

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0050716</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																										
Facility Name: <u>Boulevard Care Nursing & Rehab Center, LLC</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																										
Address: <u>3405 S. Michigan Avenue</u> <u>Chicago</u> <u>60616</u> Number City Zip Code																													
County: <u>Cook</u>																													
Telephone Number: <u>(312) 791-0035</u> Fax # <u>(312) 791-0626</u>																													
HFS ID Number: _____																													
Date of Initial License for Current Owners: <u>12/16/09</u>			Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																										
Type of Ownership:																													
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>			☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>		
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																											
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																											
	☐ "Sub-S" Corp.																												
	☒ Limited Liability Co.																												
	☐ Trust																												
	☐ Other _____																												
In the event there are further questions about this report, please contact: Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u> Email Address: _____																													
			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																										

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Boulevard Care Nursing & Rehab Center, LLC

#

0050716

Report Period Beginning:

01/01/11

Ending:

12/31/11

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
N/A					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	45,376	2,558	3,029	50,963	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,376	2,558	3,029	50,963	14

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

90.08%

SEE ACCOUNTANTS' COMPILATION REPORT

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

0

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

05/01/87

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

YES

X

Date

05/01/87

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

155

and days of care provided

3,029

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/11

Fiscal Year:

12/31/11

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

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LL # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	199,511	31,847	18,514	249,872		249,872	266	250,138			1
2	Food Purchase		286,825		286,825		286,825	(168)	286,657			2
3	Housekeeping	106,657	38,904		145,561		145,561	527	146,088			3
4	Laundry	55,539	20,360		75,899		75,899	(231)	75,668			4
5	Heat and Other Utilities			126,673	126,673		126,673	944	127,617			5
6	Maintenance	98,061		137,531	235,592		235,592	9,821	245,413			6
7	Other (specify):* Supplemental	41,184			41,184		41,184	1,286	42,470			7
8	TOTAL General Services	500,952	377,936	282,718	1,161,606		1,161,606	12,445	1,174,051			8
	B. Health Care and Programs											
9	Medical Director			12,333	12,333		12,333		12,333			9
10	Nursing and Medical Records	1,929,226	98,198	11,532	2,038,956		2,038,956	(348)	2,038,608			10
10a	Therapy	101,295			101,295		101,295		101,295			10a
11	Activities	78,879	8,157	2,544	89,580		89,580	(604)	88,976			11
12	Social Services	177,222	17,005	1,233	195,460		195,460		195,460			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,286,622	123,360	27,642	2,437,624		2,437,624	(952)	2,436,672			16
	C. General Administration											
17	Administrative	158,968			158,968		158,968	12,466	171,434			17
18	Directors Fees											18
19	Professional Services			280,682	280,682	(3,641)	277,041	(136,048)	140,993			19
20	Dues, Fees, Subscriptions & Promotions			37,053	37,053		37,053	(17,301)	19,752			20
21	Clerical & General Office Expenses	225,915	29,984	438,469	694,368		694,368	(322,728)	371,640			21
22	Employee Benefits & Payroll Taxes			675,174	675,174		675,174	(7,590)	667,584			22
23	Inservice Training & Education			427	427		427		427			23
24	Travel and Seminar			1,270	1,270		1,270	175	1,445			24
25	Other Admin. Staff Transportation			12,959	12,959		12,959	445	13,404			25
26	Insurance-Prop.Liab.Malpractice			61,855	61,855		61,855	843	62,698			26
27	Other (specify):* Supplemental							21,646	21,646			27
28	TOTAL General Administration	384,883	29,984	1,507,889	1,922,756	(3,641)	1,919,115	(448,092)	1,471,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,172,457	531,280	1,818,249	5,521,986	(3,641)	5,518,345	(436,599)	5,081,746			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 3 Supplemental Schedule - Reclassification

Description	Pg. & Line Ref.	Debit	Credit
Legal Fee	03 - 19 - 03		3,641
Real Estate Tax	04 - 33 - 33	3,641	

To reclassify legal fees to real estate tax expense based on fees were incurred as part of the process of reducing real estate taxes.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			11,657	11,657		11,657	117,415	129,072			30
31	Amortization of Pre-Op. & Org.			3,949	3,949		3,949		3,949			31
32	Interest							4,947	4,947			32
33	Real Estate Taxes					3,641	3,641	178,069	181,710			33
34	Rent-Facility & Grounds			19,332	19,332		19,332	(19,332)				34
35	Rent-Equipment & Vehicles			19,981	19,981		19,981	3,453	23,434			35
36	Other (specify):*											36
37	TOTAL Ownership			54,919	54,919	3,641	58,560	284,552	343,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,449	313,378	491,827		491,827	(63,897)	427,930			39
40	Barber and Beauty Shops			150	150		150		150			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			300,676	300,676		300,676		300,676			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		178,449	614,204	792,653		792,653	(63,897)	728,756			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,172,457	709,729	2,487,372	6,369,558		6,369,558	(215,944)	6,153,614			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

Facility Name & ID Number **Boulevard Care Nursing & Rehab Center, LLC**# **0050716**Report Period Beginning: **01/01/11**Ending: **12/31/11****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.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,802)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(423)	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	(36,691)	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	(364,954)	21		24
25	Fund Raising, Advertising and Promotional	(20,469)	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 <u>See Supplemental</u>	(79,213)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (504,552)		\$	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 Amount	2 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)	288,608		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 288,608		36
(sum of SUBTOTALS)				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (215,944)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	<u>Barber and Beauty Shops</u>					41
42	<u>Laboratory and Radiology</u>					42
43	<u>Prescription Drugs</u>					43
44						44
45	<u>Other-Attach Schedule</u>					45
46	<u>Other-Attach Schedule</u>					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (3,094)	21	1
2	Bank Charges	(25,742)	21	2
3	Patient Clothing	(604)	11	3
4	Real Estate Tax Refund & Appeal Costs	(9,102)	33	4
5	TAG Properties - Office Rental	(19,332)	34	5
6	Other Professional Fees - Non Allowable	(1,713)	19	6
7	Legal Fees - Non Allowable	(19,626)	19	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
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(79,213)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC# 0050716

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	266	0	0	0	0	0	0	0	0	266	1
2	Food Purchase	(423)	0	255	0	0	0	0	0	0	0	0	(168)	2
3	Housekeeping	0	0	538	0	(11)	0	0	0	0	0	0	527	3
4	Laundry	0	0	0	0	(231)	0	0	0	0	0	0	(231)	4
5	Heat and Other Utilities	0	0	944	0	0	0	0	0	0	0	0	944	5
6	Maintenance	0	0	2,709	7,170	(58)	0	0	0	0	0	0	9,821	6
7	Other (specify):*	0	0	0	1,286	0	0	0	0	0	0	0	1,286	7
8	TOTAL General Services	(423)	0	4,712	8,456	(300)	0	0	0	0	0	0	12,445	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(348)	0	0	0	0	0	0	(348)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(604)	0	0	0	0	0	0	0	0	0	0	(604)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(604)	0	0	0	(348)	0	0	0	0	0	0	(952)	16
	C. General Administration													
17	Administrative	0	0	2,830	9,636	0	0	0	0	0	0	0	12,466	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,339)	0	(114,709)	0	0	0	0	0	0	0	0	(136,048)	19
20	Fees, Subscriptions & Promotions	(20,469)	0	3,168	0	0	0	0	0	0	0	0	(17,301)	20
21	Clerical & General Office Expenses	(430,481)	0	11,736	96,017	0	0	0	0	0	0	0	(322,728)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(7,590)	0	0	0	0	0	0	0	(7,590)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	175	0	0	0	0	0	0	0	0	175	24
25	Other Admin. Staff Transportation	0	0	445	0	0	0	0	0	0	0	0	445	25
26	Insurance-Prop.Liab.Malpractice	0	0	843	0	0	0	0	0	0	0	0	843	26
27	Other (specify):*	0	0	0	21,646	0	0	0	0	0	0	0	21,646	27
28	TOTAL General Administration	(472,289)	0	(95,512)	119,709	0	0	0	0	0	0	0	(448,092)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(473,316)	0	(90,800)	128,165	(648)	0	0	0	0	0	0	(436,599)	29

Summary B

Facility Name & ID Number

0050716

01/01/11

12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	108,305	9,110	0	0	0	0	0	0	0	0	117,415 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,802)	0	7,749	0	0	0	0	0	0	0	0	4,947 32
33	Real Estate Taxes	(9,102)	185,774	1,397	0	0	0	0	0	0	0	0	178,069 33
34	Rent-Facility & Grounds	(19,332)	0	0	0	0	0	0	0	0	0	0	(19,332) 34
35	Rent-Equipment & Vehicles	0	0	3,453	0	0	0	0	0	0	0	0	3,453 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(31,236)	294,079	21,709	0	0	0	0	0	0	0	0	284,552 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	(269)	0	(63,628)	0	0	0	0	(63,897) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	(269)	0	(63,628)	0	0	0	0	(63,897) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(504,552)	294,079	(69,091)	128,165	(917)	0	(63,628)	0	0	0	0	(215,944) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	30	Depreciation	\$	Boulevard Property, LLC	100.00%	\$ 108,305	\$ 108,305	1
2	V	33	Real Estate Taxes		Boulevard Property, LLC	100.00%	185,774	185,774	2
3	V								3
4	V								4
5	V								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			\$			\$ 294,079	\$ * 294,079	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Boulevard Care Nursing & Rehab Center, LLC

0050716

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Eric Rothner	90.00%	Avenue Care Nursing and Rehab	Chicago, IL	Ext. Care Consult.	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ext. Care Clinical	Evanston, IL	Administrative	2
3			Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	Xcel Medical Supply	Evanston, IL	Medical Supplies	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	10
11			Snow Vally Nursing and Rehab	Lisle, IL				11
12			South Suburban Rehabilitation Center	Chicago, IL	Boulevard			12
13			Tri-State Nursing and Rehab	Lansing, IL	Property, LLC	Chicago, IL	Bldg. Company	13
14			Wheaton Care Center	Wheaton, IL				14
15			Boulevard Care Nursing and Rehab	Chicago, IL				15
16			Countryside Nursing and Rehab	Dolton, IL				16
17			Hillcrest Nursing and Rehab	Joliet, IL				17
18			Oak Park Healthcare Center	Oak Park, IL				18
19			Park House Nursing and Rehab	Chicago, IL				19
20			Timber Point Healthcare Center	Camp Point, IL				20
21			Prairie Village Healthcare Center	Jacksonville, IL				21
22			Dyer Nursing and Rehab	Dyer, IN				22
23			Lake County Nursing and Rehab	East Chicago, IN				23
24			Sebos Nursing and Rehab	Holbart, IN				24
25			Sheffield Manor Healthcare	Indianapolis, IN				25
26			McKinley Health Care Center	Canton, OH				26
27			Homestead Nursing and Rehab	Lincoln, NE				27
28			Lancaster Manor	Lincoln, NE				28
29			Golden Plaines	Hutchinson, KS				29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 266	\$ 266	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	255	255	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	538	538	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	944	944	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,709	2,709	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,830	2,830	20
21	V	19	Professional Fees	120,000	Extended Care Consulting, LLC	100.00%	5,291	(114,709)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,168	3,168	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	11,736	11,736	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	175	175	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	445	445	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	843	843	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	9,110	9,110	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,749	7,749	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,397	1,397	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	3,453	3,453	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			\$ 120,000			\$ 50,909	\$ * (69,091)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$	Extended Care Consulting, LLC	100.00%	\$ 7,170	\$ 7,170	15
16	V	06	Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,286	1,286	17
18	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	17	Administrative		Extended Care Consulting, LLC	100.00%	9,636	9,636	19
20	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	98,507	98,507	20
21	V	21	Office and Clerical	20,863	Extended Care Consulting, LLC	100.00%	18,373	(2,490)	21
22	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	18,608	18,608	22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	3,038	3,038	23
24	V	22	Employee Benefits	7,590	Extended Care Consulting, LLC	100.00%		(7,590)	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			\$ 28,453			\$ 156,618	\$ * 128,165	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03	Housekeeping	185	Xcel Supply, LLC	100.00%	174	(11)	16
17	V	04	Laundry	3,818	Xcel Supply, LLC	100.00%	3,587	(231)	17
18	V	06	Repairs and Maintenance	958	Xcel Supply, LLC	100.00%	900	(58)	18
19	V	10	Nursing	5,743	Xcel Supply, LLC	100.00%	5,395	(348)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office and Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	4,444	Xcel Supply, LLC	100.00%	4,175	(269)	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			\$ 15,148			\$ 14,231	\$ * (917)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 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	Health Insurance	\$ 121,723	CCS VEBA	100.00%	\$ 121,723	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 121,723			\$ 121,723	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 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	\$ 311,705	Tricare Rehab	100.00%	\$ 248,077	\$ (63,628)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 311,705			\$ 248,077	\$ * (63,628)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, L # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Adam Vales	Relative	Clerical		See Attached	0.73	0.02	Alloc. Sal	\$ 1,287	22 - 7	1
2	G. Matt Silvers	Relative	Administrative		See Attached	0.05	0.00	Alloc. Sal	190	17 - 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,477		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 Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	\$ 6,942	\$	50,963	\$ 266	1
2	02	Food	Patient Days	1,332,501	31	6,677		50,963	255	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		50,963	538	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		50,963	944	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		50,963	2,709	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		50,963	2,830	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		50,963	5,291	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		50,963	3,168	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		50,963	11,736	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		50,963	175	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,332,501	31	11,637		50,963	445	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		50,963	843	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		50,963	9,110	13
14	32	Interest	Patient Days	1,332,501	31	202,602		50,963	7,749	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		50,963	1,397	15
16	35	Rent - Equipment and Auto	Patient Days	1,332,501	31	90,286		50,963	3,453	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,331,098	\$		\$ 50,909	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Patient Days	1,332,501	31	\$ 187,474	\$ 187,474	50,963	\$ 7,170	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,332,501	31	33,619		50,963	1,286	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,332,501	31	251,959	251,959	50,963	9,636	5
6	21	Office and Clerical	Patient Days	1,332,501	31	2,575,611	2,575,611	50,963	98,507	6
7	21	Office and Clerical	Direct Allocation	1	1	18,373	18,373	1	18,373	7
8	27	Employee Benefits	Patient Days	1,332,501	31	486,522		50,963	18,608	8
9	27	Employee Benefits	Direct Allocation	1	1	3,038		1	3,038	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					\$ 3,556,596	\$ 3,033,417		\$ 156,618	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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, Illinois 60202
Phone Number (847) 328 - 7600
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation	1	1	\$	\$	1	\$	1
2	03	Housekeeping	Direct Allocation	1	1	174		1	174	2
3	04	Laundry	Direct Allocation	1	1	3,587		1	3,587	3
4	06	Repairs and Maintenance	Direct Allocation	1	1	900		1	900	4
5	10	Nursing	Direct Allocation	1	1	5,395		1	5,395	5
6	11	Activities	Direct Allocation	1	1			1		6
7	21	Office and Clerical	Direct Allocation	1	1			1		7
8	22	Employee Benefits	Direct Allocation	1	1			1		8
9	30	Depreciation	Direct Allocation	1	1			1		9
10	39	Ancillary	Direct Allocation	1	1	4,175		1	4,175	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					\$ 14,231	\$		\$ 14,231	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 CCS VEBA
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Health Insurance	Direct Allocation	1	1	\$ 121,723	\$	1	\$ 121,723	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					\$ 121,723	\$		\$ 121,723	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC # 0050716 Report Period Beginning: 01/01/11 Ending: 12/31/11

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, Illinois 60162
Phone Number (708) 449 - 9400
Fax Number (708) 449 - 9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation	1	1	\$ 248,077	\$	1	\$ 248,077	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					\$ 248,077	\$		\$ 248,077	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Extended Care Consulting	X		Line of Credit							7,749	6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 7,749	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,802)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (2,802)	14
15	TOTALS (line 9+line14)						\$				\$ 4,947	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

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

B. Real Estate Taxes

[illegible]

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Boulevard Care Nursing & Rehab Center, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050716

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (847) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	17-34-119-001-0000	Long Term Care Facility	\$ 52,690.55	\$ 52,690.55
2.	17-34-119-002-0000	Long Term Care Facility	\$ 8,898.68	\$ 8,898.68
3.	17-34-119-003-0000	Long Term Care Facility	\$ 87,935.16	\$ 87,935.16
4.	17-34-119-004-0000	Long Term Care Facility	\$ 8,547.20	\$ 8,547.20
5.	17-34-119-005-0000	Long Term Care Facility	\$ 9,953.12	\$ 9,953.12
6.	17-34-119-006-0000	Long Term Care Facility	\$ 9,953.12	\$ 9,953.12
7.	Allocation	Extended Care Consulting, LLC	\$ 126,481.18	\$ 1,950.21
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 304,459.01	\$ 179,928.04

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	43,293	B. General Construction Type:	Exterior	Brick	Frame	Steel	Number of Stories	3
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	--------------	--------------------------	----------

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	51,000	1995	\$ 100,000	1
2	Ext. Care Consult.			12,644	2
3	TOTALS	51,000		\$ 112,644	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Boulevard Care Nursing & Rehab Center, LLC# 0050716

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1995	1971	\$ 4,046,250	\$ 108,305	27.5	\$ 108,305	\$	2,895,511	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	4,236						9
10	Various			1988	10,046						10
11	Various			1989	5,250						11
12	Various			1990	7,780						12
13	Various			1991	16,578						13
14	Various			1992	21,502						14
15	Various			1993	25,871						15
16	Various			1994	13,356						16
17	Various			1995	12,270						17
18	Various			1996	15,797						18
19	Various			1997	7,187						19
20	Various			1998	17,815						20
21	Various			1999	6,043						21
22	Various			2000	235,020						22
23	Various			2001	61,023						23
24	Various			2002	146,838						24
25	Various			2003	206,808						25
26	Various			2004	117,077						26
27	Various			2005	1,500						27
28	Various			2006	18,167						28
29	Various			2007	7,963						29
30	Reroofed Property Using Signly Ply Bitumen			2008	4,500						30
31	Install 4 Exit check Delayed Egress Locks			2008	4,175						31
32	Fire Alarm System 1st Floor - Replace Card			2008	3,510						32
33	Nurse Station & Dining Room (Baseboard, Chair Rails, Ceiling)			2009	146,005						33
34	Install A/C Circuits & Outlets - Care Plan Office			2009	2,400						34
35	Install Camera System			2009	5,725						35
36	Wall Air Conditioners			2009	5,124						36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
37	Hot Water Tank Repair	2010	\$ 5,494	\$ 200	27.5	\$ 200	\$	\$ 391	37
38	Tuckpointing	2010	5,950	216	27.5	216		424	38
39	Boiler Repair	2010	3,582	130	27.5	130		255	39
40	Supply & Installation of Ejection Pumps	2010	5,400	196	27.5	196		270	40
41	Laundry Chute Enclosure	2010	15,000	545	27.5	545		795	41
42	Supply & Installation of Ejection Pumps	2010	9,150	333	27.5	333		458	42
43	Supply & Installation of Ejection Pumps	2010	14,550	365	27.5	365		728	43
44	Fire Damper Installation	2010	34,950	1,271	27.5	1,271		1,536	44
45	Heat Start Up and Repairs	2010	4,187	152	27.5	152		184	45
46	Tile	2010	5,482	199	27.5	199		208	46
47	Linen Chute Repair	2010	2,942	588	27.5	588		858	47
48	Walk In Frezer and Cooler	2010	6,702	1,340	27.5	1,340		1,620	48
49	Bathrooms Tile and Installation	2011	16,313	748	20	748		748	49
50	Exhaust Fan	2011	3,730	684	5	684		684	50
51	Boiler Repair	2011	10,158	1,354	5	1,354		1,354	51
52	Iron Fence Repair	2011	3,000	350	5	350		350	52
53	Iron Fence Repair	2011	2,700	90	5	90		90	53
54	Electric Switch Panel for Sump Pumps	2011	3,660	427	5	427		427	54
55	Hot Water Heater	2011	8,000	267	5	267		267	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,336,766	\$ 117,760		\$ 117,760	\$	\$ 2,907,158	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XL OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,336,766	\$ 117,760		\$ 117,760	\$	\$ 2,907,158	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting	2007	176	9		9		44	5
6	Allocations - Extended Care Consulting	2009	105	5		5		16	6
7	Allocations - Extended Care Consulting	2010	1,032	52		52		103	7
8	Allocations - Extended Care Consulting	2011	371	19		19		19	8
9									9
10	Allocations - Extended Care Consulting / 2201 Main LLC	2002	17,423	447		447		4,151	10
11	Allocations - Extended Care Consulting / 2201 Main LLC	2002	14,393	1,315		1,315		10,536	11
12	Allocations - Extended Care Consulting / 2201 Main LLC	2003	16,962	1,550		1,550		12,416	12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2005	843	90		90		483	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2009	152	8		8		23	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	TOTAL (lines 1 thru 33)		\$ 5,388,223	\$ 121,255		\$ 121,255	\$	\$ 2,934,949	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 Costs-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	\$3,634	\$726	\$726	\$	5 - 7	\$876	71
72	Current Year Purchases	19,503	1,475	1,475		5 - 7	1,475	72
73	Fully Depreciated Assets							73
74	See Supplemental	313,155	5,424	5,424		5	305,658	74
75	TOTALS	\$336,292	\$7,625	\$7,625	\$		\$308,009	75

D. Vehicle Costs. (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	Extended Care Consulting			\$12,298	\$192	\$192	\$	5	\$12,106	76
77										77
78										78
79										79
80	TOTALS			\$12,298	\$192	\$192	\$		\$12,106	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,849,457	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$129,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$129,072	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,255,064	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.

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Boulevard Property			
Prior	155,000	-	155,000
Current			
Total	155,000	-	155,000
Related Party 2 - Extended Care Consulting			
Prior	112,235	383	109,510
Current	125	12	12
Total	112,360	395	109,522
Related Party 3 - Extended Care Consulting / 2201 Mail LLC			
Prior	4,825	482	4,286
Current			
Total	4,825	482	4,286
Related Party 4 - Extended Care Consulting - Matrix Software			
Prior	40,970	4,547	36,850
Current			
Total	40,970	4,547	36,850
Total	313,155	5,424	305,658

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								5
6	See Supp.							6
7	TOTAL				\$			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 13,501 Description: See Supplemental 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	Facility	Van	\$ 827.79	\$ 9,933	17
18					18
19					19
20					20
21	TOTAL		\$ 827.79	\$ 9,933	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 14 Supplemental Schedule - Building Rental

Vendor	Description	Amount
TAG Properties	Office Rental	19,332
TAG Properties	Office Rental - Non Allowable	(19,332)
Total		<u>-</u>

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Description	Amount
Hughes Enterprises	Copier	9,600
Pitney Bowes	Postage	274
Other		174
Alloc. - Extended Care Consulting		3,453
Total		<u>13,501</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 174,248	\$		\$ 174,248	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,284			21,284	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			116,173			116,173	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				145,719		145,719	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					32,730		32,730	12
13	Other (specify): See Supplemental	39 - 03				1,673			1,673	13
14	TOTAL			\$		\$ 313,378	\$ 178,449		\$ 491,827	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

Page 16 Supplemental Schedule

IL478-2471

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 950	1
2	Cash-Patient Deposits	29,228	29,228	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 236,366)	2,964,901	2,964,901	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,759	55,759	6
7	Other Prepaid Expenses	6,142	6,142	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,056,030	\$ 3,056,980	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		4,046,250	14
15	Leasehold Improvements, at Historical Cost	139,646	139,646	15
16	Equipment, at Historical Cost	44,441	199,441	16
17	Accumulated Depreciation (book methods)	(13,998)	(3,064,472)	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): See Supplemental	7,385	7,385	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 177,474	\$ 1,428,250	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,233,504	\$ 4,485,230	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,498,562	\$ 1,498,562	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,011	28,011	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,604	145,604	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		186,877	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	505,677	1,051,443	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,177,854	\$ 2,910,497	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,077,878	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,077,878	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,177,854	\$ 5,988,375	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,055,650	\$ (1,503,145)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,233,504	\$ 4,485,230	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Page 17 Supplemental Schedule

IL478-2471

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (179,387)	1
2	Restatements (describe):		2
3	Post Cost Report Accounting Adjustments	(39,233)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (218,620)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,274,270	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,274,270	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,055,650	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Boulevard Care Nursing & Rehab Center, LLC**# **0050716**Report Period Beginning: **01/01/11**

Ending:

12/31/11**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,563,220	1
2	Discounts and Allowances for all Levels	(1,163,229)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,399,991	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,084,959	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,084,959	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,153	19
20	Radiology and X-Ray	240	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,592	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,592	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	17,657	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,643,828	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,161,606	31
32	Health Care	2,437,624	32
33	General Administration	1,922,756	33
	B. Capital Expense		
34	Ownership	54,919	34
	C. Ancillary Expense		
35	Special Cost Centers	491,977	35
36	Provider Participation Fee	300,676	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,369,558	40
41	Income before Income Taxes (line 30 minus line 40)**	1,274,270	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,274,270	43

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

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

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

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

Page 19 Supplemental Schedule

[illegible]

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,052	2,205	\$ 84,984	\$ 38.54	1
2	Assistant Director of Nursing	2,044	2,170	70,118	32.31	2
3	Registered Nurses	8,315	9,160	252,694	27.59	3
4	Licensed Practical Nurses	28,781	30,561	736,687	24.11	4
5	CNAs & Orderlies	66,631	72,842	758,167	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,299	5,949	101,295	17.03	8
9	Activity Director	2,070	2,132	28,822	13.52	9
10	Activity Assistants	5,382	5,721	50,057	8.75	10
11	Social Service Workers	11,158	11,706	177,222	15.14	11
12	Dietician					12
13	Food Service Supervisor	2,028	2,151	37,969	17.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,536	6,185	60,423	9.77	15
16	Dishwashers	10,486	11,229	101,119	9.01	16
17	Maintenance Workers	6,619	7,041	98,061	13.93	17
18	Housekeepers	10,528	11,491	106,657	9.28	18
19	Laundry	4,655	5,192	55,539	10.70	19
20	Administrator	2,044	2,172	86,058	39.62	20
21	Assistant Administrator	2,044	2,169	72,910	33.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,281	8,988	225,915	25.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,939	2,071	26,576	12.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supplemental</u>	3,944	4,292	41,184	9.60	33
34	TOTAL (lines 1 - 33)	189,836	205,427	\$ 3,172,457 *	\$ 15.44	34

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	Monthly	\$ 18,514	01 - 03	35
36	Medical Director	Monthly	12,333	09 - 03	36
37	Medical Records Consultant	Monthly	3,008	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,524	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	48	2,544	11 - 03	44
45	Social Service Consultant	21	1,233	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 46,156		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security	3,944	4,292	41,184
Total	3,944	4,292	41,184

XIX. SUPPORT SCHEDULES									
A. Administrative Salaries		Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount		Description	Amount	
Yechiel D. Mashlach	Administrator	0	\$ 86,058	Workers' Compensation Insurance	\$	135,872	IDPH License Fee	\$	1,990
Cynthia A Staine	Asst. Admin.	0	72,910	Unemployment Compensation Insurance		103,641	Advertising: Employee Recruitment		1,389
				FICA Taxes		242,389	Health Care Worker Background Check		8,471
				Employee Health Insurance		152,660	(Indicate # of checks performed 305)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions		817
				Employee Physicals		362	Licenses and Fees		3,917
				Holiday Expense		2,854	Advertising and Promotion		20,469
				Pension		23,305	Alloc. - Extended Care Consulting		3,168
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 158,968	Chicago Employer Taxes		3,687			
(List each licensed administrator separately.)				Other Employee Welfare		2,814			
B. Administrative - Other							Less: Public Relations Expense	(	
Description			Amount				Non-allowable advertising		(20,469)
			\$				Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 667,584	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,752
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Extended Care Consulting	Home Office		\$ 120,000			\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Consultant		3,226						
Frost, Ruttenberg & Rothblatt	Accounting		7,357						
Plante & Moran, PLLC	Accounting		13,900				In-State Travel		
Krupnic, Bokar & Kagda	Accounting		3,214						
Denise Carnes	Bookkeeping		1,205						
Elderlife Development	Code Compliance		6,519						
Blymas, Inc.	Accounting		960				Seminar Expense		1,270
Judy Burnell	Bookkeeping		363				Alloc. - Extended Care Consulting		175
Ron Cournaya	Medicare Cost Report		1,250						
Jared Starr	Medicare Cost Report		1,250						
See Supplemental Schedule			121,438				Entertainment Expense	(	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 280,682				TOTAL	\$	1,445

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Chad Cournaya	Other Professional	131
Hamlin & Burton Liability	MSP Services	155
TAG Properties	Non-Allowable	1,620
Smartbox of Chicago	Non-Allowable	93
Care Consultants of Illinois	Computer Maintenance	25,156
American Data	Data Processing	4,203
MDI Achieve	Data Processing	19,411
E Health Data Solutions	Data Processing	7,731
Medifax	Data Processing	307
Care Consultants of Illinois	Data Processing	232
Extended Care Consulting	Data Processing	7,119
Nebo Systems	Data Processing	104
National Datacare Corporation	Data Processing	2,679
Mobile Diagnosis	Data Processing	444
Paycor	Data Processing	4,443
Ashman & Stein	Legal	1,103
Care Consultants of Illinois	Legal	5,461
Chuhak & Tecson	Legal	5,636
Deutsch, Levy & Engel	Legal	4,070
Extended Care Consulting	Legal	277
Finkel, Martwick & Colson	Legal	3,641
Hamlin & Burton	Legal	15,350
HFG	Legal	4,791
Kohlman Chutes	Legal	300
Law Office of Stephen N.	Legal	2,157
McVey & Parksy	Legal	1,093
Meyer Magence	Legal	2,734
Sherwin Ray	Legal	881
Statland Law Offices	Legal	116
		<u>121,438</u>

Boulevard Care Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Legal Schedule

Vendor	Invoice Date	Amount	Allowable
Chuhak & Tecson, P.C.	01/31/11	792	
Kohlman Chutes, Inc.	01/31/11	300	
Meyer Magence	01/31/11	188	188
Chuhak & Tecson, P.C.	02/28/11	340	
Law Office Of Stephen N.	02/28/11	81	
Law Office Of Stephen N.	02/28/11	674	
Law Office Of Stephen N.	02/28/11	1,080	
Law Office Of Stephen N.	02/28/11	321	
Meyer Magence	02/28/11	363	363
Hamlin & Burton	03/22/11	15,350	15,350
Chuhak & Tecson, P.C.	03/31/11	108	
Meyer Magence	03/31/11	125	125
Meyer Magence	03/31/11	1,684	1,684
Chuhak & Tecson, P.C.	04/30/11	72	
Meyer Magence	04/30/11	188	188
Ashman & Stein	05/31/11	260	
Chuhak & Tecson, P.C.	05/31/11	180	
Chuhak & Tecson, P.C.	06/30/11	910	
Mcvey & Parsky, LLC	06/30/11	37	37
Meyer Magence	06/30/11	188	188
Chuhak & Tecson, P.C.	08/31/11	396	
Chuhak & Tecson, P.C.	08/31/11	160	
Mcvey & Parsky, LLC	08/31/11	56	56
Ashman & Stein	09/30/11	152	
Care Consultants Of Illinois	09/30/11	1,003	1,003
Care Consultants Of Illinois	09/30/11	817	817
Chuhak & Tecson, P.C.	09/30/11	72	
Statland Law Offices, LLC	10/06/11	116	
Ashman & Stein	10/31/11	336	
Ashman & Stein	10/31/11	355	
Chuhak & Tecson, P.C.	10/31/11	5	
Chuhak & Tecson, P.C.	10/31/11	46	
Chuhak & Tecson, P.C.	10/31/11	324	
Chuhak & Tecson, P.C.	10/31/11	36	
Mcvey & Parsky, LLC	11/15/11	1,000	
Finkel, Martwick & Colson	12/13/11	3,641	3,641
Deutsch, Levy & Engel	12/28/11	1,797	1,797
Deutsch, Levy & Engel	12/28/11	551	551
Deutsch, Levy & Engel	12/28/11	959	959
Deutsch, Levy & Engel	12/28/11	366	366
Deutsch, Levy & Engel	12/28/11	397	397
K & L Gates	12/31/11	3,642	
Chuhak & Tecson, P.C.	12/31/11	72	
Chuhak & Tecson, P.C.	12/31/11	142	
Chuhak & Tecson, P.C.	12/31/11	62	
Chuhak & Tecson, P.C.	12/31/11	10	
Chuhak & Tecson, P.C.	12/31/11	474	
Chuhak & Tecson, P.C.	12/31/11	130	
Chuhak & Tecson, P.C.	12/31/11	288	
Chuhak & Tecson, P.C.	12/31/11	565	
Chuhak & Tecson, P.C.	12/31/11	10	
Chuhak & Tecson, P.C.	12/31/11	441	
Extended Care Consulting	12/31/11	277	277
Chuhak & Tecson, P.C.	12/31/11	292	
Chuhak & Tecson, P.C.	12/31/11	137	
Chuhak & Tecson, P.C.	12/31/11	50	
Chuhak & Tecson, P.C.	12/31/11	14	
Chuhak & Tecson, P.C.	12/31/11	344	
Chuhak & Tecson, P.C.	12/31/11	43	
HFG	Various	4,791	
		47,610	27,984

Page 5 Adjustment

19,626

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

1	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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Boulevard Care Nursing & Rehab Center, LLC		STATE OF ILLINOIS	#	0050716	Report Period Beginning:	01/01/11	Ending:	12/31/11	Page 23
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.			\$		840		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.			\$		300,676					
	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.			\$		0		Has any meal income been offset against related costs?		No	
	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.					
	c. What percent of all travel expense relates to transportation of nurses and patients?			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					

SEE ACCOUNTANTS' COMPILATION REPORT