



Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	44,879	174	1,895	46,948	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,879	174	1,895	46,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.98%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 05/01/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/1987 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 1,895

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Boulevard Care Nursing & Rehab # 0050716 Report Period Beginning: 01/01/10 Ending: 12/31/10

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	214,237	49,231	13,622	277,090		277,090	416	277,506		1
2	Food Purchase		221,907		221,907		221,907	332	222,239		2
3	Housekeeping	130,653	28,038		158,691		158,691	416	159,107		3
4	Laundry	55,936	18,216		74,152		74,152	(748)	73,404		4
5	Heat and Other Utilities			130,807	130,807		130,807	1,092	131,899		5
6	Maintenance	101,000		71,366	172,366		172,366	9,058	181,424		6
7	Other (specify):*							1,571	1,571		7
8	<b>TOTAL General Services</b>	<b>501,826</b>	<b>317,392</b>	<b>215,795</b>	<b>1,035,013</b>		<b>1,035,013</b>	<b>12,137</b>	<b>1,047,150</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,947,667	36,151	16,708	2,000,526		2,000,526	20,555	2,021,081		10
10a	Therapy	56,625	693		57,318		57,318	3,358	60,676		10a
11	Activities	76,685	7,398	1,431	85,514		85,514		85,514		11
12	Social Services	295,065	8,926	12,186	316,177		316,177	2,402	318,579		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,189	5,189		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,376,042</b>	<b>53,168</b>	<b>45,325</b>	<b>2,474,535</b>		<b>2,474,535</b>	<b>31,504</b>	<b>2,506,039</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	171,811			171,811		171,811	43,083	214,894		17
18	Directors Fees										18
19	Professional Services			404,915	404,915	(8,155)	396,760	(260,664)	136,096		19
20	Dues, Fees, Subscriptions & Promotions			14,154	14,154		14,154	(1,661)	12,493		20
21	Clerical & General Office Expenses	59,546	23,911	200,923	284,380		284,380	(10,376)	274,004		21
22	Employee Benefits & Payroll Taxes			493,106	493,106		493,106	(15,451)	477,655		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,777	2,777		2,777	1,274	4,051		24
25	Other Admin. Staff Transportation			13,370	13,370		13,370	(9,355)	4,015		25
26	Insurance-Prop.Liab.Malpractice			108,763	108,763		108,763	812	109,575		26
27	Other (specify):*							29,441	29,441		27
28	<b>TOTAL General Administration</b>	<b>231,357</b>	<b>23,911</b>	<b>1,238,008</b>	<b>1,493,276</b>	<b>(8,155)</b>	<b>1,485,121</b>	<b>(222,897)</b>	<b>1,262,224</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,109,225</b>	<b>394,471</b>	<b>1,499,128</b>	<b>5,002,824</b>	<b>(8,155)</b>	<b>4,994,669</b>	<b>(179,256)</b>	<b>4,815,413</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## 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	
	<b>D. Ownership</b>											
30	Depreciation			735	735		735	186,548	187,283			30
31	Amortization of Pre-Op. & Org.			494	494		494	(494)	0			31
32	Interest			39,376	39,376		39,376	354,064	393,440			32
33	Real Estate Taxes			174,750	174,750	8,155	182,905	1,582	184,487			33
34	Rent-Facility & Grounds			645,554	645,554		645,554	(644,574)	980			34
35	Rent-Equipment & Vehicles			15,370	15,370		15,370	1,756	17,126			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			876,279	876,279	8,155	884,434	(101,118)	783,316			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,660	153,330	339,990		339,990	(63,801)	276,189			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	<b>TOTAL Special Cost Centers</b>		186,660	238,193	424,853		424,853	(63,801)	361,052			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,109,225	581,131	2,613,600	6,303,956		6,303,956	(344,174)	5,959,782			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	78,428	30		9
10	Interest and Other Investment Income	(26)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,709)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,864)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,596)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (64,775)		\$	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)	(279,400)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (279,400)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (344,174)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

**Boulevard Care Nursing & Rehab**

ID# 0050716

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (17)	21	1
2	Patient Clothing	(1,612)	10	2
3	Theft Loss	(119)	21	3
4	Collection Expense	(581)	21	4
5	Annual Report	(500)	20	5
6	Non-Allowable Amortization	(494)	31	6
7	Non-Allowable Legal	(2,915)	19	7
8	Capitalized Auto	(9,975)	25	8
9	Building Co- Bank Service Fee	(233)	21	9
10	Building Co-Filing Fees	(150)	21	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	<b>Total</b>	(16,596)		49

Boulevard Care Nursing & Rehab

ID# 0050716

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Boulevard Care Nursing & Rehab# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	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			122		3,608		(3,314)					416	1
2	Food Purchase	(8)		340									332	2
3	Housekeeping			436		48				(68)			416	3
4	Laundry									(748)			(748)	4
5	Heat and Other Utilities			991		101							1,092	5
6	Maintenance			2,848	6,109	101							9,058	6
7	Other (specify):*				1,065	506							1,571	7
8	<b>TOTAL General Services</b>	<b>(8)</b>		<b>4,737</b>	<b>7,174</b>	<b>4,364</b>		<b>(3,314)</b>		<b>(816)</b>			<b>12,137</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,612)				23,217				(1,050)			20,555	10
10a	Therapy					3,358							3,358	10a
11	Activities													11
12	Social Services					2,402							2,402	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,061	1,128						5,189	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,612)</b>				<b>33,038</b>	<b>1,128</b>			<b>(1,050)</b>			<b>31,504</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			2,018	7,837	33,228							43,083	17
18	Directors Fees													18
19	Professional Services	(2,915)		(200,437)		(57,312)							(260,664)	19
20	Fees, Subscriptions & Promotions	(4,364)		2,559		144							(1,661)	20
21	Clerical & General Office Expenses	(123,809)	383	11,955	94,993	6,102							(10,376)	21
22	Employee Benefits & Payroll Taxes				(14,287)		(1,128)			(36)			(15,451)	22
23	Inservice Training & Education													23
24	Travel and Seminar			125		1,149							1,274	24
25	Other Admin. Staff Transportation	(9,975)		620									(9,355)	25
26	Insurance-Prop.Liab.Malpractice			681		131							812	26
27	Other (specify):*				24,117	5,324							29,441	27
28	<b>TOTAL General Administration</b>	<b>(141,063)</b>	<b>383</b>	<b>(182,479)</b>	<b>112,660</b>	<b>(11,234)</b>	<b>(1,128)</b>			<b>(36)</b>			<b>(222,897)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(142,683)</b>	<b>383</b>	<b>(177,742)</b>	<b>119,834</b>	<b>26,168</b>		<b>(3,314)</b>		<b>(1,902)</b>			<b>(179,256)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Boulevard Care Nursing & Rehab# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	78,428	103,746	3,679		695							186,548	30
31	Amortization of Pre-Op. & Org.	(494)											(494)	31
32	Interest	(26)	333,808	7,021		13,261							354,064	32
33	Real Estate Taxes			1,425		157							1,582	33
34	Rent-Facility & Grounds		(645,554)	980									(644,574)	34
35	Rent-Equipment & Vehicles			1,756									1,756	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>77,908</b>	<b>(208,000)</b>	<b>14,861</b>		<b>14,113</b>							<b>(101,118)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(62,331)	(1,470)			(63,801)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>								<b>(62,331)</b>	<b>(1,470)</b>			<b>(63,801)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(64,775)	(207,617)	(162,881)	119,834	40,281		(3,314)	(62,331)	(3,371)			(344,174)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Boulevard Property, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 645,554	Boulevard Property, LLC	100.00%	\$	(645,554)	1
2	V	32 Interest		Boulevard Property, LLC	100.00%	333,808	333,808	2
3	V	21 Filing Fee		Boulevard Property, LLC	100.00%	150	150	3
4	V	30 Depreciation		Boulevard Property, LLC	100.00%	103,746	103,746	4
5	V	21 Bank Service Fee		Boulevard Property, LLC	100.00%	233	233	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 645,554			\$ 437,937	\$ * (207,617)	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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 122	\$	122	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	340		340	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	436		436	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	991		991	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,848		2,848	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,018		2,018	20
21	V	19 Professional Fees	227,213	Extended Care Consulting, LLC	100.00%	8,413		(200,437)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,559		2,559	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,955		11,955	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	125		125	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	620		620	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	681		681	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,679		3,679	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	7,021		7,021	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,425		1,425	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	980		980	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,756		1,756	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 227,213			\$ 45,969	\$ *	(162,881)	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	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	6,109	\$	6,109	15
16	V	06 Maintenance (Direct)	293	Extended Care Consulting, LLC	100.00%	293			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,021		1,021	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	44		44	18
19	V	12 Admission (Direct)	8,882	Extended Care Consulting, LLC	100.00%	8,882			19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,837		7,837	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	94,993		94,993	22
23	V	21 Office and Clerical (Direct)	35,221	Extended Care Consulting, LLC	100.00%	35,221			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,183		17,183	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,934		6,934	25
26	V	22 Employee Benefits	14,287	Extended Care Consulting, LLC	100.00%			(14,287)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 58,683			\$ 178,517	\$ *	119,834	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 48	\$	48	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	101		101	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	101		101	17
18	V	19 Professional Fees	37,770	Extended Care Clinical, LLC	100.00%	5,638		(57,312)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	144		144	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,346		1,346	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,149		1,149	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	131		131	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	695		695	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	13,261		13,261	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	157		157	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	3,608		3,608	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	506		506	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	23,217		23,217	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	3,358		3,358	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	2,402		2,402	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,061		4,061	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	33,228		33,228	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	4,756		4,756	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,324		5,324	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 37,770			\$ 103,231	\$ *	40,281	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	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing Salary	7,341	Extended Care Clinical, LLC	100.00%	7,341		17
18	V	12 Social Service Salary	3,304	Extended Care Clinical, LLC	100.00%	3,304		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,128	1,128	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22 Employee Benefits	1,128	Extended Care Clinical, LLC	100.00%		(1,128)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 11,773			\$ 11,773	\$ *	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	1 Dietary Supplies, Supplements	\$ 7,461	Care Centers Health Systems, Inc.	100.00%	\$ 4,146	\$ (3,314)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense		Care Centers Health Systems, Inc.	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,461			\$ 4,146	\$ * (3,314)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 153,330	TriCare Rehab	100.00%	\$ 90,999	\$ (62,331)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 153,330			\$ 90,999	\$ * (62,331)

\* 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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	1,019	Xcel Supply, LLC	100.00%	951	(68)	16
17	V	4 Laundry	11,221	Xcel Supply, LLC	100.00%	10,473	(748)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	15,760	Xcel Supply, LLC	100.00%	14,710	(1,050)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	536	Xcel Supply, LLC	100.00%	501	(36)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	22,057	Xcel Supply, LLC	100.00%	20,587	(1,470)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 50,593			\$ 47,221	\$ * (3,371)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 79,536	\$ 79,536	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	79,536	CCS Employee Benefits Group	100.00%		(79,536)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 79,536			\$ 79,536	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Boulevard Care Nursing & Rehab # 0050716 Report Period Beginning: 01/01/10 Ending: 12/31/10

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	90.00%	See Attached	1.19	2.56%	Mgmt Fees	\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.71	3.11%	Al. Salary/Fees	4,963	17-7	2
3	Adam Vales	Shareholder	Clerical		See Attached	0.42	1.05%	Alloc. Salary	730	22-7	3
4	G. Matt Silvers	Relative	Administrative		See Attached	0.09	0.40%	Alloc. Salary	301	17-7	4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										10
11	IL Dept. of HFS.										11
12											12
13								TOTAL	\$ 5,994		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	01	Dietary	Patient Days	1,512,273	34	\$ 3,931	\$ 46,948	\$ 122	1
2	02	Food	Patient Days	1,512,273	34	10,940	46,948	340	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	46,948	436	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	46,948	991	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	46,948	2,848	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	46,948	2,018	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	46,948	8,413	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	46,948	2,559	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	46,948	11,955	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	46,948	125	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	46,948	620	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	46,948	681	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	46,948	3,679	13
14	32	Interest	Patient Days	1,512,273	34	226,162	46,948	7,021	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	46,948	1,425	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	46,948	980	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	46,948	1,756	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 45,969	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	34	196,794	196,794	46,948	6,109	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478		293	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		46,948	1,021	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607			44	4
5	12	Admission (Direct)	Direct	34	52,036	52,036		8,882	5
6	15	Emp. Ben. - Nursing (Direct)	Direct	34	5,270				6
7	17	Administrative (Pooled)	Patient Days	34	252,448	252,448	46,948	7,837	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	46,948	94,993	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		35,221	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		46,948	17,183	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			6,934	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				\$ 5,054,827	\$ 4,364,695		\$ 178,517	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Clinical, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	03	Housekeeping	Patient Days	1,512,273	34	\$ 1,549	\$ 46,948	\$ 48	1
2	05	Utilities	Patient Days	1,512,273	34	3,268	46,948	101	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240	46,948	101	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624	46,948	5,638	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624	46,948	144	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370	46,948	1,346	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025	46,948	1,149	7
8	26	Insurance	Patient Days	1,512,273	34	4,213	46,948	131	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389	46,948	695	9
10	32	Interest	Patient Days	1,512,273	34	427,165	46,948	13,261	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058	46,948	157	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	46,948	3,608	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288	46,948	506	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	46,948	23,217	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	46,948	3,358	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	46,948	2,402	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816	46,948	4,061	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	46,948	33,228	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	46,948	4,756	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480	46,948	5,324	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,325,274	\$ 2,273,164	\$ 103,231	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Extended Care Clinical, LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 905-3000

Fax Number

( 847) 905-3030

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		7,341	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		3,304	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			1,128	5
6	17	Administration Salary	Direct Allocation		82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053				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				\$ 974,688	\$ 868,276		\$ 11,773	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Care Centers Health Systems, Inc.  
 Street Address 200 Howard  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612-5662  
 Fax Number ( 224) 612-5862

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation		\$	\$		\$ 4,146	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation						3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 4,146	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization TriCare Rehab  
 Street Address 150 Fencil Lane  
 City / State / Zip Code Hillside, IL 60162  
 Phone Number ( 773) 449-9400  
 Fax Number ( 773) 449-9700

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation		\$	\$		\$ 90,999	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 90,999	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					951	2
3	4	Laundry	Direct Allocation					10,473	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					14,710	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					501	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					20,587	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				\$	\$		\$	47,221

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CCS Employee Benefits Group, Inc.  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 79,536	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 79,536	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Boulevard Care Nursing &amp; Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	First Bank		X	Mortgage			\$	\$ 3,356,078			\$ 333,808	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	<b>Working Capital</b>																			
6	HFG		X	Line Of Credit							6,080	6								
7	First Bank		X								24,819	7								
8	See Supplemental Schedule										24,699	8								
9	TOTAL Facility Related						\$	\$ 3,356,078			\$ 389,406	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(26)	10								
11	Paid by Oak Park		X								4,061	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ 4,035	14								
15	TOTALS (line 9+line14)						\$	\$ 3,356,078			\$ 393,440	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number

Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	Alloc from Ext Care Const, Inc	X				\$	\$			\$	7,021	8						
9	Alloc from Ext Care Clinical	X									13,261	9						
10	Homewood Loan	X									4,417	10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>										24,699	14						
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$		15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>										20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	<b>176,466</b>	<b>1</b>
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.)		\$	<b>173,717</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,749)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>179,081</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>8,155</b>	<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>184,487</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<b>190,546</b>	<b>8</b>
	2006	<b>192,486</b>	<b>9</b>
	2007	<b>187,322</b>	<b>10</b>
	2008	<b>187,182</b>	<b>11</b>
	2009	<b>172,135</b>	<b>12</b>

	<b>FOR BHF USE ONLY</b>	
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009 \$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**2010 Accrual = \$170,553 X 1.05 = \$179,081**

**Allocation from Extended Care Consulting Building Alloc. \$1,425**

**Allocation from Extended Care Clinical Building Alloc. \$157**

**Beginning Accrual Adjusted**

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**





Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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).

None

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>51,000</u>	<u>1995</u>	<u>\$ 100,000</u>	<u>1</u>
2	<u>Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main</u>			<u>11,394</u>	<u>2</u>
3	<b>TOTALS</b>	<b>51,000</b>		<b>\$ 111,394</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1987	4,236		20			4,236	9
10	Various		1988	10,046		20			10,046	10
11	Various		1989	5,250		20			5,250	11
12	Various		1990	7,780		20	97	97	7,780	12
13	Various		1991	16,578		20	829	829	16,125	13
14	Various		1992	21,502		20	625	625	13,358	14
15	Various		1993	25,871		20	821	821	14,283	15
16	Various		1994	13,356		20	457	457	7,448	16
17	Various		1995	12,270		20	352	352	7,950	17
18	Various		1996	15,797		20	405	405	5,858	18
19	Various		1997	7,187		20	184	184	2,518	19
20	Various		1998	17,815		20	649	649	8,029	20
21	Various		1999	6,043		20	155	155	1,828	21
22	Various		2000	235,020		20	8,456	8,456	89,297	22
23	Various		2001	61,023		20	2,413	2,413	23,305	23
24	Various		2002	146,838		20	5,477	5,477	46,468	24
25	Various		2003	206,808		20	7,520	7,520	57,931	25
26	Various		2004	117,077		20	4,257	4,257	28,798	26
27	Various		2005	1,500		20	55	55	330	27
28	Various		2006	18,167		20	952	952	4,378	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		4,046,250	103,746		103,750	4	1,647,113	67
68		45,912	3,127		3,127		21,885	68
69			735			(735)		69
70		\$ 5,042,326	\$ 107,608		\$ 140,581	\$ 32,973	\$ 2,024,214	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

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Ending:

12/31/10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,042,326	\$ 107,608		\$ 140,581	\$ 32,973	\$ 2,024,214	1
2	Install New Transfer Switch In Place Of Old	2007	5,463		20	199	199	688	2
3	Reroofed Property Using Single Ply Bitumen	2007	2,500		20	91	91	292	3
4	Reroofed Property Using Single Ply Bitumen	2008	4,500		20	164	164	376	4
5	Install 4 Exit Check Delayed Egress Locks	2008	4,175		20	152	152	398	5
6	Fire Alarm System 1St Floor - Replace Card	2008	3,510		20	127	127	334	6
7	New Nurse Station,Dining Rm, Ceiling Fan,Baseboard,Chair Rail,	2009	146,005		20	7,300	7,300	11,061	7
8	Install A/C Circuits & Outlets - Care Plan Office	2009	2,400		20	120	120	167	8
9	Install Camera System	2009	5,725		20	286	286	295	9
10	Wall Air Conditioners	2009	5,124		20	1,024	1,024	4,098	10
11	Hot Water Tank Repair	2010	5,494		20	275	275	275	11
12	Tuckpointing	2010	5,950		20	298	298	298	12
13	Bioler Repair	2010	3,582		20	179	179	179	13
14	Supply & Installation Of Ejection Pumps	2010	5,400		20	270	270	270	14
15	Laundry Chute Enclosure	2010	15,000		20	750	750	750	15
16	Supply & Installation Of Ejection Pumps	2010	9,150		20	458	458	458	16
17	Supply & Installation Of Ejection Pumps	2010	14,550		20	728	728	728	17
18	Fire Damper Installation	2010	34,950		20	1,748	1,748	1,748	18
19	Heat Start Up And Repairs	2010	4,187		20	209	209	209	19
20	Tile	2010	5,482		20	274	274	274	20
21	Linen Chute Repair	2010	2,942		20	294	294	294	21
22	Walk In Freezer And Cooler	2010	6,702		20	335	335	335	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740	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		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740	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		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 5,335,118	\$ 107,608		\$ 155,861	\$ 48,253	\$ 2,047,740

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>Boulevard Property, LLC</b>	1971	4,046,250	103,746	39	103,750	4	1,647,113	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ <b>4,046,250</b>	\$ <b>103,746</b>		\$ <b>103,750</b>	\$ <b>4</b>	\$ <b>1,647,113</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	<b>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	14,143	363	39	363		3,007	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,558	40	39	40		331	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from Extended Care Consulting	2007	143	7	20	7		29	9
10	Allocated from Extended Care Consulting	2009	85	4	20	4		9	10
11	Allocated from Extended Care Consulting	2010	832	42	20	42		42	11
12									12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2002	11,683	1,068	20	1,068		7,484	13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2003	13,768	1,258	20	1,258		8,820	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2005	684	73	20	73		319	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2009	123	6	20	6		12	16
17									17
18	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,287	118	20	118		824	18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,517	139	20	139		972	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	75	8	20	8		35	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	14	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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								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		\$ 45,912	\$ 3,127		\$ 3,127		\$ 21,885	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 236,640	\$ 701	\$ 19,680	\$ 18,979	10	\$ 178,667	71
72	Current Year Purchases	4,087	45	408	363	10	408	72
73	Fully Depreciated Assets	394,776				10	394,776	73
74								74
75	TOTALS	\$ 635,503	\$ 746	\$ 20,088	\$ 19,342		\$ 573,851	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		2008 CHEVROLET VAN	2008	\$ 54,167	\$	\$ 10,833	\$ 10,833	5	\$ 27,713	76
77		Allocated From EC Consulting	2010	9,983	156	156		5	9,671	77
78		Allocated From EC Clinical	2010	1,735	347	347		5	810	78
79										79
80	TOTALS			\$ 65,885	\$ 503	\$ 11,336	\$ 10,833		\$ 38,194	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)	\$ 6,147,900	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,857	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,286	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 78,428	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,659,785	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

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	Alloc. From Extended Care Consulting				980			5
6								6
7	TOTAL				\$ 980			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: \$ 17,126 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	76,711	\$		\$	76,711	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				15,474				15,474	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				61,145				61,145	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					109,585			109,585	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <b>See Supplemental</b>							77,075			77,075	13
14	<b>TOTAL</b>			\$		\$	153,330	\$	186,660	\$	339,990	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Boulevard Care Nursing & Rehab**

# **0050716**

Report Period Beginning: **01/01/10**

Ending: **12/31/10**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/10** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ <b>1,056</b>	1
2	Cash-Patient Deposits	<b>20,557</b>	<b>20,557</b>	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	<b>1,518,080</b>	<b>1,518,080</b>	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	<b>52,527</b>	<b>52,527</b>	6
7	Other Prepaid Expenses	<b>22,759</b>	<b>22,759</b>	7
8	Accounts Receivable (owners or related parties)	<b>74,025</b>	<b>227,872</b>	8
9	Other(specify): <b>See Attached Schedule</b>	<b>782,745</b>	<b>782,745</b>	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ <b>2,470,693</b>	\$ <b>2,625,596</b>	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		<b>100,000</b>	13
14	Buildings, at Historical Cost		<b>4,046,250</b>	14
15	Leasehold Improvements, at Historical Cost	<b>103,746</b>	<b>103,746</b>	15
16	Equipment, at Historical Cost	<b>13,278</b>	<b>168,278</b>	16
17	Accumulated Depreciation (book methods)	<b>(736)</b>	<b>(1,802,849)</b>	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): <b>See Attached Schedule</b>	<b>3,949</b>	<b>3,949</b>	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ <b>120,237</b>	\$ <b>2,619,374</b>	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ <b>2,590,930</b>	\$ <b>5,244,970</b>	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ <b>1,180,640</b>	\$ <b>1,180,640</b>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	<b>20,771</b>	<b>20,771</b>	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<b>226,461</b>	<b>226,461</b>	30
31	Accrued Taxes Payable (excluding real estate taxes)	<b>11,027</b>	<b>11,027</b>	31
32	Accrued Real Estate Taxes(Sch.IX-B)	<b>179,081</b>	<b>179,081</b>	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>See Attached Schedule</b>	<b>1,152,337</b>	<b>1,589,100</b>	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ <b>2,770,317</b>	\$ <b>3,207,080</b>	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		<b>3,356,078</b>	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>See Attached Schedule</b>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ <b>3,356,078</b>	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ <b>2,770,317</b>	\$ <b>6,563,158</b>	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ <b>(179,387)</b>	\$ <b>(1,318,188)</b>	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ <b>2,590,930</b>	\$ <b>5,244,970</b>	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(60,863)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(60,863)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(118,524)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(118,524)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(179,387)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Boulevard Care Nursing & Rehab**# **0050716**Report Period Beginning: **01/01/10**Ending: **12/31/10**

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,087,587	1
2	Discounts and Allowances for all Levels	(327,015)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,760,572</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	334,068	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 334,068</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	73,736	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,199	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,814	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 90,749</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 26</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>	17	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 17</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,185,432</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,035,013	31
32	Health Care	2,474,535	32
33	General Administration	1,493,276	33
<b>B. Capital Expense</b>			
34	Ownership	876,279	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	339,990	35
36	Provider Participation Fee	84,863	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,303,956</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(118,524)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (118,524)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? [Not Complete](#) If not, please attach a reconciliation.

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

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

Facility Name & ID Number Boulevard Care Nursing & Rehab

# 0050716

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,840	2,411	\$ 84,780	\$ 35.16	1
2	Assistant Director of Nursing	1,952	2,165	68,229	31.51	2
3	Registered Nurses	8,452	9,446	252,069	26.69	3
4	Licensed Practical Nurses	29,056	31,310	743,017	23.73	4
5	CNAs & Orderlies	66,562	74,976	772,636	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,455	4,186	56,625	13.53	8
9	Activity Director	1,699	1,854	28,874	15.57	9
10	Activity Assistants	5,153	5,502	47,811	8.69	10
11	Social Service Workers	15,352	16,552	295,065	17.83	11
12	Dietician					12
13	Food Service Supervisor	2,268	2,392	42,968	17.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,202	18,359	171,269	9.33	15
16	Dishwashers					16
17	Maintenance Workers	7,323	7,953	101,000	12.70	17
18	Housekeepers	11,561	11,519	130,653	11.34	18
19	Laundry	4,478	5,148	55,936	10.87	19
20	Administrator	2,048	2,450	96,705	39.47	20
21	Assistant Administrator	1,888	2,289	75,106	32.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,863	4,216	59,546	14.12	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	2,021	2,137	26,936	12.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	185,173	204,865	\$ 3,109,225 *	\$ 15.18	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	270	\$ 13,622	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant	Monthly	1,880	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,487	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,431	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	See Attached	578	19,527		48
49	TOTAL (lines 35 - 48)	875	\$ 58,947		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Boulevard Care Nursing &amp; Rehab

# 0050716

Report Period Beginning: 01/01/10

Ending: 12/31/10

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (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? N/A
- (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 Years
- (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
- (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. N/A
- (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 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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
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: N/A
- (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.