING SALARIES	CENSUS DAYS	356,012	8	194,059	48,181	26,263	4
5	10A	THERAPY SALARIES	CENSUS DAYS	356,012	8	48,814	48,181	6,606	5
6	17	ADMIN. SALARIES	CENSUS DAYS	356,012	8	840,831	48,181	113,794	6
7	19	PROFESSIONAL FEES	CENSUS DAYS	356,012	8	64,478	48,181	8,726	7
8	20	ADVERTISING	CENSUS DAYS	356,012	8	14,148	48,181	1,915	8
9	21	TOTAL OFFICE	CENSUS DAYS	356,012	8	138,156	48,181	18,697	9
10	21	CLERICAL SALARIES	CENSUS DAYS	356,012	8	547,685	48,181	74,121	10
11	23	SEMINARS	CENSUS DAYS	356,012	8	6,573	48,181	890	11
12	24	TRAVEL	CENSUS DAYS	356,012	8	1,601	48,181	217	12
13	25	TRANSPORTATION	CENSUS DAYS	356,012	8	70,475	48,181	9,538	13
14	26	INSURANCE	CENSUS DAYS	356,012	8	12,432	48,181	1,682	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	356,012	8	353,538	48,181	47,846	15
16	30	DEPRECIATION (SL)	CENSUS DAYS	356,012	8	59,093	48,181	7,998	16
17	32	INTEREST	CENSUS DAYS	356,012	8	646,953	48,181	87,556	17
18	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	356,012	8	42,734	48,181	5,783	18
19	33	REAL ESTATE TAX-TAG 18 PPTY	CENSUS DAYS	356,012	8	40,394	48,181	5,467	19
20	35	EQUIPMENT RENT	CENSUS DAYS	356,012	8	57,785	48,181	7,820	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,249,230	\$ 1,682,181	\$ 439,736	25

Facility Name & ID Number BOULEVARD CARE NURSING & REHAB

0050716

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization EXTENDED CARE CONSULTING/CLINICAL
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847) 905-3000
 Fax Number (847) 491-9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE & REPAIR	CENSUS DAYS	58,508	8	\$ 32	7,798	\$ 4	1
2	20	DUES/LICENSES	CENSUS DAYS	58,508	8	184	7,798	25	2
3	21	OFFICE EXPENSES	CENSUS DAYS	58,508	8	7,605	7,798	1,014	3
4	23	SEMINARS	CENSUS DAYS	58,508	8	1,657	7,798	221	4
5	24	TRAVEL	CENSUS DAYS	58,508	8	57	7,798	8	5
6	25	TRANSPORTATION	CENSUS DAYS	58,508	8	14,249	7,798	1,899	6
7	27	EMPLOYEE BENEFITS	CENSUS DAYS	58,508	8	17,921	7,798	2,389	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 41,705	\$	\$ 5,560	25

Facility Name & ID Number

BOULEVARD CARE NURSING & REHAB

0050716

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	3,456,951	496,386	2									
3											3									
4											4									
5	CARAPLUS MANAGEMENT ALLOCATION									93,339	5									
Working Capital																				
6	CAREPLUS MGMT		X	WORKING CAPITAL						4,835	6									
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCING						2,426	7									
8	FIFTH THIRD BANK		X	AUTO	\$827.79	12/08		42,200	34,418	8.1300	2,906	8								
9	TOTAL Facility Related				\$827.79			\$ 4,699,652	\$ 3,491,369		\$ 599,892	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES							442	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related							\$	\$		\$ 442	14								
15	TOTALS (line 9+line14)							\$ 4,699,652	\$ 3,491,369		\$ 600,334	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

1. Real Estate Tax accrual used on 2008 report.		\$	187,175	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.)		\$	187,182	2
3. Under or (over) accrual (line 2 minus line 1).		\$	7	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	188,729	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 \$ 461 For 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(461)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	188,275	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	186,405	8	
	2005	190,546	9	
	2006	192,486	10	
	2007	187,322	11	
	2008	187,182	12	
THE CURRENT YEAR REAL ESTATE ACCRUAL FOR BOULEVARD CARE CENTER INC IS BASED ON ~ 101% OF PRIOR YEAR REAL ESTATE TAX BILL FOR 10 MONTH = 155,973 PLUS				
FOR BOULEVARD CARE NURSING & REHAB CENTER, LLC =9,700				
THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL				
		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

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

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	\$	\$ 1,543,363	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LIGHT FIXTURES		1987	3,077		20			3,077	9
10		LEASEHOLD IMPROVEMENTS		1987	1,159	37	15		(37)	1,159	10
11		FIRE ALARM SERVICE		1988	10,046	319	20		(319)	10,046	11
12		ROOFING		1989	2,000	63	20		(63)	2,000	12
13		SEWER REPAIR		1989	3,250		15			3,250	13
14		ROOFING & AWNING		1990	7,780	247	20	389	142	7,683	14
15		LEASEHOLD IMPROVEMENTS		1991	16,578	482	20	829	347	15,296	15
16		LEASEHOLD IMPROVEMENTS		1992	1,800		15			1,800	16
17		LEASEHOLD IMPROVEMENTS		1992	19,702	625	31.5	625		10,933	17
18		LEASEHOLD IMPROVEMENTS		1993	25,871	736	31.5	821	85	13,462	18
19		LEASEHOLD IMPROVEMENTS		1994	8,666	222	39	222		3,349	19
20		LEASEHOLD IMPROVEMENTS		1994	4,690		20	235	235	3,642	20
21		ROOF REPAIRS		1995	1,500	38	39	38		566	21
22		ELEVATOR REPAIR / DOOR		1995	5,575	143	39	143		2,008	22
23		LANDSCAPING / FENCE REPAIR		1995	5,195	346	15	346		5,024	23
24		SUMP PUMP		1996	2,840	73	39	73		1,001	24
25		WALK-IN FREEZER REPAIR		1996	3,187	81	39	81		1,104	25
26		ROOF REPAIRS		1996	8,735	224	39	224		2,996	26
27		SECURITY SYSTEM		1996	1,035	27	39	27		352	27
28		ELEVATOR REPAIR		1997	6,017	154	39	154		1,955	28
29		WINDOWS		1997	1,170	30	39	30		379	29
30		CARPETING		1998	2,187	56	39	56		656	30
31		FIRE DAMPERS		1998	8,240	212	39	212		2,363	31
32		SEWER REPAIRS		1998	2,704	69	39	69		773	32
33		IRON FENCE		1998	4,684	312	15	312		3,588	33
34		INSTALL PIPE		1999	6,043	155	39	155		1,673	34
35		FLOORING-RESIDENT BATHROOMS		2000	23,773	865	27.5	865		8,467	35
36		ALARM SYSTEM		2000	94,362	3,431	27.5	3,431		33,596	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **BOULEVARD CARE NURSING & REHAB**# **0050716**

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SMALL SERVICE ELEVATOR	2000	\$ 64,585	\$ 2,348	27.5	\$ 2,348		\$ 21,426	37
38	AWNING	2000	2,700	98	27.5	98		894	38
39	INSTALL NEW ROOF SYSTEM	2000	49,600	1,804	27.5	1,804		16,458	39
40	REPAIR SMALL & LARGE PASSENGER ELEVATORS	2001	5,786	210	27.5	210		1,847	40
41	INSTALL NEW STEAM TABLE	2001	4,147	151	27.5	151		1,327	41
42	EJECTOR PUMP	2001	2,878	105	27.5	105		914	42
43	INTERIOR ENTRANCE-INSTALL ALUMINUM DOOR	2001	2,748	100	27.5	100		854	43
44	RESIDENT ROOMS-CLOSETS	2001	20,078	730	27.5	730		6,175	44
45	EXISTING SPRINKLER SYSTEM-PLACARD	2001	3,600	131	27.5	131		1,097	45
46	INSTALL CHAIN FENCE	2001	1,400	83	15	93	10	917	46
47	FIRE ALARM REPAIR	2001	6,392	232	27.5	232		1,904	47
48	REPLACEMENT CARPET FOR 5 OFFICES	2001	3,294		20	165	165	1,485	48
49	REPLACEMENT OF WINDOW	2001	2,880	105	27.5	105		853	49
50	INSTALL BASEBOARD COVERS, WALK-IN COOLER	2001	3,314		20	166	166	1,494	50
51	NEW WALL, FLOORING-ELEVATORS	2001	4,506		20	225	225	2,025	51
52	FLOORING-1ST, 2ND, 3RD FL CORR/DAYROOM/NURSES ST	2002	49,673	1,806	27.5	1,806		14,230	52
53	NEW WINDOW TREATMENTS, DRAPERY PANELS	2002	6,807		20	340	340	2,720	53
54	2ND & 3RD FLOOR-WOOD BASEBOARD	2002	3,367		20	168	168	1,344	54
55	WALLCOVERING-LOBBY 1ST, 2ND & 3RD FLOOR	2002	31,043	1,129	27.5	1,129		8,232	55
56	INSTALL NEW SUSPENDED CEILING & LIGHTING	2002	46,843	1,703	27.5	1,703		12,134	56
57	ELECTRICAL WORK-1ST, 2ND AND 3RD FLOOR	2002	9,105	331	27.5	331		2,331	57
58	ELEVATOR-INSTALL OF CONTROLLER, CAR & HALL ST.	2003	99,988	3,636	27.5	3,636		25,301	58
59	REMODELING OF SHOWER & TUB ROOMS	2003	35,363	1,286	27.5	1,286		8,841	59
60	2ND&3RD FL -HANDRAILS&BUMPERS/1ST FL NURSE STA	2003	63,426	2,306	27.5	2,306		14,334	60
61	SOCIAL SERVICES-INSTALL NEW STEEL FRAME	2003	2,469	90	27.5	90		596	61
62	ELECTRICAL WORK FOR ELEVATOR	2003	5,562	202	27.5	202		1,339	62
63	REMODELING OF THE SHOWER, TUB, RESIDENT ROOMS	2004	109,477	3,981	27.5	3,981		23,057	63
64	REPAIR MASONRY ABOVE TOP FLOOR WINDOWS	2004	7,600	276	27.5	276		1,484	64
65	REPLACE MAIN ENTRANCE	2005	1,500	55	27.5	55		275	65
66	NEW LANDSCAPING	2006	9,600	640	15	640		2,347	66
67	INSTALL EXHAUST FANS	2006	5,500	200	27.5	200		692	67
68	INSTALL EMERGENCY LIGHTS	2006	3,067	112	27.5	112		387	68
69	INSTALL NEW TRANSFER SWITCH IN PLACE OF OLD	2007	5,463	199	27.5	199		489	69
70	TOTAL (lines 4 thru 69)		\$ 5,001,877	\$ 136,742		\$ 138,206	\$ 1,464	\$ 1,865,364	70

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

Facility Name & ID Number **BOULEVARD CARE NURSING & REHAB**# **0050716**

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,001,877	\$ 136,742		\$ 138,206	\$ 1,464	\$ 1,865,364	1
2	REROOFED PROPERTY USING SINGLE PLY BITUMEN	2007	2,500	91	27.5	91		201	2
3	REROOFED PROPERTY USING SINGLE PLY BITUMEN	2008	4,500	164	27.5	164		212	3
4	INSTALL 4 EXIT CHECK DELAYED EGRESS LOCKS	2008	4,175	152	27.5	152		246	4
5	FIRE ALARM SYSTEM 1ST FLOOR-REPLACED CARD	2008	3,510	127	27.5	127		207	5
6	INSTALLATION OF NEW NURSES STATION; DINING ROOM	2009	146,005	3,761	27.5	3,761		3,761	6
7	INSTALLATION OF CEILING FANS, BASEBOARD AND								7
8	SHOEBASE, CHAIR RAILS MANTEL MOLDINGS,WALL,								8
9	WASHROOM REPAIR AND PAINTING,REMODEL BEDROOMS								9
10	INSTALL A/C, CIRCUITS &OUTLETS IN CARE PLAN OFFIC	2009	2,400	47	27.5	47		47	10
11	INSTALLED CAMERA SYSTEM	2009	5,725	9	27.5	9		9	11
12	WALL AIR CONDITIONERS	2009	5,124	3,074	5	3,074		3,074	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22	RELATED PARTY ALLOCATION:								22
23	CAREPLUS REHAB								23
24	ROOF EXHAUST VENTILATOR	2003	950	24	39	24			24
25	MOTORS, ROOF VENTILATOR	2003	836	21	39	21			25
26	WALK-IN COOLER EVAPORATOR	2003	1,422	37	39	37			26
27	RECIRCULATING PUMP MOTOR	2003	576	14	39	14			27
28									28
29	CAREPLUS MGMT								29
30	BUILDING-TAG-18 PROPERTIES	2004	59,443	2,046	39	2,046			30
31	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	23,353	1,233	39	1,233			31
32	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		9	39	9			32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,262,396	\$ 147,551		\$ 149,015	\$ 1,464	\$ 1,873,121	34

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

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	\$ 225,292	\$ 11,758	\$ 18,544	\$ 6,786	5-15	\$ 155,503	71
72	Current Year Purchases	4,346	2,608	217	(2,391)	8	217	72
73	Fully Depreciated Assets	151,782					151,782	73
74	RELATED PART SL DEPRECIATION		12,340	12,340				74
75	TOTALS	\$ 381,420	\$ 26,706	\$ 31,101	\$ 4,395		\$ 307,502	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	FACILITY	2008 CHEVROLET EXP VAN	2008	\$ 42,200	\$ 5,100	\$ 8,440	\$ 3,340	5	\$ 16,880	76
77										77
78										78
79										79
80	TOTALS			\$ 42,200	\$ 5,100	\$ 8,440	\$ 3,340		\$ 16,880	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)	\$ 5,786,016	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,357	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,556	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,199	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,197,503	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: \$ **16,526** Description: **WASHER/DRYER-\$9,600 ; COPIER \$6,926**

(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			N/A		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. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

* 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	\$		\$ 46,492	\$		\$ 46,492	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			710			710	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			240,357			240,357	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				104,522		104,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39-2					381		381	12
13	Other (specify): MEDICAL SUPPLIES	39-2					600		600	13
14	TOTAL			\$		\$ 287,559	\$ 105,503		\$ 393,062	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 NURSING & REHAB**

0050716

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,853	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>20,000</u>)	939,043		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,220		6
7	Other Prepaid Expenses	21,509		7
8	Accounts Receivable (owners or related parties)	73,776		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	23,056		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,112,457	\$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,112,457	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 352,527	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	747,038		29
30	Accrued Salaries Payable	37,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,016		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,756		32
33	Accrued Interest Payable			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)	\$ 1,173,320	\$	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)	\$ 1,173,320	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (60,863)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,112,457	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	279,585	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) ADJ FOR BOULEVARD CARE CENTER	(340,448)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (60,863)	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)	\$ (60,863)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BOULEVARD CARE NURSING & REHAB**# **0050716**Report Period Beginning: **01/01/2009**Ending: **12/31/2009**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,340,799	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,340,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,110	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,110	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***	8,041	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,041	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)	\$ 6,356,950	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,065,077	31
32	Health Care	2,282,735	32
33	General Administration	1,453,194	33
B. Capital Expense			
34	Ownership	798,433	34
C. Ancillary Expense			
35	Special Cost Centers	393,062	35
36	Provider Participation Fee	84,864	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,077,365	40
41	Income before Income Taxes (line 30 minus line 40)**	279,585	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 279,585	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 NURSING & REHAB**

0050716

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,970	2,088	\$ 77,206	\$ 36.98	1
2	Assistant Director of Nursing	1,976	2,085	62,230	29.85	2
3	Registered Nurses	3,654	3,824	95,556	24.99	3
4	Licensed Practical Nurses	29,669	31,693	709,777	22.40	4
5	CNAs & Orderlies	64,881	72,208	737,223	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,576	4,389	59,306	13.51	8
9	Activity Director	1,875	2,107	28,896	13.71	9
10	Activity Assistants	4,858	5,384	45,165	8.39	10
11	Social Service Workers	1,350	1,410	33,815	23.98	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,280	40,869	17.93	13
14	Head Cook	3,932	4,575	44,633	9.76	14
15	Cook Helpers/Assistants	12,228	13,443	123,783	9.21	15
16	Dishwashers					16
17	Maintenance Workers	5,388	6,185	71,041	11.49	17
18	Housekeepers	12,411	14,127	141,859	10.04	18
19	Laundry	3,960	4,644	49,287	10.61	19
20	Administrator	2,020	2,219	85,970	38.74	20
21	Assistant Administrator	1,958	2,095	72,932	34.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,086	4,298	78,210	18.20	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	1,372	1,561	17,588	11.27	31
32	Other Health Care(specify)	12,047	13,232	236,183	17.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,281	193,847	\$ 2,811,529 *	\$ 14.50	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	\$ 14,978	1-3	35
36	Medical Director	O	9,750	9-3	36
37	Medical Records Consultant	N	0	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	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,555	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)		\$ 28,723		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	50
51	Licensed Practical Nurses		N/A	51
52	Certified Nurse Assistants/Aides			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		
DEBRA BROWN	ADMINISTRATOR	0	\$ 85,970	Workers' Compensation Insurance	\$ 66,375	IDPH License Fee	\$		
CYNTHIA STAINE	ASST ADM	0	72,932	Unemployment Compensation Insurance	24,737	Advertising: Employee Recruitment	50		
				FICA Taxes	210,850	Health Care Worker Background Check	180		
				Employee Health Insurance	96,247	(Indicate # of checks performed <u>9</u>)			
				Employee Meals	24,638	Patient Background Checks	9 196		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0		
				EMPLOYEE BENEFITS - OTHER	1,444	MARKETING/ADV/PROMO	28,442		
				EMPLOYEE PHYSICAL EXAMS	283	LICENSES/DUES/SUBSCRIPTIONS	3,779		
				PENSION/PROFIT SHARING PLANS	24,931	MGMT CO ALLOC	1,940		
				CHICAGO HEAD TAX	4,252	TRUST/FRANCHISE/CONTRIB/ETC	0		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(28,442)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 158,902				\$ 453,757			\$ 6,145		
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	MANAGEMENT FEES		\$ 125,000				Out-of-State Travel	\$	
							In-State Travel		
								0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			MGMT CO ALLOC		225
\$ 125,000				\$			Seminar Expense		852
C. Professional Services							Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
AMERICAN DATA	DATA PROCESSING		\$ 4,571				TOTAL		
NATIONAL DATACARE	DATA PROCESSING		2,836				\$ 1,077		
MDI ACHIEVE	DATA PROCESSING		1,602						
EMDEON BUSINESS SERVICE	DATA PROCESSING		350						
NEBO SYSTEM	DATA PROCESSING		56						
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		4,166						
CAREPLUS MGMT	ADMINIST. CONSULTANT		77,500						
KBKB, LTD	ACCOUNTING FEES		10,500						
MEYER MAGENCE	LEGAL FEES		1,975						
ECONOCARE	PURCHASE CONSULTANT		1,395						
PERSONNEL PLANNER	UC CONSULTANT		1,815						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 106,766									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **BOULEVARD CARE NURSING & REHAB**# **0050716**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****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 HEALTH CARE \$930
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
BOULEVARD CARE CENTER INC # 0032276 11/1/09
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,864
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. \$ 24,638 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: _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.