



Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>218</u>	Skilled (SNF)	<u>218</u>	<u>79,570</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>110</u>	Intermediate (ICF)	<u>110</u>	<u>40,150</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>328</u>	TOTALS	<u>328</u>	<u>119,720</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>3,208</u>	<u>74</u>	<u>10,365</u>	<u>13,647</u>	8
9	SNF/PED					9
10	ICF	<u>100,339</u>	<u>538</u>	<u>215</u>	<u>101,092</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>103,547</u>	<u>612</u>	<u>10,580</u>	<u>114,739</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.84%

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)

NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 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 10,365Medicare Intermediary BLUE CROSS-BLUE SHIELD

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **PRESIDENTIAL PAVILION** # **0045526** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

**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	362,635	50,114	15,548	428,297		428,297		428,297		1
2	Food Purchase		483,187		483,187	(28,908)	454,279	(766)	453,513		2
3	Housekeeping	427,326	56,622		483,948		483,948	10,013	493,961		3
4	Laundry	159,869	46,123	17,112	223,104		223,104		223,104		4
5	Heat and Other Utilities			288,501	288,501		288,501	835	289,336		5
6	Maintenance	124,601	52,727	70,257	247,585		247,585	12,524	260,109		6
7	Other (specify):* security	204,242		30,625	234,867		234,867	155	235,022		7
8	<b>TOTAL General Services</b>	1,278,673	688,773	422,043	2,389,489	(28,908)	2,360,581	22,761	2,383,342		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,752,163	129,665	36,232	3,918,060		3,918,060		3,918,060		10
10a	Therapy	142,903		73,000	215,903		215,903		215,903		10a
11	Activities	204,649	44,518	5,858	255,025		255,025		255,025		11
12	Social Services	261,600		1,087	262,687		262,687		262,687		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,361,315	174,183	128,177	4,663,675		4,663,675		4,663,675		16
	<b>C. General Administration</b>										
17	Administrative	167,992		600,000	767,992		767,992	(246,160)	521,832		17
18	Directors Fees										18
19	Professional Services			48,662	48,662		48,662	24,831	73,493		19
20	Dues, Fees, Subscriptions & Promotions			45,041	45,041		45,041	(18,516)	26,525		20
21	Clerical & General Office Expenses	358,151	30,055	128,353	516,559		516,559	(176,224)	340,335		21
22	Employee Benefits & Payroll Taxes			981,782	981,782	28,908	1,010,690		1,010,690		22
23	Inservice Training & Education							26	26		23
24	Travel and Seminar			2,564	2,564		2,564		2,564		24
25	Other Admin. Staff Transportation			14,105	14,105		14,105	1,418	15,523		25
26	Insurance-Prop.Liab.Malpractice			305,199	305,199		305,199	29,914	335,113		26
27	Other (specify):*			548,015	548,015		548,015	(525,033)	22,982		27
28	<b>TOTAL General Administration</b>	526,143	30,055	2,673,721	3,229,919	28,908	3,258,827	(909,744)	2,349,083		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,166,131	893,011	3,223,941	10,283,083		10,283,083	(886,983)	9,396,100		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	15,548
	REPAIRS & MAINTENANCE	0
		0
		15,548
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	17,112
		0
		17,112
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	114,799
	ELECTRICITY	125,059
	WATER	45,548
	CABLE TV - LOBBY	3,095
		0
		288,501
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,020
	PAINTING & DECORATING	2,789
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,857
	ELEVATOR MAINTENANCE & REPAIR	23,022
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,825
	FIRE SERVICE	7,744
		0
		0
		0
		0
		70,257
7	<b>OTHER</b>	
	SCAVENGER	30,625
	SECURITY SERVICE	0
		0
		0
		30,625
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	12,312
	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	13,120
	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
	<b>DENTAL</b>	4,800
		0
		36,232
10a	<b>THERAPY</b>	
	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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	73,000
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		73,000
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	5,858
		0
		5,858
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,087
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,087
13	<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
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	600,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	22,933
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	25,729
		0
		48,662
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,976
	EMPLOYEE WANT ADS XIX F	601
	CONTRIBUTIONS VI 20 XIX F	1,200
	DUES & SUBSCRIPTIONS XIX F	14,846
	LICENSES & PERMITS XIX F	5,249
	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	10,169
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		45,041
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	150
	EQUIPMENT REPAIR & MAINTENANCE	6,690
	OUTSIDE CLERICAL SERVICES	96,000
	PENALTIES / OVERDRAFT CHARGES VI 18	290
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	22,898
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	2,325
		128,353

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	451,517
	UNEMPLOYMENT COMPENSATION XIX D	55,652
	WORKERS COMPENSATION INSURANC XIX D	132,373
	HOSPITALIZATION INSURANCE XIX D	268,129
	EMPLOYEE BENEFITS - OTHER XIX D	4,884
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	58,391
	CHICAGO HEAD TAX XIX D	10,836
		0
		981,782
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,564
	TRAVEL XIX G	0
		2,564
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	14,105
		14,105
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	305,199
		305,199
27	<b>OTHER</b>	
	BAD DEBTS VI 24	548,015
		548,015

GRAND TOTAL COLUMN 3 OTHER

**3,223,941**

**PRESIDENTIAL PAVILION  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	483,187
LESS SALES TAX	<u>(766)</u>
NET FOOD	482,421
TOTAL PATIENT CENSUS	114,739
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	344,217
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	21,900
PATIENT MEALS	344,217
ADD EMPLOYEE MEALS	<u>21,900</u>
TOTAL MEALS/YEAR	366,117
NET FOOD	482,421
DIVIDE TOTAL MEALS/YEAR	<u>366,117</u>
COST PER MEAL	1.32
TIME EMPLOYEE MEALS	<u>21,900</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>28,908</b>
	=====

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			38,484	38,484		38,484	780,224	818,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,717	43,717		43,717	941,683	985,400			32
33	Real Estate Taxes							389,927	389,927			33
34	Rent-Facility & Grounds			2,040,000	2,040,000		2,040,000	(2,040,000)				34
35	Rent-Equipment & Vehicles			40,953	40,953		40,953	6,437	47,390			35
36	Other (specify):* <b>IME</b>			25,584	25,584		25,584	63,678	89,262			36
37	<b>TOTAL Ownership</b>			2,188,738	2,188,738		2,188,738	141,949	2,330,687			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,013	402,386	483,399		483,399		483,399			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>		81,013	581,966	662,979		662,979		662,979			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,166,131	974,024	5,994,645	13,134,800		13,134,800	(745,034)	12,389,766			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	54,596	30		9
10	Interest and Other Investment Income	(71,611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(766)	2		13
14	Non-Care Related Interest		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	(290)	21		18
19	Entertainment		20		19
20	Contributions	(11,369)	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	(548,015)	27		24
25	Fund Raising, Advertising and Promotional	(12,976)	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	(136,706)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (727,137)		\$	30

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

		1	2	
		<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)	(17,897)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (17,897)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (745,034)		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	
		<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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARIES	(134,381)	21	2
3	STAFF DEVELOPMENT	(2,325)	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>	(136,706)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	(766)	0	0	0	0	0	0	0	0	0	0	(766)	2
3	Housekeeping	0	0	10,013	0	0	0	0	0	0	0	0	10,013	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	835	0	0	0	0	0	0	0	835	5
6	Maintenance	0	5,155	3,516	3,853	0	0	0	0	0	0	0	12,524	6
7	Other (specify):*	0	0	114	41	0	0	0	0	0	0	0	155	7
8	<b>TOTAL General Services</b>	<b>(766)</b>	<b>5,155</b>	<b>13,643</b>	<b>4,729</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>22,761</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	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	<b>TOTAL Health Care and Programs</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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(261,734)	15,574	0	0	0	0	0	0	0	0	(246,160)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	928	11,780	123	12,000	0	0	0	0	0	0	24,831	19
20	Fees, Subscriptions & Promotions	(24,345)	0	5,765	64	0	0	0	0	0	0	0	(18,516)	20
21	Clerical & General Office Expenses	(136,996)	12,776	(52,023)	19	0	0	0	0	0	0	0	(176,224)	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	26	0	0	0	0	0	0	0	0	26	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	444	974	0	0	0	0	0	0	0	0	1,418	25
26	Insurance-Prop.Liab.Malpractice	0	1,675	389	223	27,627	0	0	0	0	0	0	29,914	26
27	Other (specify):*	(548,015)	14,579	8,403	0	0	0	0	0	0	0	0	(525,033)	27
28	<b>TOTAL General Administration</b>	<b>(709,356)</b>	<b>(231,332)</b>	<b>(9,112)</b>	<b>429</b>	<b>39,627</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(909,744)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(710,122)</b>	<b>(226,177)</b>	<b>4,531</b>	<b>5,158</b>	<b>39,627</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(886,983)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION# 0045526

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	54,596	104	238	2,371	722,915	0	0	0	0	0	0	780,224	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71,611)	0	0	4,213	1,009,081	0	0	0	0	0	0	941,683	32
33	Real Estate Taxes	0	0	0	3,271	386,656	0	0	0	0	0	0	389,927	33
34	Rent-Facility & Grounds	0	0	0	0	(2,040,000)	0	0	0	0	0	0	(2,040,000)	34
35	Rent-Equipment & Vehicles	0	847	4,546	1,044	0	0	0	0	0	0	0	6,437	35
36	Other (specify):*	0	0	0	(25,584)	89,262	0	0	0	0	0	0	63,678	36
37	<b>TOTAL Ownership</b>	<b>(17,015)</b>	<b>951</b>	<b>4,784</b>	<b>(14,685)</b>	<b>167,914</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>141,949</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(727,137)	(225,226)	9,315	(9,527)	207,541	0	0	0	0	0	0	(745,034)	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
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	\$ 300,000	EMI ENTERPRISES,INC.		\$	(300,000)	1
2	V	6	DRIVERS' SALARY			5,155		5,155	2
3	V	17	OFFICER SALARY			26,414		26,414	3
4	V	17	REGIONAL DIRECTOR			11,852		11,852	4
5	V	19	ACCOUNTING FEES			928		928	5
6	V	21	OFFICE			12,776		12,776	6
7	V	25	TRANSPORTATION			444		444	7
8	V	26	INSURANCE			1,675		1,675	8
9	V	27	EMPLOYEE BENEFITS			14,579		14,579	9
10	V	30	DEPRECIATION S/L			104		104	10
11	V	35	AUTO LEASE			847		847	11
12	V								12
13	V								13
14	Total		\$ 300,000			\$ 74,774	\$ *	(225,226)	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)	15
16	V	3 HOUSEKEEPING SALARIES				10,013	10,013	16
17	V	6 PAINTERS' SALARIES				3,516	3,516	17
18	V	7 SCAVENGER				114	114	18
19	V	17 CFO SALARY -				15,574	15,574	19
20	V	19 PROFESSIONAL FEES				11,780	11,780	20
21	V	20 WANT ADS / BACKGRD CKS				5,765	5,765	21
22	V	21 OFFICE EXPENSE				43,977	43,977	22
23	V	23 SEMINARS				26	26	23
24	V	25 TRANSPORTATION				974	974	24
25	V	26 INSURANCE				389	389	25
26	V	27 EMPLOYEE BENEFITS				8,403	8,403	26
27	V	30 DEPRECIATION S.L.				238	238	27
28	V	35 EQUIPMENT RENT				4,546	4,546	28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 96,000			\$ 105,315	\$ * 9,315	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	36 OFFICE RENT	\$ 25,584	IME REALTY		\$ 835	\$ (25,584)
16	V	5 UTILITIES				835	835
17	V	6 PAINTERS FEES				1,683	1,683
18	V	6 REPAIRS /MAINT				2,170	2,170
19	V	7 ALARM SERVICE				41	41
20	V	19 PROFESSIONAL FEES				123	123
21	V	21 OFFICE EXPENSE				19	19
22	V	26 INSURANCE				223	223
23	V	30 DEPRECIATION				2,371	2,371
24	V	32 INTEREST				4,213	4,213
25	V	33 R/E TAX				3,271	3,271
26	V	35 STORAGE FEES				1,044	1,044
27	V	20 LICENSES & PERMITS				64	64
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			\$ 16,057	\$ * (9,527)

\* 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	\$ 2,040,000	BEVERLY PAVILION LLC		\$	(2,040,000)
16	V	19 PROFESSIONAL FEES				12,000	12,000
17	V	26 INSURANCE				27,627	27,627
18	V	30 DEPR. S.L. BUILDING & IMP				651,952	651,952
19	V	30 DEPR. S.L. EQUIP & FURN				70,963	70,963
20	V	32 INTEREST				1,009,081	1,009,081
21	V	33 REAL ESTATE TAXES				386,656	386,656
22	V	36 M.I.P. INSURANCE				89,262	89,262
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		\$ 2,040,000			\$ 2,247,541	\$ * 207,541

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

Facility Name &amp; ID Number

PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	ADMINISTRATIVE					COMP EMI		\$ 26,414	17-7	1
2											2
3					SEE						3
4	PHILIP ESFORMES	ADMINISTRATIVE			ATTACHED		MGMT FEE		300,000	17-3	4
5					SCHEDULE						5
6											6
7	AVRUM WEINFELD	CFO					COMP EKS		15,574	17-7	7
8											8
9											9
10	FLORA WEISS	CLERICAL					COMP EKS		2,266	21-7	10
11											11
12	MICHAEL ROSEN	ADMINISTRATOR					SALARY		161,992	17-1	12
13								TOTAL	\$ 506,246		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:

01/01/2009

Ending: 2/31/2009

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	DRIVERS' SALARY	PATIENT DAYS	847,051	14	\$ 38,060	\$ 114,739	\$ 5,155	1
2	17	OFFICER SALARY	PATIENT DAYS	847,051	14	195,000	114,739	26,414	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	114,739	11,852	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	114,739	928	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	114,739	12,776	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	114,739	444	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	114,739	1,675	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	114,739	14,579	8
9	30	DEPRECIATION S/L	PATIENT DAYS	847,051	14	765	114,739	104	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	114,739	847	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					\$ 552,018	\$ 378,811	\$ 74,774	25

Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 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

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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 114,739	\$ 10,013	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	847,051	14	25,953	114,739	3,516	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842	114,739	114	3
4	17	CFO SALARY - A. WEINFELD	PATIENT DAYS	847,051	14	114,971	114,739	15,574	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	114,739	11,780	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	847,051	14	42,556	114,739	5,765	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	114,739	43,977	7
8	23	SEMINAR	PATIENT DAYS	847,051	14	190	114,739	26	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194	114,739	974	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872	114,739	389	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031	114,739	8,403	11
12	30	DEPRECIATION S.L	PATIENT DAYS	847,051	14	1,757	114,739	238	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562	114,739	4,546	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					\$ 777,478	\$ 535,978	\$ 105,315	25

Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	\$ 6,106	\$ 25,584	\$ 835	1
2	6	PAINTERS FEES	INCOME	187,059	15	12,303	25,584	1,683	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	15,863	25,584	2,170	3
4	7	ALARM SERVICE	INCOME	187,059	15	301	25,584	41	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	897	25,584	123	5
6	21	OFFICE EXPENSE	INCOME	187,059	15	136	25,584	19	6
7	26	INSURANCE	INCOME	187,059	15	1,627	25,584	223	7
8	30	DEPRECIATION	INCOME	187,059	15	17,336	25,584	2,371	8
9	32	INTEREST	INCOME	187,059	15	30,806	25,584	4,213	9
10	33	R/E TAX	INCOME	187,059	15	23,914	25,584	3,271	10
11	35	STORAGE FEES	INCOME	187,059	15	7,635	25,584	1,044	11
12	20	LICENSES & PERMITS	INCOME	187,059	15	468	25,584	64	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					\$ 117,392	\$	\$ 16,057	25

Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	\$ 12,000	\$	1	\$ 12,000	1
2	26	INSURANCE	DIRECT	1	27,627		1	27,627	2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT	1	651,952		1	651,952	3
4	30	DEPR. S.L. EQUIP	DIRECT	1	70,963		1	70,963	4
5	32	INTEREST	DIRECT	1	1,009,081		1	1,009,081	5
6	33	REAL ESTATE TAXES	DIRECT	1	386,656		1	386,656	6
7	36	M.I.P. INSURANCE	DIRECT	1	89,262		1	89,262	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				\$ 2,247,541	\$		\$ 2,247,541	25

Facility Name &amp; ID Number

PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	HUD (Beverly)		X	MORTGAGE	\$99,236.00	3/10/05	\$ 18,706,800	\$ 17,512,231	3/10/40	0.0540	\$ 963,608	1								
2												2								
3	Wedgewood Realty (Beverly)		X	MORTGAGE	\$15,000.00	3/10/05	1,650,600	796,436	12/10/15	0.0459	45,473	3								
4												4								
5	RELATED PARTY - IME											5								
	<b>Working Capital</b>																			
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	400,000		REVOLV	PRIME +	38,374	6								
7	INSURANCE FINANCING										5,343	7								
8	RELATED PARTY - IME										4,213	8								
9	TOTAL Facility Related				\$114,236.00		\$ 20,757,400	\$ 18,308,667			\$ 1,057,011	9								
	<b>B. Non-Facility Related*</b>																			
10	IRS, IDR, ETC		X	LATE FEES								10								
11			X									11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 20,757,400	\$ 18,308,667			\$ 1,057,011	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 89,262 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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>398,287</b>	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.)		\$	<b>392,472</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(5,815)</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>392,471</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>386,656</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>334,092</b>	8	
	2005	<b>337,493</b>	9	
	2006	<b>392,766</b>	10	
	2007	<b>388,573</b>	11	
	2008	<b>392,472</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:**

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



Facility Name & ID Number PRESIDENTIAL PAVILION

# 0045526

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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>2006</u>	<u>\$ 1,500,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 1,500,000</b>	<b>3</b>

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

Report Period Beginning:

**01/01/2009**

Ending:

**12/31/2009****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	\$	\$ 3,040,356	4
5											5
6											6
7		RELATED PARY OFFICE IME			75,472	2,278	39	2,278			7
8											8
		Improvement Type**									
9		AWNINGS	2001		10,500	382	27.5	382		3,104	9
10		FENCE	2001		2,100	140	15	140		1,138	10
11		ELEVATOR	2001		18,340	667	27.5	667		5,419	11
12		ALARM	2001		5,686	207	27.5	207		1,682	12
13		WINDOWS	2001		4,149	151	27.5	151		1,227	13
14		BOILER	2001		3,000	109	27.5	109		668	14
15		FURNISHING WALLPAPER & BORDERS	2001		12,953		5			12,953	15
16		KITCHEN SINK & DRAIN	2001		2,525	92	27.5	92		747	16
17		DOORS	2001		15,100	549	27.5	549		4,450	17
18		ELEVATOR	2002		222,811	8,102	27.5	8,102		64,816	18
19		FENCE	2002		3,100	207	15	207		1,553	19
20		DOORS & LOCKS	2002		21,741	791	27.5	791		6,229	20
21		SHOWER ROOMS	2002		4,669	170	27.5	170		1,240	21
22		ALARM AND SPRINKLER	2002		11,881	432	27.5	432		3,149	22
23		EJECTOR & SEWEGE PUMP	2002		14,604	531	27.5	531		3,872	23
24		ROOF DRAIN	2002		3,100	113	27.5	113		852	24
25		FURNISHING - CARPETS AND DRAPERIES	2002		91,494		5			91,494	25
26		ELEVATOR	2003		110,562	4,020	27.5	4,020		27,303	26
27		PARKING LOT	2003		64,182	4,279	15	4,279		27,814	27
28		FIRE ALARM SYSTEM	2003		25,000	909	27.5	909		5,946	28
29		ROOF	2003		26,500	964	27.5	964		6,226	29
30		EXTERIOR WALL	2003		9,796	356	27.5	356		2,270	30
31		SINKS	2003		3,146	114	27.5	114		746	31
32		BUILT IN WARDROBE	2003		19,398	705	27.5	705		4,436	32
33		REBUILD A/C & HEATING RETURN FAN	2004		4,700	171	27.5	171		1,005	33
34		FIRE ALARM SYSTEM	2004		13,201	480	27.5	480		2,780	34
35		BUILT IN WARDROBE	2004		21,807	793	27.5	793		4,395	35
36		MASONRY REPAIRS	2004		61,620	2,241	27.5	2,241		11,859	36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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	\$	\$ 568	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		1,038	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		1,481	39
40	FLOOR TILING	2004	5,326	194	27.5	194		978	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		1,004	41
42	DOORS	2005	4,506	164	27.5	164		745	42
43	FLOOR TILING	2005	1,536	56	27.5	56		254	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		15,459	44
45	CONCRETE PATIO	2005	3,015	201	15	201		930	45
46	SHOWER	2006	3,040	111	27.5	111		393	46
47	DUCT WORK	2006	5,600	204	27.5	204		723	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		1,217	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		24,866	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		11,082	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		1,105	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		987	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		555	53
54	SHOWERS - BEVERLY	2008	9,120	333	27.5	333		577	54
55	DOORS - BEVERLY	2008	4,520	164	27.5	164		321	55
56	BOLIER - BEVERLY	2008	5,295	193	27.5	193		281	56
57	FLOORS - BEVERLY	2008	6,260	228	27.5	228		295	57
58	ROOFING - BEVERLY	2008	3,800	138	27.5	138		167	58
59	EXTERIOR WALL - BEVERLY	2008	20,000	727	27.5	727		757	59
60	ROOFING - BEVERLY	2009	10,333	259	27.5	259		259	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)		\$ 18,970,727	\$ 687,661		\$ 687,661	\$	\$ 3,405,771	70

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 596,488	\$ 5,053	\$ 59,649	\$ 54,596	10 YRS	\$ 447,260	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>	762,587	71,398	71,398		10 YRS		74
75	<b>TOTALS</b>	\$ 1,359,075	\$ 76,451	\$ 131,047	\$ 54,596		\$ 447,260	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)	\$ 21,829,802	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 764,112	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 818,708	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,596	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,853,031	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	10801/01	\$ 2,040,000			3
4	Additions							4
5								5
6								6
7	TOTAL		328		\$ 2,040,000			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: \$ 12,201 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			\$ _____	\$ 28,752	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 28,752	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.	/2010	\$ _____
13.	/2011	\$ _____
14.	/2012	\$ _____

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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	\$		\$ 290,554	\$		\$ 290,554	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,026			1,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			110,806			110,806	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				78,313		78,313	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>supplies</u>	39-2					2,700		2,700	13
14	<b>TOTAL</b>			\$		\$ 402,386	\$ 81,013		\$ 483,399	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: **01/01/2009**

Ending: **12/31/2009**

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

As of **12/31/2009** (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	\$ 105,344	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250,000) )	2,682,019		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	148,911		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	370,599		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,306,873	\$	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)	(907,847)		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 (sum of lines 11 thru 23)</b>	\$ 652,018	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,958,891	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 488,446	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,559		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,643		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 (sum of lines 26 thru 37)</b>	\$ 743,648	\$	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 (sum of lines 39 thru 44)</b>	\$ 387,693	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,131,341	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,827,550	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,958,891	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,710,841</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,710,841</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,251,209</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>(1,134,500)</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>116,709</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>2,827,550</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	\$ 13,981,594	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,981,594	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	332,804	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 332,804	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***	71,611	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 71,611	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>	\$ 14,386,009	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,389,489	31
32	Health Care	4,663,675	32
33	General Administration	3,229,919	33
<b>B. Capital Expense</b>			
34	Ownership	2,188,738	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	483,399	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>	\$ 13,134,800	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,251,209	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,251,209	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: **01/01/2009**

Ending:

**12/31/2009**

**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	3,097	3,280	\$ 172,347	\$ 52.54	1
2	Assistant Director of Nursing	2,050	2,153	69,959	32.49	2
3	Registered Nurses	11,977	13,254	374,727	28.27	3
4	Licensed Practical Nurses	54,543	57,693	1,362,086	23.61	4
5	CNAs & Orderlies	129,865	140,674	1,444,305	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,315	11,723	142,903	12.19	8
9	Activity Director	1,909	2,149	40,027	18.63	9
10	Activity Assistants	17,344	18,582	164,622	8.86	10
11	Social Service Workers	19,393	20,366	261,600	12.84	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,153	30,549	14.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,269	34,078	332,086	9.74	15
16	Dishwashers					16
17	Maintenance Workers	9,100	9,593	124,601	12.99	17
18	Housekeepers	43,330	46,410	427,326	9.21	18
19	Laundry	15,276	16,905	159,869	9.46	19
20	Administrator	1,848	2,080	161,992	77.88	20
21	Assistant Administrator	792	832	6,000	7.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,698	29,761	358,151	12.03	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	3,987	4,180	47,010	11.25	31
32	Other Health Care(specify)	11,817	12,699	281,729	22.19	32
33	Other(specify) <u>security</u>	21,881	23,181	204,242	8.81	33
34	TOTAL (lines 1 - 33)	420,561	451,746	\$ 6,166,131 *	\$ 13.65	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	\$ 15,548	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	13,120	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		73,000	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	5,858	11-3	44
45	Social Service Consultant	E	1,087	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 120,613		49

**C. CONTRACT NURSES**

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

**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	\$ 161,992	Workers' Compensation Insurance	\$ 132,373	IDPH License Fee	\$	
J LEGUM	ASST ADMIN		6,000	Unemployment Compensation Insurance	55,652	Advertising: Employee Recruitment	601	
	OTHER ADMIN		0	FICA Taxes	451,517	Health Care Worker Background Check	0	
				Employee Health Insurance	268,129	(Indicate # of checks performed)		
				Employee Meals	28,908	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	11,369	
				EMPLOYEE BENEFITS - OTHER	4,884	MARKETING/ADV/PROMO	12,976	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	20,095	
				PENSION/PROFIT SHARING PLANS	58,391	MGMT CO ALLOC	5,829	
				CHICAGO HEAD TAX	10,836	TRUST/FRANCHISE/CONTRIB/ETC	(11,369)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(12,976)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 167,992	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,010,690	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,525	
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
MANAGEMENT FEE - EMI			\$ 300,000			\$	Out-of-State Travel	\$
PHILIP ESFORMES LTD			300,000				In-State Travel	0
							Seminar Expense	2,564
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 600,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,564
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			48,662					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,662					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number **PRESIDENTIAL PAVILION**# **0045526**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****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. ICLTC \$13,086 IL ASSOC H C \$1,760
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES 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. \$ 28,908 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: \_\_\_\_\_
- (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.