



Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	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	1,695	88	9,128	10,911	8
9	SNF/PED					9
10	ICF	105,047	1,122	93	106,262	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	106,742	1,210	9,221	117,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.87%

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 9,128

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

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

Facility Name & ID Number **PRESIDENTIAL PAVILION** # **0045526** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	360,893	44,871	15,932	421,696		421,696		421,696		1
2	Food Purchase		444,006		444,006	(14,250)	429,756	(2,453)	427,303		2
3	Housekeeping	405,297	64,316		469,613		469,613		469,613		3
4	Laundry	162,406	36,405	9,588	208,399		208,399	2,663	211,062		4
5	Heat and Other Utilities			341,755	341,755		341,755	706	342,461		5
6	Maintenance	82,395	41,362	100,042	223,799		223,799	11,239	235,038		6
7	Other (specify):* <b>SECURITY</b>	183,971		31,315	215,286		215,286	149	215,435		7
8	<b>TOTAL General Services</b>	1,194,962	630,960	498,632	2,324,554	(14,250)	2,310,304	12,304	2,322,608		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,500	12,500		12,500		12,500		9
10	Nursing and Medical Records	3,879,009	119,882	39,530	4,038,421		4,038,421	2,588	4,041,009		10
10a	Therapy	154,261		66,825	221,086		221,086		221,086		10a
11	Activities	180,907	58,201	4,608	243,716		243,716		243,716		11
12	Social Services	233,624		2,160	235,784		235,784		235,784		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,447,801	178,083	125,623	4,751,507		4,751,507	2,588	4,754,095		16
	<b>C. General Administration</b>										
17	Administrative	162,445		706,000	868,445		868,445	(310,684)	557,761		17
18	Directors Fees										18
19	Professional Services			215,304	215,304		215,304	29,777	245,081		19
20	Dues, Fees, Subscriptions & Promotions			41,329	41,329		41,329	(12,707)	28,622		20
21	Clerical & General Office Expenses	306,534	28,477	179,551	514,562		514,562	(184,681)	329,881		21
22	Employee Benefits & Payroll Taxes			1,032,347	1,032,347	14,250	1,046,597		1,046,597		22
23	Inservice Training & Education							90	90		23
24	Travel and Seminar			2,317	2,317		2,317		2,317		24
25	Other Admin. Staff Transportation			9,937	9,937		9,937	1,910	11,847		25
26	Insurance-Prop.Liab.Malpractice			317,365	317,365		317,365	31,704	349,069		26
27	Other (specify):*			936,760	936,760		936,760	(914,522)	22,238		27
28	<b>TOTAL General Administration</b>	468,979	28,477	3,440,910	3,938,366	14,250	3,952,616	(1,359,113)	2,593,503		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,111,742	837,520	4,065,165	11,014,427		11,014,427	(1,344,221)	9,670,206		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	15,932
	REPAIRS & MAINTENANCE	0
		0
		15,932
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	9,588
		0
		9,588
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	135,395
	ELECTRICITY	166,884
	WATER	36,946
	CABLE TV - LOBBY	2,530
		0
		341,755
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,800
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	57,031
	ELEVATOR MAINTENANCE & REPAIR	23,117
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,250
	FIRE SERVICE	7,844
		0
		0
		0
		0
		100,042
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	31,315
	SECURITY SERVICE	0
		0
		0
		31,315
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,500
		12,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	638
	LABORATORY & XRAY EXPENSE	13,292
	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	0
	PHARMACY CONSULTANT XVIII B 39-2	14,170
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	6,000
	PSYCHIATRIC XVIII B ___-2	630
	RN CONSULTANT XVIII B 38-2	0
	<b>DENTAL</b>	4,800
		0
		39,530
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	66,825
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		66,825
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,608
		0
		4,608
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,160
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,160
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	706,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	27,342
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	187,962
		0
		215,304
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,733
	EMPLOYEE WANT ADS XIX F	1,719
	CONTRIBUTIONS VI 20 XIX F	800
	DUES & SUBSCRIPTIONS XIX F	13,826
	LICENSES & PERMITS XIX F	8,070
	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	4,181
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		41,329
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,325
	OUTSIDE CLERICAL SERVICES	97,000
	PENALTIES / OVERDRAFT CHARGES VI 18	3,045
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	29,859
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	43,322
		179,551

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	447,778
	UNEMPLOYMENT COMPENSATION XIX D	123,082
	WORKERS COMPENSATION INSURANC XIX D	152,491
	HOSPITALIZATION INSURANCE XIX D	235,760
	EMPLOYEE BENEFITS - OTHER XIX D	3,000
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	57,888
	CHICAGO HEAD TAX XIX D	12,348
		0
		1,032,347
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,317
	TRAVEL XIX G	0
		2,317
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,937
		9,937
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	317,365
		317,365
27	<b>OTHER</b>	
	BAD DEBTS VI 24	936,760
		936,760

GRAND TOTAL COLUMN 3 OTHER

4,065,165

**PRESIDENTIAL PAVILION  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	444,006
LESS SALES TAX	<u>(2,453)</u>
NET FOOD	441,553

TOTAL PATIENT CENSUS	117,173
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	351,519

ADD # EMPLOYEE MEALS/DAY	32
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	11,680

PATIENT MEALS	351,519
ADD EMPLOYEE MEALS	<u>11,680</u>
TOTAL MEALS/YEAR	363,199

NET FOOD	441,553
DIVIDE TOTAL MEALS/YEAR	<u>363,199</u>

COST PER MEAL	1.22
TIME EMPLOYEE MEALS	<u>11,680</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>14,250</b>

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Facility Name &amp; ID Number

PRESIDENTIAL PAVILION

#0045526

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			56,099	56,099		56,099	765,083	821,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,352	6,352		6,352	1,015,586	1,021,938			32
33	Real Estate Taxes							450,908	450,908			33
34	Rent-Facility & Grounds			1,920,000	1,920,000		1,920,000	(1,920,000)				34
35	Rent-Equipment & Vehicles			52,192	52,192		52,192	7,761	59,953			35
36	Other (specify):* <b>IME</b>			25,584	25,584		25,584	65,657	91,241			36
37	<b>TOTAL Ownership</b>			2,060,227	2,060,227		2,060,227	384,995	2,445,222			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,547	358,782	489,329		489,329		489,329			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,580	179,580		179,580		179,580			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		130,547	538,362	668,909		668,909		668,909			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,111,742	968,067	6,663,754	13,743,563		13,743,563	(959,226)	12,784,337			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	45,684	30		9
10	Interest and Other Investment Income	(32,713)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,453)	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		20		17
18	Fines and Penalties	(3,045)	21		18
19	Entertainment		20		19
20	Contributions	(4,981)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(936,760)	27		24
25	Fund Raising, Advertising and Promotional	(12,733)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(151,507)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,098,508)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	139,282		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 139,282</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (959,226)</b>		<b>37</b>

**\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,194	6	1
2	MARKETING SALARIES	(109,379)	21	2
3	STAFF DEVELOPMENT	(43,322)	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	<b>Total</b>	(151,507)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,453)	0	0	0	0	0	0	0	0	0	0	(2,453)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,663	0	0	0	0	0	0	0	0	2,663	4
5	Heat and Other Utilities	0	0	0	706	0	0	0	0	0	0	0	706	5
6	Maintenance	1,194	3,793	3,544	2,708	0	0	0	0	0	0	0	11,239	6
7	Other (specify):*	0	0	70	79	0	0	0	0	0	0	0	149	7
8	<b>TOTAL General Services</b>	<b>(1,259)</b>	<b>3,793</b>	<b>6,277</b>	<b>3,493</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,304</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,588	0	0	0	0	0	0	0	0	0	2,588	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>2,588</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,588</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(327,694)	17,010	0	0	0	0	0	0	0	0	(310,684)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,156	16,491	130	12,000	0	0	0	0	0	0	29,777	19
20	Fees, Subscriptions & Promotions	(17,714)	0	5,007	0	0	0	0	0	0	0	0	(12,707)	20
21	Clerical & General Office Expenses	(155,746)	19,867	(48,916)	114	0	0	0	0	0	0	0	(184,681)	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	90	0	0	0	0	0	0	0	0	90	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	836	1,074	0	0	0	0	0	0	0	0	1,910	25
26	Insurance-Prop.Liab.Malpractice	0	1,169	928	157	29,450	0	0	0	0	0	0	31,704	26
27	Other (specify):*	(936,760)	12,653	9,585	0	0	0	0	0	0	0	0	(914,522)	27
28	<b>TOTAL General Administration</b>	<b>(1,110,220)</b>	<b>(292,013)</b>	<b>1,269</b>	<b>401</b>	<b>41,450</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,359,113)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,111,479)</b>	<b>(285,632)</b>	<b>7,546</b>	<b>3,894</b>	<b>41,450</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,344,221)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	45,684	472	559	2,266	716,102	0	0	0	0	0	0	765,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,713)	0	0	4,264	1,044,035	0	0	0	0	0	0	1,015,586	32
33	Real Estate Taxes	0	0	0	3,175	447,733	0	0	0	0	0	0	450,908	33
34	Rent-Facility & Grounds	0	0	0	0	(1,920,000)	0	0	0	0	0	0	(1,920,000)	34
35	Rent-Equipment & Vehicles	0	1,896	5,110	755	0	0	0	0	0	0	0	7,761	35
36	Other (specify):*	0	0	0	(25,584)	91,241	0	0	0	0	0	0	65,657	36
37	<b>TOTAL Ownership</b>	<b>12,971</b>	<b>2,368</b>	<b>5,669</b>	<b>(15,124)</b>	<b>379,111</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>384,995</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,098,508)</b>	<b>(283,264)</b>	<b>13,215</b>	<b>(11,230)</b>	<b>420,561</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(959,226)</b>	<b>45</b>

**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
				EMI ENTERPRISES	LINCOLNWOOD	MGMT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
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	\$ 353,000	EMI ENTERPRISES, INC		\$	(353,000)	1
2	V	6	DRIVERS' SALARY			3,793		3,793	2
3	V	10	NURSING CONSULTANTS			2,588		2,588	3
4	V	17	OFFICER SALARY			25,306		25,306	4
5	V	19	ACCOUNTING FEES			1,156		1,156	5
6	V	21	OFFICER SALARY			19,867		19,867	6
7	V	25	TRANSPORTATION			836		836	7
8	V	26	INSURANCE			1,169		1,169	8
9	V	27	EMPLOYEE BENEFITS			12,653		12,653	9
10	V	30	DEPRECIATION			472		472	10
11	V	35	AUTO LEASE			1,896		1,896	11
12	V								12
13	V								13
14	Total		\$ 353,000			\$ 69,736	\$ *	(283,264)	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	\$ 97,000	EKS MANAGEMENT		\$	\$ (97,000)
16	V	4 HOUSEKEEPING SALARIES				2,663	2,663
17	V	6 PAINTERS' SALARIES				3,544	3,544
18	V	7 SCAVENGER				70	70
19	V	17 CFO SALARY - A. WEINFELD				17,010	17,010
20	V	19 PROFESSIONAL FEES				16,491	16,491
21	V	20 WANT ADS / BACKGRD CKS				5,007	5,007
22	V	21 OFFICE EXPENSE				48,084	48,084
23	V	23 SEMINARS				90	90
24	V	25 TRANSPORTATION				1,074	1,074
25	V	26 INSURANCE				928	928
26	V	27 EMPLOYEE BENEFITS				9,585	9,585
27	V	30 DEPRECIATION S.L.				559	559
28	V	35 EQUIPMENT RENT				5,110	5,110
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 97,000			\$ 110,215	\$ * 13,215

\* 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		\$	(25,584)
16	V	5 UTILITIES				706	706
17	V	6 PAINTERS FEES				841	841
18	V	6 REPAIRS /MAINT				1,867	1,867
19	V	7 ALARM SERVICE				79	79
20	V	19 PROFESSIONAL FEES				130	130
21	V	21 OFFICE EXPENSE				114	114
22	V	26 INSURANCE				157	157
23	V	30 DEPRECIATION				2,266	2,266
24	V	32 INTEREST				4,264	4,264
25	V	33 R/E TAX				3,175	3,175
26	V	35 STORAGE FEES				755	755
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			\$ 14,354	\$ * (11,230)

\* 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	\$ 1,920,000	BEVERLY PAVILION LLC		\$	(1,920,000)
16	V	19 PROFESSIONAL FEES				12,000	12,000
17	V	26 INSURANCE				29,450	29,450
18	V	30 DEPR. S.L BUILDING & IMP				642,302	642,302
19	V	30 DEPR. S.L EQUIP				73,800	73,800
20	V	32 INTEREST				1,044,035	1,044,035
21	V	33 REAL ESTATE TAXES				447,733	447,733
22	V	36 M.I.P. INSURANCE				91,241	91,241
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		\$ 1,920,000			\$ 2,340,561	\$ * 420,561

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

Facility Name &amp; ID Number

PRESIDENTIAL PAVILION

#

0045526

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	ADMIN.	40.00		LIST		SALARY	\$ 25,306	17-7	1
2						ATTACHED					2
3											3
4	PHILIP ESFORMES	MEMBER	ADMIN.	40.00		LIST		MGMT FEE	353,000	17-3	4
5						ATTACHED					5
6											6
7	AVRUM WEINFELD		CFO	3.00		LIST		Salary fr EKS	17,010	17-7	7
8	FLORA WEISS		CLERICAL	3.00		ATTACHED		Comp fr EKS	2,285	21-7	8
9											9
10	MICHAEL ROSEN	ADMINISTRATOR		3.00		40+	100.00	SALARY	162,445	17-1	10
11											11
12											12
13								TOTAL	\$ 560,046		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: **01/01/2007** Ending: **2/31/2007**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization EMI ENTERPRISES  
 Street Address 6865 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847 ) 674 - 5795  
 Fax Number ( 847 ) 674 - 5794

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	342,637	4	\$ 11,091	\$ 11,091	117,173	\$ 3,793	1
2	10	NURSING CONSULTANT	PATIENT DAYS	342,637	4	7,567	117,173	2,588	2	
3	17	OFFICER SALARY	PATIENT DAYS	342,637	4	74,000	117,173	25,306	3	
4	19	ACCOUNTING FEES	PATIENT DAYS	342,637	4	3,380	117,173	1,156	4	
5	21	OFFICE	PATIENT DAYS	342,637	4	58,095	117,173	19,867	5	
6	25	TRANSPORTATION	PATIENT DAYS	342,637	4	2,444	117,173	836	6	
7	26	INSURANCE	PATIENT DAYS	342,637	4	3,417	117,173	1,169	7	
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	342,637	4	37,000	117,173	12,653	8	
9	30	DEPRECIATION	PATIENT DAYS	342,637	4	1,380	117,173	472	9	
10	35	AUTO LEASE	PATIENT DAYS	342,637	4	5,543	117,173	1,896	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					\$ 203,917	\$ 128,856		\$ 69,736	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

# **0045526**

Report Period Beginning:

**01/01/2007**

Ending: **2/31/2007**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization 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	857,979	14	\$ 19,500	\$ 117,173	\$ 2,663	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	857,979	14	25,953	117,173	3,544	2
3	7	SCAVENGER	PATIENT DAYS	857,979	14	512	117,173	70	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	857,979	14	124,552	117,173	17,010	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	857,979	14	120,756	117,173	16,491	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	857,979	14	36,665	117,173	5,007	6
7	21	OFFICE EXPENSE	PATIENT DAYS	857,979	14	352,089	117,173	48,084	7
8	23	SEMINAR	PATIENT DAYS	857,979	14	659	117,173	90	8
9	25	TRANSPORTATION	PATIENT DAYS	857,979	14	7,865	117,173	1,074	9
10	26	INSURANCE	PATIENT DAYS	857,979	14	6,798	117,173	928	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	857,979	14	70,186	117,173	9,585	11
12	30	DEPRECIATION S.L	PATIENT DAYS	857,979	14	4,096	117,173	559	12
13	35	EQUIPMENT RENT	PATIENT DAYS	857,979	14	37,419	117,173	5,110	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					\$ 807,050	\$ 270,576	\$ 110,215	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

# **0045526** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	15	\$ 5,162	\$ 25,584	\$ 706	1
2	6	PAINTERS FEES	INCOME	187,059	15	6,152	25,584	841	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	13,651	25,584	1,867	3
4	7	ALARM SERVICE	INCOME	187,059	15	575	25,584	79	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	952	25,584	130	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	831	25,584	114	6
7	26	INSURANCE	INCOME	187,059	15	1,150	25,584	157	7
8	30	DEPRECIATION	INCOME	187,059	15	16,570	25,584	2,266	8
9	32	INTEREST	INCOME	187,059	15	31,178	25,584	4,264	9
10	33	R/E TAX	INCOME	187,059	15	23,213	25,584	3,175	10
11	35	STORAGE FEES	INCOME	187,059	15	5,519	25,584	755	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					\$ 104,953	\$	\$ 14,354	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

# **0045526** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization 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	\$ 12,000	\$	1	\$ 12,000	1
2	26	INSURANCE	DIRECT	1	29,450		1	29,450	2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT	1	642,302		1	642,302	3
4	30	DEPR. S.L. EQUIP	DIRECT	1	73,800		1	73,800	4
5	32	INTEREST	DIRECT	1	1,044,035		1	1,044,035	5
6	33	REAL ESTATE TAXES	DIRECT	1	447,733		1	447,733	6
7	36	M.I.P. INSURANCE	DIRECT	1	91,241		1	91,241	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				\$ 2,340,561	\$		\$ 2,340,561	25

Facility Name &amp; ID Number

PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Cambridge(Beverly)		X	MORTGAGE	\$99,236.00	3/10/05	\$ 18,706,800	\$ 18,189,859			\$ 988,228	1						
2	Wedgewood Realty(Beverly)		x	MORTGAGE	\$15,000.00	3/10/05	1,650,600	1,200,288	11/10/15	0.0459	55,807	2						
3												3						
4	RELATED PARTY - IME										4,264	4						
5												5						
	<b>Working Capital</b>																	
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	400,000	270,000	REVOLV	PRIME +	6,352	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$114,236.00		\$ 20,757,400	\$ 19,660,147			\$ 1,054,651	9						
	<b>B. Non-Facility Related*</b>																	
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 20,757,400	\$ 19,660,147			\$ 1,054,651	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2006 report.		\$	<b>347,618</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>392,766</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>45,148</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>402,585</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>447,733</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2002</b>	<b>335,896</b>	<b>8</b>
	<b>2003</b>	<b>326,832</b>	<b>9</b>
	<b>2004</b>	<b>334,092</b>	<b>10</b>
	<b>2005</b>	<b>337,493</b>	<b>11</b>
	<b>2006</b>	<b>392,766</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

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

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

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

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PRESIDENTIAL PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045526

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>20-31-108-044-0000</u>	<u>NURSING HOME</u>	\$ <u>392,766.00</u>	\$ <u>392,766.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>392,766.00</u>	\$ <u>392,766.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

Report Period Beginning:

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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	328		2005		\$ 17,449,000	\$ 634,509	27.5	\$ 634,509	\$	\$ 1,771,338	4
5											5
6											6
7	RELATED PARTY				75,472	2,178	39	2,178			7
8	OFFICE - IME										8
	<b>Improvement Type**</b>										
9	AWNINGS		2001		10,500	382	27.5	382		2,340	9
10	FENCE		2001		2,100	140	15	140		858	10
11	ELEVATOR		2001		18,340	667	27.5	667		4,085	11
12	ALARM		2001		5,686	207	27.5	207		1,268	12
13	WINDOWS		2001		4,149	151	27.5	151		925	13
14	BOILER		2001		3,000	109	27.5	109		450	14
15	FURNISHINGWALLPAPER & BORDERS		2001		12,953		5			12,953	15
16	KITCHEN SINK & DRAIN		2001		2,525	92	27.5	92		563	16
17	DOORS		2001		15,100	549	27.5	549		3,352	17
18	ELEVATOR		2002		222,811	8,102	27.5	8,102		48,612	18
19	FENCE		2002		3,100	207	15	207		1,139	19
20	DOORS & LOCKS		2002		21,741	791	27.5	791		4,647	20
21	SHOWER ROOMS		2002		4,669	170	27.5	170		900	21
22	ALARM AND SPRINKLER		2002		11,881	432	27.5	432		2,285	22
23	EJECTOR & SEWEGE PUMP		2002		14,604	531	27.5	531		2,810	23
24	ROOF DRAIN		2002		3,100	113	27.5	113		626	24
25	FURNISHING - CARPETS AND DRAPERIES		2002		91,494	3,689	5	9,149	5,460	91,494	25
26	ELEVATOR		2003		110,562	4,020	27.5	4,020		19,263	26
27	PARKING LOT		2003		64,182	4,279	15	4,279		19,256	27
28	FIRE ALARM SYSTEM		2003		25,000	909	27.5	909		4,128	28
29	ROOF		2003		26,500	964	27.5	964		4,298	29
30	EXTERIOR WALL		2003		9,796	356	27.5	356		1,558	30
31	SINKS		2003		3,146	114	27.5	114		518	31
32	BUILT IN WARDROBE		2003		19,398	705	27.5	705		3,026	32
33	REBUILD A/C & HEATING RETURN FAN		2004		4,700	171	27.5	171		663	33
34	FIRE ALARM SYSTEM		2004		13,201	480	27.5	480		1,820	34
35	BUILT IN WARDROBE		2004		21,807	793	27.5	793		2,809	35
36	MASONRY REPAIRS		2004		61,620	2,241	27.5	2,241		7,377	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DOORS	2004	\$ 2,995	\$ 109	27.5	\$ 109	\$	\$ 350	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		626	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		636	39
40	FLOOR TILING	2004	5,326	194	27.5	194		590	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		562	41
42	DOORS	2005	4,506	164	27.5	164		417	42
43	FLOOR TILING	2005	1,536	56	27.5	56		142	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		8,255	44
45	CONCRETE PATIO	2005	3,015	201	15	201		528	45
46	SHOWER	2006	3,040	111	27.5	111		171	46
47	DUCT WORK	2006	5,600	204	27.5	204		315	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		738	48
49	FIRE ALARM - BEVERLY	2007	273,534	4,974	27.5	4,974		4,974	49
50	COOLING TOWERS - BEVERLY	2007	121,905	2,216	27.5	2,216		2,216	50
51	SHOWERS - BEVERLY	2007	12,160	221	27.5	221		221	51
52	AIR CLEANERS - BEVERLY	2007	10,851	197	27.5	197		197	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		185	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)		\$ 18,911,399	\$ 681,600		\$ 687,060	\$ 5,460	\$ 2,036,484	70

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

Facility Name & ID Number **PRESIDENTIAL PAVILION**

# **0045526**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 587,572	\$ 17,196	\$ 58,757	\$ 41,561	10 YRS	\$ 327,516	71
72	Current Year Purchases	8,916	1,783	446	(1,337)	10YRS	446	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>	<b>738,000</b>	<b>74,919</b>	<b>74,919</b>		<b>10YRS</b>		74
75	<b>TOTALS</b>	\$ 1,334,488	\$ 93,898	\$ 134,122	\$ 40,224		\$ 327,962	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 21,745,887	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 775,498	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 821,182	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,684	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,364,446	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	<b>TOTALS</b>	\$	\$	\$	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	\$ 1,920,000			3
4	Additions							4
5								5
6								6
7	TOTAL		328		\$ 1,920,000			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: \$ 18,280 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			\$	\$ 33,912	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 33,912	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. /2008 \$ \_\_\_\_\_

13. /2009 \$ \_\_\_\_\_

14. /2010 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

**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	\$		\$ 250,058	\$		\$ 250,058	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			646			646	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			108,078			108,078	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 prescrpts				130,158		130,158	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>SUPPLIES</b>						389		389	13
14	<b>TOTAL</b>			\$		\$ 358,782	\$ 130,547		\$ 489,329	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 &amp; ID Number      PRESIDENTIAL PAVILION

#      0045526

Report Period Beginning:    01/01/2007

Ending:      12/31/2007

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

As of    12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 132,794	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (100,000) )	3,132,493		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,868		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	282,623		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,700,778	\$	10
	<b>B. Long-Term Assets</b>			
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	963,377		15
16	Equipment, at Historical Cost	596,488		16
17	Accumulated Depreciation (book methods)	(825,961)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 733,904	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,434,682	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 527,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	270,000		29
30	Accrued Salaries Payable	166,162		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,839		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 997,204	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	387,693		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 387,693	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,384,897	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,049,785	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,434,682	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,874,198</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,874,201</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>103,084</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(927,500)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(824,416)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,049,785</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 13,477,408	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,477,408	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	337,332	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 337,332	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	32,713	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 32,713	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,847,453	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,324,554	31
32	Health Care	4,751,507	32
33	General Administration	3,938,366	33
	<b>B. Capital Expense</b>		
34	Ownership	2,060,227	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	489,329	35
36	Provider Participation Fee	179,580	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,743,563	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	103,890	41
42	<b>Income Taxes</b>	(806)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 103,084	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: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	5,169	5,703	\$ 236,688	\$ 41.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,505	14,926	399,008	26.73	3
4	Licensed Practical Nurses	56,601	60,291	1,336,312	22.16	4
5	CNAs & Orderlies	150,421	162,507	1,618,447	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,253	13,873	154,261	11.12	8
9	Activity Director					9
10	Activity Assistants	18,568	19,697	180,907	9.18	10
11	Social Service Workers	18,723	19,441	233,624	12.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,816	38,618	360,893	9.35	15
16	Dishwashers					16
17	Maintenance Workers	7,339	7,990	82,395	10.31	17
18	Housekeepers	43,921	46,983	405,297	8.63	18
19	Laundry	16,670	18,225	162,406	8.91	19
20	Administrator	2,086	2,476	162,445	65.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,006	27,146	306,534	11.29	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	4,694	5,083	53,261	10.48	31
32	Other Health C: <u>MDS</u>	10,498	10,724	235,293	21.94	32
33	Other(specify) <u>SECURITY</u>	21,515	22,609	183,971	8.14	33
34	TOTAL (lines 1 - 33)	443,785	476,292	\$ 6,111,742 *	\$ 12.83	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	\$ 15,932	1-3	35
36	Medical Director	O	12,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	14,170	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		66,825	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,608	11-3	44
45	Social Service Consultant	E	2,160	12-3	45
46	Other(specify) <u>DENTAL</u>	S	4,800	10-3	46
47	<u>Psychiatric</u>		630	10-3	47
48	<u>Physicians</u>		6,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 127,625		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	51	638	10-3	52
53	TOTAL (lines 50 - 52)	51	\$ 638		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	\$ 162,445	Workers' Compensation Insurance	\$ 152,491	IDPH License Fee	\$ 1,990	
	ASST ADMIN		0	Unemployment Compensation Insurance	123,082	Advertising: Employee Recruitment	1,719	
	OTHER ADMIN		0	FICA Taxes	447,778	Health Care Worker Background Check	0	
				Employee Health Insurance	235,760	(Indicate # of checks performed )		
				Employee Meals	14,250	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,981	
				EMPLOYEE BENEFITS - OTHER	3,000	MARKETING/ADV/PROMO	12,733	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	19,906	
				PENSION/PROFIT SHARING PLANS	57,888	MGMT CO ALLOC	5,007	
				CHICAGO HEAD TAX	12,348	TRUST/FRANCHISE/CONTRIB/ETC	(4,981)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(12,733)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 162,445	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,046,597	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,622	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
EMI MANAGEMENT FEE			\$ 353,000				Out-of-State Travel	\$
PHILLIP ESFORMES			353,000				In-State Travel	0
							Seminar Expense	2,317
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 706,000	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,317
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			215,304					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 215,304					

\* 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	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2002	\$ 10,449	3 YRS	\$ 3,483	\$ 1,741														
2	PAINT/DECORATING	2006	3,582	3 YRS			1,194	1,194	1,194											
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
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15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$ 14,031		\$ 3,483	\$ 1,741	\$ 1,194	\$ 1,194	\$ 1,194	\$	\$	\$								

Facility Name & ID Number **PRESIDENTIAL PAVILION**# **0045526**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$13,531
- (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. \$ 1,070 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 14,250 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees