

Facility Name & ID Number PRESIDENTIAL PAVILION

0045526 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	79,788	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,260	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	120,048	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	619	71	11,373	12,063	8
9	SNF/PED					9
10	ICF	104,665	950	366	105,981	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	105,284	1,021	11,739	118,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.33%

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 11,373

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **PRESIDENTIAL PAVILION** # **0045526** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	365,057	41,345	15,210	421,612		421,612		421,612		1
2	Food Purchase		462,821		462,821	(26,791)	436,030	(2,366)	433,664		2
3	Housekeeping	393,002	59,983		452,985		452,985		452,985		3
4	Laundry	171,372	37,233	14,373	222,978		222,978	2,678	225,656		4
5	Heat and Other Utilities			364,271	364,271		364,271	764	365,035		5
6	Maintenance	90,783	46,808	91,751	229,342		229,342	13,319	242,661		6
7	Other (specify):* SECURITY	210,943		31,662	242,605		242,605	160	242,765		7
8	TOTAL General Services	1,231,157	648,190	517,267	2,396,614	(26,791)	2,369,823	14,555	2,384,378		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,773,214	124,723	38,206	3,936,143		3,936,143		3,936,143		10
10a	Therapy	147,036		72,000	219,036		219,036		219,036		10a
11	Activities	192,264	53,638	5,608	251,510		251,510		251,510		11
12	Social Services	258,544		2,503	261,047		261,047		261,047		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,371,058	178,361	130,317	4,679,736		4,679,736		4,679,736		16
	C. General Administration										
17	Administrative	163,921		630,000	793,921		793,921	(259,228)	534,693		17
18	Directors Fees										18
19	Professional Services			175,231	175,231		175,231	29,098	204,329		19
20	Dues, Fees, Subscriptions & Promotions			41,038	41,038		41,038	(22,253)	18,785		20
21	Clerical & General Office Expenses	346,089	30,346	182,757	559,192		559,192	(223,634)	335,558		21
22	Employee Benefits & Payroll Taxes			907,575	907,575	26,791	934,366		934,366		22
23	Inservice Training & Education							13	13		23
24	Travel and Seminar			5,720	5,720		5,720		5,720		24
25	Other Admin. Staff Transportation			17,188	17,188		17,188	1,918	19,106		25
26	Insurance-Prop.Liab.Malpractice			320,026	320,026		320,026	30,519	350,545		26
27	Other (specify):*			853,539	853,539		853,539	(828,187)	25,352		27
28	TOTAL General Administration	510,010	30,346	3,133,074	3,673,430	26,791	3,700,221	(1,271,754)	2,428,467		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,112,225	856,897	3,780,658	10,749,780		10,749,780	(1,257,199)	9,492,581		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	15,210
	REPAIRS & MAINTENANCE	0
		0
		15,210
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	14,373
		0
		14,373
5	HEAT & OTHER UTILITIES	
	GAS HEAT	160,863
	ELECTRICITY	163,397
	WATER	38,271
	CABLE TV - LOBBY	1,740
		0
		364,271
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,943
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	36,560
	ELEVATOR MAINTENANCE & REPAIR	29,478
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,845
	FIRE SERVICE	12,868
	PAINTING & DECORATING	2,057
		0
		0
		0
		91,751
7	OTHER	
	SCAVENGER	31,662
	SECURITY SERVICE	0
		0
		0
		31,662
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	13,882
	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	13,524
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	6,000
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	4,800
		0
		38,206
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	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	72,000
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		72,000
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	5,608
		0
		5,608
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,503
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,503
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	630,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	27,465
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	147,766
		0
		175,231
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,736
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	10,164
	LICENSES & PERMITS XIX F	4,315
	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	13,323
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		41,038
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	5,960
	OUTSIDE CLERICAL SERVICES	96,000
	PENALTIES / OVERDRAFT CHARGES VI 18	1,374
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	28,166
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	51,257
		182,757

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	448,345
	UNEMPLOYMENT COMPENSATION XIX D	85,965
	WORKERS COMPENSATION INSURANC XIX D	73,153
	HOSPITALIZATION INSURANCE XIX D	232,835
	EMPLOYEE BENEFITS - OTHER XIX D	660
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	54,797
	CHICAGO HEAD TAX XIX D	11,820
		0
		907,575
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	5,720
	TRAVEL XIX G	0
		5,720
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	17,188
		17,188
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	320,026
		320,026
27	OTHER	
	BAD DEBTS VI 24	853,539
		853,539

GRAND TOTAL COLUMN 3 OTHER

3,780,658

**PRESIDENTIAL PAVILION
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	462,821
LESS SALES TAX	<u>(2,366)</u>
NET FOOD	460,455

TOTAL PATIENT CENSUS	118,044
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	354,132

ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	21,960

PATIENT MEALS	354,132
ADD EMPLOYEE MEALS	<u>21,960</u>
TOTAL MEALS/YEAR	376,092

NET FOOD	460,455
DIVIDE TOTAL MEALS/YEAR	<u>376,092</u>

COST PER MEAL	1.22
TIME EMPLOYEE MEALS	<u>21,960</u>
EMPLOYEE MEAL RECLASSIFICATION	26,791

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			43,402	43,402		43,402	778,019	821,421		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			52,501	52,501		52,501	1,022,364	1,074,865		32
33	Real Estate Taxes							387,581	387,581		33
34	Rent-Facility & Grounds			2,020,000	2,020,000		2,020,000	(2,020,000)			34
35	Rent-Equipment & Vehicles			46,310	46,310		46,310	6,202	52,512		35
36	Other (specify):* IME			25,584	25,584		25,584	64,947	90,531		36
37	TOTAL Ownership			2,187,797	2,187,797		2,187,797	239,113	2,426,910		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		114,146	395,326	509,472		509,472		509,472		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			180,072	180,072		180,072		180,072		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		114,146	575,398	689,544		689,544		689,544		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,112,225	971,043	6,543,853	13,627,121		13,627,121	(1,018,086)	12,609,035		45

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

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,678	30		9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,366)	2		13
14	Non-Care Related Interest	(2,716)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,374)	21		18
19	Entertainment		20		19
20	Contributions	(13,823)	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	(853,539)	27		24
25	Fund Raising, Advertising and Promotional	(12,736)	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	(189,692)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,026,581)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	8,495		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,495		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,018,086)		37

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

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

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

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1194	6	1
2	MARKETING SALARIES	(139,629)	21	2
3	STAFF DEVELOPMENT	(51,257)	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	(189,692)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(2,366)	0	0	0	0	0	0	0	0	0	0	(2,366)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,678	0	0	0	0	0	0	0	0	2,678	4
5	Heat and Other Utilities	0	0	0	764	0	0	0	0	0	0	0	764	5
6	Maintenance	1,194	5,144	3,565	3,416	0	0	0	0	0	0	0	13,319	6
7	Other (specify):*	0	0	119	41	0	0	0	0	0	0	0	160	7
8	TOTAL General Services	(1,172)	5,144	6,362	4,221	0	0	0	0	0	0	0	14,555	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	(276,199)	16,971	0	0	0	0	0	0	0	0	(259,228)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	534	16,272	292	12,000	0	0	0	0	0	0	29,098	19
20	Fees, Subscriptions & Promotions	(26,559)	0	4,306	0	0	0	0	0	0	0	0	(22,253)	20
21	Clerical & General Office Expenses	(192,260)	13,747	(45,188)	67	0	0	0	0	0	0	0	(223,634)	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	13	0	0	0	0	0	0	0	0	13	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	805	1,113	0	0	0	0	0	0	0	0	1,918	25
26	Insurance-Prop.Liab.Malpractice	0	1,059	836	174	28,450	0	0	0	0	0	0	30,519	26
27	Other (specify):*	(853,539)	14,801	10,551	0	0	0	0	0	0	0	0	(828,187)	27
28	TOTAL General Administration	(1,072,358)	(245,253)	4,874	533	40,450	0	0	0	0	0	0	(1,271,754)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,073,530)	(240,109)	11,236	4,754	40,450	0	0	0	0	0	0	(1,257,199)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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	49,678	184	404	2,371	725,382	0	0	0	0	0	0	778,019	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,729)	0	0	4,353	1,020,740	0	0	0	0	0	0	1,022,364	32
33	Real Estate Taxes	0	0	0	3,306	384,275	0	0	0	0	0	0	387,581	33
34	Rent-Facility & Grounds	0	0	0	0	(2,020,000)	0	0	0	0	0	0	(2,020,000)	34
35	Rent-Equipment & Vehicles	0	956	4,442	804	0	0	0	0	0	0	0	6,202	35
36	Other (specify):*	0	0	0	(25,584)	90,531	0	0	0	0	0	0	64,947	36
37	TOTAL Ownership	46,949	1,140	4,846	(14,750)	200,928	0	0	0	0	0	0	239,113	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)	(1,026,581)	(238,969)	16,082	(9,996)	241,378	0	0	0	0	0	0	(1,018,086)	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
				EMI ENTERPRISES	LINCOLNWOOD	MGMT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		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	\$ 315,000	EMI ENTERPRISES,INC.		\$	(315,000)	1
2	V	6 DRIVERS' SALARY				5,144	5,144	2
3	V	17 OFFICER SALARY				26,783	26,783	3
4	V	17 REGIONAL DIRECTOR				12,018	12,018	4
5	V	19 ACCOUNTING FEES				534	534	5
6	V	21 OFFICE				13,747	13,747	6
7	V	25 TRANSPORTATION				805	805	7
8	V	26 INSURANCE				1,059	1,059	8
9	V	27 EMPLOYEE BENEFITS				14,801	14,801	9
10	V	30 DEPRECIATION S/L				184	184	10
11	V	35 AUTO LEASE				956	956	11
12	V							12
13	V							13
14	Total		\$ 315,000			\$ 76,031	\$ * (238,969)	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	\$ 96,000	EKS MANAGEMENT		\$	(96,000)
16	V	4 HOUSEKEEPING SALARIES				2,678	2,678
17	V	6 PAINTERS' SALARIES				3,565	3,565
18	V	7 SCAVENGER				119	119
19	V	17 CFO SALARY - A. WEINFELD				16,971	16,971
20	V	19 PROFESSIONAL FEES				16,272	16,272
21	V	20 WANT ADS / BACKGRD CKS				4,306	4,306
22	V	21 OFFICE EXPENSE				50,812	50,812
23	V	23 SEMINARS				13	13
24	V	25 TRANSPORTATION				1,113	1,113
25	V	26 INSURANCE				836	836
26	V	27 EMPLOYEE BENEFITS				10,551	10,551
27	V	30 DEPRECIATION S.L.				404	404
28	V	35 EQUIPMENT RENT				4,442	4,442
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 96,000			\$ 112,082	\$ * 16,082

* 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				764	764
17	V	6 PAINTERS FEES				1,683	1,683
18	V	6 REPAIRS /MAINT				1,733	1,733
19	V	7 ALARM SERVICE				41	41
20	V	19 PROFESSIONAL FEES				292	292
21	V	21 OFFICE EXPENSE				67	67
22	V	26 INSURANCE				174	174
23	V	30 DEPRECIATION				2,371	2,371
24	V	32 INTEREST				4,353	4,353
25	V	33 R/E TAX				3,306	3,306
26	V	35 STORAGE FEES				804	804
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			\$ 15,588	\$ * (9,996)

* 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	\$ 2,020,000	BEVERLY PAVILION LLC		\$	(2,020,000)
16	V	19 PROFESSIONAL FEES				12,000	12,000
17	V	26 INSURANCE				28,450	28,450
18	V	30 DEPR. S.L. BUILDING & IMP				650,525	650,525
19	V	30 DEPR. S.L. EQUIP & FURN				74,857	74,857
20	V	32 INTEREST				1,020,740	1,020,740
21	V	33 REAL ESTATE TAXES				384,275	384,275
22	V	36 M.I.P. INSURANCE				90,531	90,531
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		\$ 2,020,000			\$ 2,261,378	\$ * 241,378

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

Facility Name & ID Number

PRESIDENTIAL PAVILION

0045526

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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		ADMIN	40.00		LIST		Comp fr EMI	\$ 26,783	17-7	1
2						ATTACHED					2
3											3
4	PHILIP ESFORMES		ADMIN	40.00		LIST		MGMT FEE	315,000	17-3	4
5						ATTACHED					5
6											6
7	AVRUM WEINFELD		CFO	3.00				Comp fr EKS	16,971	17-7	7
8											8
9											9
10	FLORA WEISS		CLERICAL	3.00				Comp fr EKS	2,296	21-7	10
11											11
12	MICHAEL ROSEN		Adimistrator	3.00		40+	100.00	SALARY	163,921	17-1	12
13								TOTAL	\$ 524,971		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: **01/01/2008** Ending: **2/31/2008**

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 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	6	DRIVERS' SALARY	PATIENT DAYS	859,462	14	\$ 37,451	\$ 37,451	118,044	\$ 5,144	1
2	17	OFFICER SALARY	PATIENT DAYS	859,462	14	195,000	195,000	118,044	26,783	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	859,462	14	87,500	87,500	118,044	12,018	3
4	19	ACCOUNTING FEES	PATIENT DAYS	859,462	14	3,885		118,044	534	4
5	21	OFFICE	PATIENT DAYS	859,462	14	100,089	57,703	118,044	13,747	5
6	25	TRANSPORTATION	PATIENT DAYS	859,462	14	5,861		118,044	805	6
7	26	INSURANCE	PATIENT DAYS	859,462	14	7,710		118,044	1,059	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	107,763		118,044	14,801	8
9	30	DEPRECIATION S/L	PATIENT DAYS	859,462	14	1,340		118,044	184	9
10	35	AUTO LEASE	PATIENT DAYS	859,462	14	6,960		118,044	956	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					\$ 553,559	\$ 377,654		\$ 76,031	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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	859,462	14	\$ 19,500	\$ 118,044	\$ 2,678	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	859,462	14	25,953	118,044	3,565	2
3	7	SCAVENGER	PATIENT DAYS	859,462	14	866	118,044	119	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	859,462	14	123,563	118,044	16,971	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	859,462	14	118,475	118,044	16,272	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	859,462	14	31,349	118,044	4,306	6
7	21	OFFICE EXPENSE	PATIENT DAYS	859,462	14	369,953	118,044	50,812	7
8	23	SEMINAR	PATIENT DAYS	859,462	14	95	118,044	13	8
9	25	TRANSPORTATION	PATIENT DAYS	859,462	14	8,106	118,044	1,113	9
10	26	INSURANCE	PATIENT DAYS	859,462	14	6,085	118,044	836	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	859,462	14	76,819	118,044	10,551	11
12	30	DEPRECIATION S.L	PATIENT DAYS	859,462	14	2,943	118,044	404	12
13	35	EQUIPMENT RENT	PATIENT DAYS	859,462	14	32,345	118,044	4,442	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					\$ 816,052	\$ 521,578	\$ 112,082	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526

Report Period Beginning:

01/01/2008

Ending: **2/31/2008**

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	\$ 5,588	\$ 25,584	\$ 764	1
2	6	PAINTERS FEES	INCOME	187,059	15	12,303	25,584	1,683	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	12,671	25,584	1,733	3
4	7	ALARM SERVICE	INCOME	187,059	15	301	25,584	41	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	2,135	25,584	292	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	489	25,584	67	6
7	26	INSURANCE	INCOME	187,059	15	1,275	25,584	174	7
8	30	DEPRECIATION	INCOME	187,059	15	17,336	25,584	2,371	8
9	32	INTEREST	INCOME	187,059	15	31,829	25,584	4,353	9
10	33	R/E TAX	INCOME	187,059	15	24,171	25,584	3,306	10
11	35	STORAGE FEES	INCOME	187,059	15	5,882	25,584	804	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					\$ 113,980	\$	\$ 15,588	25

Facility Name & ID Number **PRESIDENTIAL PAVILION**

0045526 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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 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

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
2	26	INSURANCE	DIRECT						2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT						3
4	30	DEPR. S.L. EQUIP	DIRECT						4
5	32	INTEREST	DIRECT						5
6	33	REAL ESTATE TAXES	DIRECT						6
7	36	M.I.P. INSURANCE	DIRECT						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

PRESIDENTIAL PAVILION

0045526

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 17,976,038			\$ 970,437	1						
2												2						
3	Wedgewood Realty (Beverly)		x	MORTGAGE	\$15,000.00	3/10/05	1,650,600	1,071,671	11/10/05	0.0459	50,303	3						
4												4						
5	Related Party -IME										4,353	5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	400,000	2,395,000	REVOLV	PRIME+	49,785	6						
7												7						
8												8						
9	TOTAL Facility Related				\$114,236.00		\$ 20,757,400	\$ 21,442,709			\$ 1,074,878	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11	CENTERS FOR MEDICARE		X								2,716	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 2,716	14						
15	TOTALS (line 9+line14)						\$ 20,757,400	\$ 21,442,709			\$ 1,077,594	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 90,531 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 2007 report.		\$	402,585	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.)		\$	388,573	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(14,012)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	398,287	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.		\$	384,275	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	326,832	8
	2004	334,092	9
	2005	337,493	10
	2006	392,766	11
	2007	388,573	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>388,573.00</u>	\$ <u>388,573.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>388,573.00</u>	\$ <u>388,573.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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	TOTALS			\$ 1,500,000	3

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

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 2,405,847	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AWNINGS		2001		10,500	382	27.5	382		2,722	9
10	FENCE		2001		2,100	140	15	140		998	10
11	ELEVATOR		2001		18,340	667	27.5	667		4,752	11
12	ALARM		2001		5,686	207	27.5	207		1,475	12
13	WINDOWS		2001		4,149	151	27.5	151		1,076	13
14	BOILER		2001		3,000	109	27.5	109		559	14
15	FURNISHINGWALLPAPER & BORDERS		2001		12,953		5			12,953	15
16	KITCHEN SINK & DRAIN		2001		2,525	92	27.5	92		655	16
17	DOORS		2001		15,100	549	27.5	549		3,901	17
18	ELEVATOR		2002		222,811	8,102	27.5	8,102		56,714	18
19	FENCE		2002		3,100	207	15	207		1,346	19
20	DOORS & LOCKS		2002		21,741	791	27.5	791		5,438	20
21	SHOWER ROOMS		2002		4,669	170	27.5	170		1,070	21
22	ALARM AND SPRINKLER		2002		11,881	432	27.5	432		2,717	22
23	EJECTOR & SEWEGE PUMP		2002		14,604	531	27.5	531		3,341	23
24	ROOF DRAIN		2002		3,100	113	27.5	113		739	24
25	FURNISHING - CARPETS AND DRAPERIES		2002		91,494		5			91,494	25
26	ELEVATOR		2003		110,562	4,020	27.5	4,020		23,283	26
27	PARKING LOT		2003		64,182	4,279	15	4,279		23,535	27
28	FIRE ALARM SYSTEM		2003		25,000	909	27.5	909		5,037	28
29	ROOF		2003		26,500	964	27.5	964		5,262	29
30	EXTERIOR WALL		2003		9,796	356	27.5	356		1,914	30
31	SINKS		2003		3,146	114	27.5	114		632	31
32	BUILT IN WARDROBE		2003		19,398	705	27.5	705		3,731	32
33	REBUILD A/C & HEATING RETURN FAN		2004		4,700	171	27.5	171		834	33
34	FIRE ALARM SYSTEM		2004		13,201	480	27.5	480		2,300	34
35	BUILT IN WARDROBE		2004		21,807	793	27.5	793		3,602	35
36	MASONRY REPAIRS		2004		61,620	2,241	27.5	2,241		9,618	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	\$	\$ 459	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		832	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		1,272	39
40	FLOOR TILING	2004	5,326	194	27.5	194		784	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		783	41
42	DOORS	2005	4,506	164	27.5	164		581	42
43	FLOOR TILING	2005	1,536	56	27.5	56		198	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		11,857	44
45	CONCRETE PATIO	2005	3,015	201	15	201		729	45
46	SHOWER	2006	3,040	111	27.5	111		282	46
47	DUCT WORK	2006	5,600	204	27.5	204		519	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		738	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		14,920	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		6,649	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		663	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		592	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		370	53
54	SHOWERS - BEVERLY	2008	9,120	244	27.5	244		244	54
55	DOORS - BEVERLY	2008	4,520	157	27.5	157		157	55
56	BOLIER - BEVERLY	2008	5,295	88	27.5	88		88	56
57	FLOORS - BEVERLY	2008	6,260	67	27.5	67		67	57
58	ROOFING - BEVERLY	2008	3,800	29	27.5	29		29	58
59	EXTERIOR WALL -	2008	20,000	30	27.5	30		30	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)		\$ 18,884,922	\$ 683,956		\$ 683,956	\$	\$ 2,720,388	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:

01/01/2008

Ending:

12/31/2008

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	\$ 596,488	\$ 9,971	\$ 59,649	\$ 49,678	10 YRS	\$ 387,611	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	759,149	74,857	74,857		10 YRS		74
75	TOTALS	\$ 1,355,637	\$ 84,828	\$ 134,506	\$ 49,678		\$ 387,611	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	TOTALS			\$	\$	\$	\$		\$	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)	\$ 21,740,559	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 768,784	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 818,462	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,678	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,107,999	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	\$ 2,020,000			3
4	Additions							4
5								5
6								6
7	TOTAL		328		\$ 2,020,000			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: \$ 14,958 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	FACILITY VAN	2006 FORD E350	\$ 745.22	\$ 8,929	17
18	ADMINISTRATOR	2007 BMW 530XI	#####	13,714	18
19	B. CZERNIAK-OFFICE	2007 TOYOTA AVALON	725.72	8,709	19
20					20
21	TOTAL		\$ #####	\$ 31,352	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 269,463	\$		\$ 269,463	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			285			285	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			125,578			125,578	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				113,186		113,186	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39-2					960		960	13
14	TOTAL			\$		\$ 395,326	\$ 114,146		\$ 509,472	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: **01/01/2008**Ending: **12/31/2008****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2008**

(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	\$ 278,037	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 700,000)	5,039,286		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,906		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	356,828		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,826,057	\$	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	963,377		15
16	Equipment, at Historical Cost	596,488		16
17	Accumulated Depreciation (book methods)	(869,363)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 690,502	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,516,559	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 795,347	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,395,000		29
30	Accrued Salaries Payable	198,282		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,396		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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,418,025	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	387,693		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)	\$ 387,693	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,805,718	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,710,841	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,516,559	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,049,785	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,049,788	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	460,053	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	(799,000)	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)	\$ (338,947)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,710,841	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	\$ 14,079,127	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,079,127	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	261,204	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 261,204	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,340,344	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,396,614	31
32	Health Care	4,679,736	32
33	General Administration	3,673,430	33
	B. Capital Expense		
34	Ownership	2,187,797	34
	C. Ancillary Expense		
35	Special Cost Centers	509,472	35
36	Provider Participation Fee	180,072	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	246,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,873,121	40
41	Income before Income Taxes (line 30 minus line 40)**	467,223	41
42	Income Taxes	(7,170)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 460,053	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: 01/01/2008

Ending:

12/31/2008

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	5,174	5,753	\$ 235,911	\$ 41.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,066	15,343	431,796	28.14	3
4	Licensed Practical Nurses	58,273	61,416	1,346,048	21.92	4
5	CNAs & Orderlies	135,841	149,453	1,464,329	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,045	13,386	147,036	10.98	8
9	Activity Director					9
10	Activity Assistants	19,360	20,511	192,264	9.37	10
11	Social Service Workers	19,568	20,876	258,544	12.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,535	38,460	365,057	9.49	15
16	Dishwashers					16
17	Maintenance Workers	7,463	7,910	90,783	11.48	17
18	Housekeepers	41,363	44,356	393,002	8.86	18
19	Laundry	16,945	18,904	171,372	9.07	19
20	Administrator	2,178	2,601	163,921	63.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	29,181	30,213	346,089	11.45	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	4,279	4,428	48,711	11.00	31
32	Other Health C: MDS	8,254	9,775	246,419	25.21	32
33	Other(specify) SECURITY	24,153	24,983	210,943	8.44	33
34	TOTAL (lines 1 - 33)	433,678	468,368	\$ 6,112,225 *	\$ 13.05	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	\$ 15,210	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	13,524	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		72,000	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	5,608	11-3	44
45	Social Service Consultant	E	2,503	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 120,845		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	\$ 163,921	Workers' Compensation Insurance	\$ 73,153	IDPH License Fee	\$ 0	
	ASST ADMIN		0	Unemployment Compensation Insurance	85,965	Advertising: Employee Recruitment	0	
	OTHER ADMIN		0	FICA Taxes	448,345	Health Care Worker Background Check	0	
				Employee Health Insurance	232,835	(Indicate # of checks performed _____)		
				Employee Meals	26,791	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	13,823	
				EMPLOYEE BENEFITS - OTHER	660	MARKETING/ADV/PROMO	12,736	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	14,479	
				PENSION/PROFIT SHARING PLANS	54,797	MGMT CO ALLOC	4,306	
				CHICAGO HEAD TAX	11,820	TRUST/FRANCHISE/CONTRIB/ETC	(13,823)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(12,736)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 163,921	TOTAL (agree to Schedule V, line 22, col.8)	\$ 934,366	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,785	
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			\$ 315,000			\$	Out-of-State Travel	\$
PHILIP ESFORMES LTD			315,000					
							In-State Travel	0
							Seminar Expense	5,720
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 630,000	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 5,720
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			175,231					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 175,231					

* 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	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2006	\$ 3,585	3 YRS	\$	\$ 1,194	\$ 1,194	\$ 1,194	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
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7																				
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12																				
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14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,585		\$	\$ 1,194	\$ 1,194	\$ 1,194	\$	\$	\$	\$								

Facility Name & ID Number **PRESIDENTIAL PAVILION**# **0045526**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****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 \$10129
- (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. \$ 646 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. \$ 180,072
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. \$ 26,791 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