

Facility Name & ID Number PRESIDENTIAL PAVILION

0045526 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	<u>218</u>	Skilled (SNF)	<u>218</u>	<u>79,570</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>110</u>	Intermediate (ICF)	<u>110</u>	<u>40,150</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>328</u>	TOTALS	<u>328</u>	<u>119,720</u>	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	<u>5,088</u>	<u>179</u>	<u>15,158</u>	<u>20,425</u>	8
9	SNF/PED					9
10	ICF	<u>97,426</u>	<u>575</u>		<u>98,001</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>102,514</u>	<u>754</u>	<u>15,158</u>	<u>118,426</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.92%

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)

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 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 53 and days of care provided 15,158

Medicare Intermediary BLUE CROSS-BLUE SHIELD

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **PRESIDENTIAL PAVILION** # **0045526** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	375,726	39,133	14,400	429,259		429,259	0	429,259		1
2	Food Purchase		415,235		415,235	(10,311)	404,924	(1,707)	403,217		2
3	Housekeeping	369,400	38,969	0	408,369		408,369	0	408,369		3
4	Laundry	170,208	30,636	13,725	214,569	0	214,569	2,673	217,242		4
5	Heat and Other Utilities			275,849	275,849		275,849	773	276,622		5
6	Maintenance	268,797	60,713	84,266	413,776		413,776	6,987	420,763		6
7	Other (specify):*			34,122	34,122		34,122	191	34,313		7
8	TOTAL General Services	1,184,131	584,686	422,362	2,191,179	(10,311)	2,180,868	8,917	2,189,785		8
	B. Health Care and Programs										
9	Medical Director	0		8,500	8,500		8,500	0	8,500		9
10	Nursing and Medical Records	3,921,395	111,623	38,069	4,071,087		4,071,087	0	4,071,087		10
10a	Therapy	153,112		74,889	228,001		228,001	0	228,001		10a
11	Activities	194,293	50,688	4,224	249,205		249,205	0	249,205		11
12	Social Services	202,686		2,930	205,616		205,616	0	205,616		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	4,471,486	162,311	128,612	4,762,409	0	4,762,409	0	4,762,409		16
	C. General Administration										
17	Administrative	162,445		731,000	893,445		893,445	(320,637)	572,808		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			83,838	83,838		83,838	31,867	115,705		19
20	Dues, Fees, Subscriptions & Promotions			27,746	27,746		27,746	(6,737)	21,009		20
21	Clerical & General Office Expenses	296,246	30,276	156,602	483,124		483,124	(147,897)	335,227		21
22	Employee Benefits & Payroll Taxes			1,018,628	1,018,628	10,311	1,028,939	0	1,028,939		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,930	1,930		1,930	15	1,945		24
25	Other Admin. Staff Transportation			10,087	10,087		10,087	1,571	11,658		25
26	Insurance-Prop.Liab.Malpractice			300,881	300,881		300,881	31,126	332,007		26
27	Other (specify):*			371,781	371,781		371,781	(346,826)	24,955		27
28	TOTAL General Administration	458,691	30,276	2,702,493	3,191,460	10,311	3,201,771	(757,518)	2,444,253		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,114,308	777,273	3,253,467	10,145,048	0	10,145,048	(748,601)	9,396,447		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	14,400
	REPAIRS & MAINTENANCE	0
		0
		14,400
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	13,725
		0
		13,725
5	HEAT & OTHER UTILITIES	
	GAS HEAT	120,983
	ELECTRICITY	115,763
	WATER	39,103
	CABLE TV - LOBBY	0
		0
		275,849
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,400
	PAINTING & DECORATING	3,582
	BUILDING REPAIRS	1,863
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	37,443
	ELEVATOR MAINTENANCE & REPAIR	27,807
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,175
	FIRE SERVICE	2,996
		0
		0
		0
		0
		84,266
7	OTHER	
	SCAVENGER	34,122
	SECURITY SERVICE	0
		0
		0
		34,122
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,500
		8,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	18,712
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	52
	PHARMACY CONSULTANT XVIII B 39-2	10,498
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	6,000
	PSYCHIATRIC XVIII B ___-2	1,207
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	1,600
		0
		38,069
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,684
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	4,405
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	68,800
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		74,889
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,224
		0
		4,224
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,930
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,930
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	731,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,943
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	56,895
		0
		83,838
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,776
	EMPLOYEE WANT ADS XIX F	1,223
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,777
	LICENSES & PERMITS XIX F	0
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,970
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		27,746
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,214
	EQUIPMENT REPAIR & MAINTENANCE	6,159
	OUTSIDE CLERICAL SERVICES	96,500
	PENALTIES / OVERDRAFT CHARGES VI 18	217
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	27,419
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	24,093
		156,602

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	452,628
	UNEMPLOYMENT COMPENSATION XIX D	150,846
	WORKERS COMPENSATION INSURANC XIX D	140,383
	HOSPITALIZATION INSURANCE XIX D	200,991
	EMPLOYEE BENEFITS - OTHER XIX D	5,010
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	56,302
	CHICAGO HEAD TAX XIX D	12,468
		0
		1,018,628
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,930
	TRAVEL XIX G	0
		1,930
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,087
		10,087
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	300,881
		300,881
27	OTHER	
	BAD DEBTS VI 24	371,781
		371,781

GRAND TOTAL COLUMN 3 OTHER

3,253,467

PRESIDENTIAL PAVILION
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	415,235	PATIENT MEALS	355278
LESS SALES TAX	(1,707)	ADD EMPLOYEE MEALS	9125
	-----		-----
NET FOOD	413,528	TOTAL MEALS/YEAR	364403
TOTAL PATIENT CENSUS	118,426	NET FOOD	413528
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	364403

TOTAL PATIENT MEALS	355278	COST PER MEAL	1.13
		TIME EMPLOYEE MEALS	9125
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	10311
	-----		=====
TOTAL EMPLOYEE MEALS	9125		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			87,516	87,516		87,516	733,525	821,041		30
31	Amortization of Pre-Op. & Org.			585	585		585	0	585		31
32	Interest			83,285	83,285		83,285	1,064,663	1,147,948		32
33	Real Estate Taxes			(64,420)	(64,420)		(64,420)	354,281	289,861		33
34	Rent-Facility & Grounds			1,875,000	1,875,000		1,875,000	(1,875,000)	0		34
35	Rent-Equipment & Vehicles			57,829	57,829		57,829	8,042	65,871		35
36	Other (specify):* IME			25,584	25,584		25,584	76,438	102,022		36
37	TOTAL Ownership			2,065,379	2,065,379	0	2,065,379	361,949	2,427,328		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		148,909	366,437	515,346		515,346	0	515,346		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			179,580	179,580		179,580	0	179,580		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	148,909	546,017	694,926	0	694,926	0	694,926		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,114,308	926,182	5,864,863	12,905,353	0	12,905,353	(386,652)	12,518,701		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,897	30		9
10	Interest and Other Investment Income	(9)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,707)	2		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	0	20		17
18	Fines and Penalties	(217)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,970)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(371,781)	27		24
25	Fund Raising, Advertising and Promotional	(8,776)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(123,748)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (490,311)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	103,659		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 103,659		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (386,652)		37

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

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

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

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (2,388)	6	1
2	MARKETING SALARY	(97,267)	21	2
3	STAFF DEVELOPMENT	(24,093)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(123,748)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,707)	0	0	0	0	0	0	0	0	0	0	(1,707)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,673	0	0	0	0	0	0	0	0	2,673	4
5	Heat and Other Utilities	0	0	0	773	0	0	0	0	0	0	0	773	5
6	Maintenance	(2,388)	4,409	3,558	1,408	0	0	0	0	0	0	0	6,987	6
7	Other (specify):*	0	0	113	78	0	0	0	0	0	0	0	191	7
8	TOTAL General Services	(4,095)	4,409	6,344	2,259	0	0	0	0	0	0	0	8,917	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	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(337,341)	16,704	0	0	0	0	0	0	0	0	(320,637)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,517	17,733	117	11,500	0	0	0	0	0	0	31,867	19
20	Fees, Subscriptions & Promotions	(14,746)	0	8,009	0	0	0	0	0	0	0	0	(6,737)	20
21	Clerical & General Office Expenses	(121,577)	25,543	(52,007)	144	0	0	0	0	0	0	0	(147,897)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15	0	0	0	0	0	0	0	0	15	24
25	Other Admin. Staff Transportation	0	695	876	0	0	0	0	0	0	0	0	1,571	25
26	Insurance-Prop.Liab.Malpractice	0	403	543	326	29,854	0	0	0	0	0	0	31,126	26
27	Other (specify):*	(371,781)	12,279	12,676	0	0	0	0	0	0	0	0	(346,826)	27
28	TOTAL General Administration	(508,104)	(295,904)	4,549	587	41,354	0	0	0	0	0	0	(757,518)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(512,199)	(291,495)	10,893	2,846	41,354	0	0	0	0	0	0	(748,601)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	21,897	525	532	2,262	708,309	0	0	0	0	0	0	733,525	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9)	0	0	4,548	1,060,124	0	0	0	0	0	0	1,064,663	32
33	Real Estate Taxes	0	0	0	3,261	351,020	0	0	0	0	0	0	354,281	33
34	Rent-Facility & Grounds	0	0	0	0	(1,875,000)	0	0	0	0	0	0	(1,875,000)	34
35	Rent-Equipment & Vehicles	0	996	6,298	748	0	0	0	0	0	0	0	8,042	35
36	Other (specify):*	0	0	0	(25,584)	102,022	0	0	0	0	0	0	76,438	36
37	TOTAL Ownership	21,888	1,521	6,830	(14,765)	346,475	0	0	0	0	0	0	361,949	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(490,311)	(289,974)	17,723	(11,919)	387,829	0	0	0	0	0	0	(386,652)	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
				EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY	LINCOLNWOOD	HOME OFFICE
				BEVERLY		
				PAVILION , LLC	LINCOLNWOOD	LANDLORD

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	EMI	\$ 365,500	EMI ENTERPRISES, INC		\$	(365,500)	1
2	V	6	DRIVERS' SALARY			4,409		4,409	2
3	V	17	OFFICER'S SALARY			28,159		28,159	3
4	V	19	ACCOUNTING FEES			2,517		2,517	4
5	V	21	OFFICE EXPENSE			25,543		25,543	5
6	V	25	TRANSPORTATION			695		695	6
7	V	26	INSURANCE			403		403	7
8	V	27	EMPLOYEE BENEFITS			12,279		12,279	8
9	V	30	DEPRECIATION			525		525	9
10	V	35	AUTO LEASE			996		996	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 365,500			\$ 75,526	\$ *	(289,974)	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	21 OUTSIDE CLERICAL	\$ 96,500	EKS MANAGEMENT		\$	\$ (96,500)
16	V	4 HOUSEKEEPING SALARIES				2,673	2,673
17	V	6 PAINTERS' SALARIES				3,558	3,558
18	V	7 SCAVENGER				113	113
19	V	17 CFO SALARY - A. WEINFELD				16,704	16,704
20	V	19 PROFESSIONAL FEES				17,733	17,733
21	V	20 WANT ADS / BACKGRD CKS				8,009	8,009
22	V	21 OFFICE EXPENSE				44,493	44,493
23	V	24 IN- STATE TRAVEL				15	15
24	V	25 TRANSPORTATION				876	876
25	V	26 INSURANCE				543	543
26	V	27 EMPLOYEE BENEFITS				12,676	12,676
27	V	30 DEPRECIATION S.L.				532	532
28	V	35 EQUIPMENT RENT				6,298	6,298
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 96,500			\$ 114,223	\$ * 17,723

* 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	36 OFFICE RENT	\$ 25,584	IME REALTY		\$ 773	\$ (25,584)
16	V	5 UTILITIES				773	773
17	V	6 REPAIRS / MAINTENANCE				1,408	1,408
18	V	7 ALARM SERVICE				78	78
19	V	19 PROFESSIONAL FEES				117	117
20	V	21 OFFICE EXPENSE				144	144
21	V	26 INSURANCE				326	326
22	V	30 DEPRECIATION				2,262	2,262
23	V	32 INTEREST				4,548	4,548
24	V	33 R/E TAX				3,261	3,261
25	V	35 STORAGE FEES				748	748
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		\$ 25,584			\$ 13,665	\$ * (11,919)

* 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	34 RENT	\$ 1,875,000	BEVERLY PAVILION LLC		\$	(1,875,000)
16	V	19 PROFESSIONAL FEES				11,500	11,500
17	V	26 INSURANCE				29,854	29,854
18	V	30 DEPR. S.L BUILDING				634,509	634,509
19	V	30 DEPR. S.L EQUIP				73,800	73,800
20	V	32 INTEREST				1,060,124	1,060,124
21	V	33 REAL ESTATE TAXES				351,020	351,020
22	V	36 M.I.P. INSURANCE				102,022	102,022
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		\$ 1,875,000			\$ 2,262,829	\$ * 387,829

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

Facility Name & ID Number

PRESIDENTIAL PAVILION

0045526

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	MORRIS ESFORMES	MEMBER	ADMIN.	40.00	SEE			SALARY	\$ 28,159	17-7	1
2					ATTACHED						2
3					SCHEDULE						3
4	PHILIP ESFORMES	MEMBER	ADMIN.	40.00				MGMT FEE	365,500	17-3	4
5											5
6											6
7	AVRUM WEINFELD		CFO	3.00				SALARY	16,704	17-7	7
8											8
9											9
10	MICHAEL ROSEN	ADMINISTRATOR		3.00				SALARY	162,445	17-1	10
11											11
12											12
13								TOTAL	\$ 572,808		13

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

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

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning:

01/01/2006

Ending: **2/31/2006**

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 EMI ENTERPRISES
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674 - 1946
 Fax Number (847) 674 - 1962

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	6	DRIVER'S SALARY	PATIENT DAYS	778,042	14	\$ 28,965	\$ 118,426	\$ 4,409	1
2	17	OFFICER'S SALARY	PATIENT DAYS	778,042	14	185,000	118,426	28,159	2
3	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	118,426	2,517	3
4	21	OFFICE EXPENSE	PATIENT DAYS	778,042	14	167,811	118,426	25,543	4
5	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	118,426	695	5
6	26	INSURANCE	PATIENT DAYS	778,042	14	2,648	118,426	403	6
7	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	118,426	12,279	7
8	30	DEPRECIATION	PATIENT DAYS	778,042	14	3,451	118,426	525	8
9	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	118,426	996	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					\$ 496,190	\$ 345,993	\$ 75,526	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning:

01/01/2006

Ending: **2/31/2006**

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 EKS MANAGEMENT
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674 - 1946
 Fax Number (847) 674 - 1962

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	\$ 19,500	\$ 118,426	\$ 2,673	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	863,827	14	25,953	118,426	3,558	2
3	7	SCAVENGER	PATIENT DAYS	863,827	14	825	118,426	113	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	863,827	14	121,844	118,426	16,704	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	118,426	17,733	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423	118,426	8,009	6
7	21	OFFICE EXPENSE	PATIENT DAYS	863,827	14	324,544	118,426	44,493	7
8	24	IN- STATE TRAVEL	PATIENT DAYS	863,827	14	112	118,426	15	8
9	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	118,426	876	9
10	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	118,426	543	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	118,426	12,676	11
12	30	DEPRECIATION S.L	PATIENT DAYS	863,827	14	3,880	118,426	532	12
13	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	118,426	6,298	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					\$ 833,178	\$ 496,665	\$ 114,223	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526 Report Period Beginning: **01/01/2006** Ending: **2/31/2006**

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 IME REALTY CORP
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674 - 1946
 Fax Number (847) 674 - 1962

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	5 UTILITIES	INCOME	344,402	16	\$ 10,404	\$ 0	25,584	\$ 773	1
2	6 REPAIRS / MAINT	INCOME	344,402	16	18,957		25,584	1,408	2
3	7 ALARM SERVICE	INCOME	344,402	16	1,056		25,584	78	3
4	19 PROFESSIONAL FEES	INCOME	344,402	16	1,575		25,584	117	4
5	21 OFFICE EXPENSE	INCOME	344,402	16	1,942		25,584	144	5
6	26 INSURANCE	INCOME	344,402	16	4,387		25,584	326	6
7	30 DEPRECIATION	INCOME	344,402	16	30,446		25,584	2,262	7
8	32 INTEREST	INCOME	344,402	16	61,229		25,584	4,548	8
9	33 R/E TAX	INCOME	344,402	16	43,904		25,584	3,261	9
10	35 STORAGE FEES	INCOME	344,402	16	10,073		25,584	748	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				\$ 183,973	\$		\$ 13,665	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526 Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

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 BEVERLY PAVILION LLC
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847)674-5795
 Fax Number (847)674-5794

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	19	PROFESSIONAL FEES	DIRECT	1	\$ 11,500	\$ 0	1	\$ 11,500	1
2	26	INSURANCE	DIRECT	1	29,854	0	1	29,854	2
3	30	DEPR. S.L. BUILDING	DIRECT	1	634,509	0	1	634,509	3
4	30	DEPR. S.L. EQUIP	DIRECT	1	73,800	0	1	73,800	4
5	32	INTEREST	DIRECT	1	1,060,124	0	1	1,060,124	5
6	33	REAL ESTATE TAXES	DIRECT	1	351,020	0	1	351,020	6
7	36	M.I.P. INSURANCE	DIRECT	1	102,022	0	1	102,022	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				\$ 2,262,829	\$		\$ 2,262,829	25

Facility Name & ID Number

PRESIDENTIAL PAVILION

0045526

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge(Beverly)		X	MORTGAGE	\$99,236.00	3/10/05	\$ 18,706,800	\$ 18,189,858			\$ 997,692	1						
2	Wedgewood Realty(Beverly)		X	MORTGAGE	\$15,000.00	3/10/05	1,650,600	1,200,288	11/10/15	0.0450	62,432	2						
3	IME										4,548	3						
4												4						
5												5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	400,000	255,000	REVOLV	PRIME +	83,285	6						
7												7						
8												8						
9	TOTAL Facility Related				\$114,236.00		\$ 20,757,400	\$ 19,645,146			\$ 1,147,957	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 20,757,400	\$ 19,645,146			\$ 1,147,957	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 132,296 Line # 36

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	401,913	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	337,493	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(64,420)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	351,020	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	286,600	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	83,725	8
	2002	335,896	9
	2003	326,832	10
	2004	334,092	11
	2005	337,493	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number PRESIDENTIAL PAVILION

0045526

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7 + BASEMENT

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: 3,900 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 585 4. Dates Incurred: 10/01/01

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>2005</u>	<u>\$ 1,500,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 1,500,000	3

Facility Name & ID Number **PRESIDENTIAL PAVILION**# **0045526**

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	328		2005		\$ 17,449,000	\$ 634,509	27.5	\$ 634,509	\$	\$ 1,136,829	4
5											5
6											6
7	RELATED PARTY				75,472	2,173	39	2,173			7
8	OFFICE										8
	Improvement Type**										
9	AWNINGS		2001		10,500	382	27.5	382		1,958	9
10	FENCE		2001		2,100	140	15	140		718	10
11	ELEVATOR		2001		18,340	667	27.5	667		3,418	11
12	ALARM		2001		5,686	207	27.5	207		1,061	12
13	WINDOWS		2001		4,149	151	27.5	151		774	13
14	BOILER		2001		3,000	109	27.5	109		341	14
15	FURNISHINGWALLPAPER & BORDERS		2001		12,953	891	5	0	(891)	12,953	15
16	KITCHEN SINK & DRAIN		2001		2,525	92	27.5	92		471	16
17	DOORS		2001		15,100	549	27.5	549		2,803	17
18	ELEVATOR		2002		222,811	8,102	27.5	8,102		40,510	18
19	FENCE		2002		3,100	207	15	207		932	19
20	DOORS & LOCKS		2002		21,741	791	27.5	791		3,856	20
21	SHOWER ROOMS		2002		4,669	170	27.5	170		730	21
22	ALARM AND SPRINKLER		2002		11,881	432	27.5	432		1,853	22
23	EJECTOR & SEWEGE PUMP		2002		14,604	531	27.5	531		2,279	23
24	ROOF DRAIN		2002		3,100	113	27.5	113		513	24
25	FURNISHING - CARPETS AND DRAPERIES		2002		91,494	7,378	5	18,299	10,921	82,345	25
26	ELEVATOR		2003		110,562	4,020	27.5	4,020		15,243	26
27	PARKING LOT		2003		64,182	4,279	15	4,279		14,977	27
28	FIRE ALARM SYSTEM		2003		25,000	909	27.5	909		3,219	28
29	ROOF		2003		26,500	964	27.5	964		3,334	29
30	EXTERIOR WALL		2003		9,796	356	27.5	356		1,202	30
31	SINKS		2003		3,146	114	27.5	114		404	31
32	BUILT IN WARDROBE		2003		19,398	705	27.5	705		2,321	32
33	REBUILD A/C & HEATING RETURN FAN		2004		4,700	171	27.5	171		492	33
34	FIRE ALARM SYSTEM		2004		13,201	480	27.5	480		1,340	34
35	BUILT IN WARDROBE		2004		21,807	793	27.5	793		2,016	35
36	MASONRY REPAIRS		2004		61,620	2,241	27.5	2,241		5,136	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.

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 DOORS	2004	\$ 2,995	\$ 109	27.5	\$ 109	\$	\$ 241	37
38 BOILER REPAIR	2004	5,650	206	27.5	206		420	38
39 HOT WATER HEATER	2004	5,756	209	27.5	209		427	39
40 FLOOR TILING	2004	5,326	194	27.5	194		396	40
41 REMODEL BATHROOM	2005	6,080	221	27.5	221		341	41
42 DOORS	2005	4,506	164	27.5	164		253	42
43 FLOOR TILING	2005	1,536	56	27.5	56		86	43
44 2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		4,653	44
45 CONCRETE PATIO	2005	3,015	201	15	201		327	45
46 SHOWER	2006	3,040	60	27.5	60		60	46
47 DUCT WORK	2006	5,600	111	27.5	111		111	47
48 A/C COOLING TOWER	2006	13,161	259	27.5	259		259	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								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 18,487,849	\$ 678,018		\$ 688,048	\$ 10,030	\$ 1,351,602	70

**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	\$ 573,374	\$ 43,340	\$ 57,337	\$ 13,997	10 YRS	\$ 268,049	71
72	Current Year Purchases	14,198	2,840	710	(2,130)	10 YRS	710	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	738,000	74,946	74,946	0	10YRS		74
75	TOTALS	\$ 1,325,572	\$ 121,126	\$ 132,993	\$ 11,867		\$ 268,759	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 21,313,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 799,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 821,041	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,897	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,620,361	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: _____

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:	328	10/01/01	\$ 1,875,000			3
4	Additions						4
5							5
6							6
7	TOTAL	328		\$ 1,875,000			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: \$ 17,787 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ 40,042	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 40,042	21

10. Effective dates of current rental agreement:

Beginning 10/01/01

Ending 09/30/08

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

Fiscal Year Ending Annual Rent

12. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 258,639	\$		\$ 258,639	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			107,798			107,798	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				133,947		133,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): SUPPLIES	39-2					14,962		14,962	13
14	TOTAL			\$		\$ 366,437	\$ 148,909		\$ 515,346	14

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

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 177,093	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 600,000)	3,693,961		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	169,975		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,041,029	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	858,930		15
16	Equipment, at Historical Cost	692,019		16
17	Accumulated Depreciation (book methods)	(769,862)		17
18	Deferred Charges	205,370		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 986,457	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,027,486	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 272,383	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	255,000		29
30	Accrued Salaries Payable	138,167		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,187		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,185		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 701,922	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	451,366		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 451,366	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,153,288	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,874,198	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,027,486	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,577,265	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,577,269	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,280,929	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	(984,000)	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)	\$ 296,929	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,874,198	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,031,681	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,031,681	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	181,758	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 181,758	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,213,448	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,191,179	31
32	Health Care	4,762,409	32
33	General Administration	3,191,460	33
	B. Capital Expense		
34	Ownership	2,065,379	34
	C. Ancillary Expense		
35	Special Cost Centers	515,346	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,905,353	40
41	Income before Income Taxes (line 30 minus line 40)**	1,308,095	41
42	Income Taxes	(27,166)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,280,929	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number PRESIDENTIAL PAVILION

0045526

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	5,112	5,793	\$ 232,409	\$ 40.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,612	14,300	348,542	24.37	3
4	Licensed Practical Nurses	62,529	66,152	1,381,192	20.88	4
5	CNAs & Orderlies	162,760	178,658	1,680,101	9.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,271	14,069	153,112	10.88	8
9	Activity Director					9
10	Activity Assistants	21,419	22,845	194,293	8.50	10
11	Social Service Workers	15,354	16,316	202,686	12.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,323	41,389	375,726	9.08	15
16	Dishwashers					16
17	Maintenance Workers	30,091	31,899	268,797	8.43	17
18	Housekeepers	42,561	46,010	369,400	8.03	18
19	Laundry	17,043	19,859	170,208	8.57	19
20	Administrator	2,086	2,281	162,445	71.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,205	27,266	296,246	10.87	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	6,175	6,628	65,062	9.82	31
32	Other Health C: <u>MDS</u>	9,216	9,845	214,089	21.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	463,757	503,310	\$ 6,114,308 *	\$ 12.15	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 14,400	1-3	35
36	Medical Director	O	8,500	9-3	36
37	Medical Records Consultant	N	52	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,498	10-3	39
40	Physical Therapy Consultant	L	1,684	10a-3	40
41	Occupational Therapy Consultant	Y	4,405	10a-3	41
42	Respiratory Therapy Consultant		68,800	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,224	11-3	44
45	Social Service Consultant	E	2,930	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	S	6,000	10-3	46
47	<u>PSYCHIATRIC</u>		1,207	10-3	47
48	<u>DENTAL</u>		1,600	10-3	48
49	TOTAL (lines 35 - 48)		\$ 124,300		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MICHAEL ROSEN	ADMINISTRATOR	3.00%	\$ 162,445	Workers' Compensation Insurance	\$ 140,383	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	150,846	Advertising: Employee Recruitment	1,223	
				FICA Taxes	452,628	Health Care Worker Background Check (Indicate # of checks performed _____)	0	
				Employee Health Insurance	200,991	Patient Background Checks	0	
				Employee Meals	10,311	TRUST/FRANCHISE/CONTRIB/ETC	5,970	
				Illinois Municipal Retirement Fund (IMRF)*		MARKETING/ADV/PROMO	8,776	
				EMPLOYEE BENEFITS - OTHER	5,010	LICENSES/DUES/SUBSCRIPTIONS	11,777	
				EMPLOYEE PHYSICAL EXAMS	0	MGMT CO ALLOC	8,009	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 162,445	PENSION/PROFIT SHARING PLANS	56,302	TRUST/FRANCHISE/CONTRIB/ETC	(5,970)	
				CHICAGO HEAD TAX	12,468	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE	0	Non-allowable advertising	(8,776)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Yellow page advertising	(0)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,028,939	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,009	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount	
EMI ENTERPRISES			\$ 365,500			Out-of-State Travel	\$	
PHILIP ESFORMES, INC			365,500			In-State Travel	0	
						Seminar Expense	1,930	
						MGMT ALLOC	15	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 731,000			Entertainment Expense	()	
				TOTAL		TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,945	
C. Professional Services								
Vendor/Payee	Type			Amount				
				\$				
SEE SCHEDULE ATTACHED			83,838					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 83,838					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2002	\$ 10,449	3 YRS	\$ 3,483	\$ 3,483	\$ 1,741	\$	\$	\$	\$	\$								
2	PAINT/DECORATING	2006	3,582	3 YRS				1,194	1,194	1,194										
3																				
4																				
5																				
6																				
7																				
8																				
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16																				
17																				
18																				
19																				
20	TOTALS		\$ 14,031		\$ 3,483	\$ 3,483	\$ 1,741	\$ 1,194	\$ 1,194	\$ 1,194	\$	\$								

Facility Name & ID Number **PRESIDENTIAL PAVILION**# **0045526**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$11,742
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,580
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. \$ 10,311 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees