FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0045526

Facility Name: PRESIDENTIAL PAVILION

Address: 8001 SOUTH WESTERN AVENUE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,845	90	9,591	31,526	8
9	SNF/PED					9
10	ICF	82,287	55		82,342	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	104,132	145	9,591	113,868	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.11%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 9,591

Medicare Intermediary BLUE CROSS-BLUE SHIELD

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	374,268	46,153	14,648	435,069		435,069		435,069			1
2	Food Purchase		512,178		512,178	(21,024)	491,154	(654)	490,500			2
3	Housekeeping	425,105	63,177		488,282		488,282	1,617	489,899			3
4	Laundry	169,673	40,177	17,439	227,289		227,289		227,289			4
5	Heat and Other Utilities			279,192	279,192		279,192	790	279,982			5
6	Maintenance	127,846	33,189	67,085	228,120		228,120	14,629	242,749			6
7	Other (specify):* SECURITY	207,226		32,634	239,860		239,860	141	240,001			7
8	TOTAL General Services	1,304,118	694,874	410,998	2,409,990	(21,024)	2,388,966	16,523	2,405,489			8
	B. Health Care and Programs											
9	Medical Director			9,500	9,500		9,500		9,500			9
10	Nursing and Medical Records	3,778,934	148,984	41,888	3,969,806		3,969,806		3,969,806			10
10a	Therapy	138,143			138,143		138,143		138,143			10a
11	Activities	197,047	43,729	5,608	246,384		246,384		246,384			11
12	Social Services	260,043		1,467	261,510		261,510		261,510			12
13	CNA Training											13
14	Program Transportation			188	188		188		188			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,374,167	192,713	58,651	4,625,531		4,625,531		4,625,531			16
	C. General Administration											
17	Administrative	165,849		640,000	805,849		805,849	(269,602)	536,247			17
18	Directors Fees											18
19	Professional Services			133,164	133,164		133,164	23,601	156,765			19
20	Dues, Fees, Subscriptions & Promotions			48,547	48,547		48,547	(21,453)	27,094			20
21	Clerical & General Office Expenses	375,272	37,393	130,753	543,418		543,418	(152,910)	390,508			21
22	Employee Benefits & Payroll Taxes			1,023,975	1,023,975	21,024	1,044,999		1,044,999			22
23	Inservice Training & Education			2,449	2,449		2,449	24	2,473			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			27,547	27,547		27,547	(12,587)	14,960			25
26	Insurance-Prop.Liab.Malpractice			282,916	282,916		282,916	27,815	310,731			26
27	Other (specify):*			620,634	620,634		620,634	(595,539)	25,095			27
28	TOTAL General Administration	541,121	37,393	2,909,985	3,488,499	21,024	3,509,523	(1,000,651)	2,508,872			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,219,406	924,980	3,379,634	10,524,020		10,524,020	(984,128)	9,539,892			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.

Facility Name & ID#: PRESIDENTIAL PAVILION #0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,648	
	REPAIRS & MAINTENANCE		0	
			0	14,648
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		17,439	
			0	17,439
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		87,445	
	ELECTRICITY		136,589	
	WATER		51,386	
	CABLE TV - LOBBY		3,772	
			0	279,192
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,732	
	PAINTING & DECORATING		868	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		24,784	
	ELEVATOR MAINTENANCE & REPAIR		20,966	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		9,070	
	FIRE SERVICE		6,665	
			0	
			0	
			0	
			0	67,085
7	**OTHER**			
	SCAVENGER		32,634	
	SECURITY SERVICE		0	
			0	
			0	32,634
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,500	9,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		12,656	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	20,932	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	3,500	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		4,800	
			0	41,888
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	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
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	1,467	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,467
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		188	188
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	640,000	640,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,061	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	112,103	
			0	133,164
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,611	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	14,845	
	LICENSES & PERMITS	XIX F	5,134	
	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	11,527	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,930	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				48,547
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		150	
	EQUIPMENT REPAIR & MAINTENANCE		8,162	
	OUTSIDE CLERICAL SERVICES		96,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	270	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26,171	
	MESSENGER SERVICE		0	
			0	130,753

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	452,361	
	UNEMPLOYMENT COMPENSATION	XIX D	58,736	
	WORKERS COMPENSATION INSURANC	XIX D	144,627	
	HOSPITALIZATION INSURANCE	XIX D	290,325	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,854	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	65,212	
	CHICAGO HEAD TAX	XIX D	10,860	
			0	1,023,975
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,449	
				2,449
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		27,547	
				27,547
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		282,916	
				282,916
27	**OTHER**			
	BAD DEBTS	VI 24	620,634	
				620,634

GRAND TOTAL COLUMN 3 OTHER **3,379,634**

PRESIDENTIAL PAVILION
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	512,178
LESS SALES TAX	(654)
NET FOOD	511,524
TOTAL PATIENT CENSUS	113,868
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	341,604
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	341,604
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	356,204
NET FOOD	511,524
DIVIDE TOTAL MEALS/YEAR	356,204
COST PER MEAL	1.44
TIME EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**21,024**
	========

Facility Name & ID Number PRESIDENTIAL PAVILION #0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,383	36,383		36,383	788,627	825,010			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,219	10,219		10,219	943,853	954,072			32
33	Real Estate Taxes							742,033	742,033			33
34	Rent-Facility & Grounds			2,089,400	2,089,400		2,089,400	(2,089,400)				34
35	Rent-Equipment & Vehicles			42,479	42,479		42,479	5,658	48,137			35
36	Other (specify):* IME			25,584	25,584		25,584	63,116	88,700			36
37	**TOTAL Ownership**			2,204,065	2,204,065		2,204,065	453,887	2,657,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,686	593,445	661,131		661,131		661,131			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	**TOTAL Special Cost Centers**		67,686	773,025	840,711		840,711		840,711			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,219,406	992,666	6,356,724	13,568,796		13,568,796	(530,241)	13,038,555			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: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	56,697	30		9
10	Interest and Other Investment Income	(50,461)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(654)	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	(270)	21		18
19	Entertainment		20		19
20	Contributions	(12,027)	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	(620,634)	27		24
25	Fund Raising, Advertising and Promotional	(14,611)	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	(140,676)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (782,636)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	252,395		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 252,395		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (530,241)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	MARKETING SALARIES	(126,024)	21	2
3	NONALLOWABLE TRAVEL	(14,502)	25	3
4	BANK CHARGES	(150)	21	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**	(140,676)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(654)	0	0	0	0	0	0	0	0	0	0	(654)	2
3	Housekeeping	0	0	1,617	0	0	0	0	0	0	0	0	1,617	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	790	0	0	0	0	0	0	0	790	5
6	Maintenance	0	5,335	6,410	2,884	0	0	0	0	0	0	0	14,629	6
7	Other (specify):*	0	0	59	82	0	0	0	0	0	0	0	141	7
8	**TOTAL General Services**	(654)	5,335	8,086	3,756	0	0	0	0	0	0	0	16,523	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	(285,090)	15,488	0	0	0	0	0	0	0	0	(269,602)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	879	10,586	136	12,000	0	0	0	0	0	0	23,601	19
20	Fees, Subscriptions & Promotions	(26,638)	0	5,052	133	0	0	0	0	0	0	0	(21,453)	20
21	Clerical & General Office Expenses	(126,444)	14,936	(41,439)	37	0	0	0	0	0	0	0	(152,910)	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	24	0	0	0	0	0	0	0	0	24	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(14,502)	308	1,607	0	0	0	0	0	0	0	0	(12,587)	25
26	Insurance-Prop.Liab.Malpractice	0	1,408	684	166	25,557	0	0	0	0	0	0	27,815	26
27	Other (specify):*	(620,634)	16,807	8,288	0	0	0	0	0	0	0	0	(595,539)	27
28	**TOTAL General Administration**	(788,218)	(250,752)	290	472	37,557	0	0	0	0	0	0	(1,000,651)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(788,872)	(245,417)	8,376	4,228	37,557	0	0	0	0	0	0	(984,128)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	56,697	0	207	2,374	729,349	0	0	0	0	0	0	788,627	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50,461)	0	0	4,108	990,206	0	0	0	0	0	0	943,853	32
33	Real Estate Taxes	0	0	0	3,325	738,708	0	0	0	0	0	0	742,033	33
34	Rent-Facility & Grounds	0	0	0	0	(2,089,400)	0	0	0	0	0	0	(2,089,400)	34
35	Rent-Equipment & Vehicles	0	650	3,919	1,089	0	0	0	0	0	0	0	5,658	35
36	Other (specify):*	0	0	0	(25,584)	88,700	0	0	0	0	0	0	63,116	36
37	TOTAL Ownership	6,236	650	4,126	(14,688)	457,563	0	0	0	0	0	0	453,887	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)	(782,636)	(244,767)	12,502	(10,460)	495,120	0	0	0	0	0	0	(530,241)	45

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	EMI	$ 320,000	EMI ENTERPRISES,INC.		$	$ (320,000)	1
2	V	6	DRIVERS' SALARY				5,335	5,335	2
3	V	17	OFFICER SALARY				26,268	26,268	3
4	V	17	REGIONAL DIRECTOR				8,642	8,642	4
5	V	19	ACCOUNTING FEES				879	879	5
6	V	21	OFFICE				14,936	14,936	6
7	V	25	TRANSPORTATION				308	308	7
8	V	26	INSURANCE				1,408	1,408	8
9	V	27	EMPLOYEE BENEFITS				16,807	16,807	9
10	V	35	AUTO LEASE				650	650	10
11	V								11
12	V								12
13	V								13
14	Total			$ 320,000			$ 75,233	$ * (244,767)	14

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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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				1,617	1,617	16
17	V	6	PAINTERS' SALARIES				6,410	6,410	17
18	V	7	SCAVENGER				59	59	18
19	V	17	CFO SALARY -				15,488	15,488	19
20	V	19	PROFESSIONAL FEES				10,586	10,586	20
21	V	20	WANT ADS / BACKGRD CKS				5,052	5,052	21
22	V	21	OFFICE EXPENSE				54,561	54,561	22
23	V	23	SEMINARS				24	24	23
24	V	25	TRANSPORTATION				1,607	1,607	24
25	V	26	INSURANCE				684	684	25
26	V	27	EMPLOYEE BENEFITS				8,288	8,288	26
27	V	30	DEPRECIATION S.L.				207	207	27
28	V	35	EQUIPMENT RENT				3,919	3,919	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			$ 108,502	$ * 12,502	39

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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 25,584	IME REALTY		$	$ (25,584)	15
16	V	5	UTILITIES				790	790	16
17	V	6	PAINTERS FEES				841	841	17
18	V	6	REPAIRS /MAINT				2,043	2,043	18
19	V	7	ALARM SERVICE				82	82	19
20	V	19	PROFEESIONAL FEES				136	136	20
21	V	20	LICENSE & PERMITS				133	133	21
22	V	21	OFFICE EXPENSE				37	37	22
23	V	26	INSURANCE				166	166	23
24	V	30	DEPRECIATION S/L				2,374	2,374	24
25	V	32	INTEREST				4,108	4,108	25
26	V	33	RE TAX				3,325	3,325	26
27	V	35	STORAGE FEES				1,089	1,089	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,584			$ 15,124	$ * (10,460)	39

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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 2,089,400	BEVERLY PAVILION LLC		$	$ (2,089,400)	15
16	V	19	PROFESSIONAL FEES				12,000	12,000	16
17	V	26	INSURANCE				25,557	25,557	17
18	V	30	DEPR. S.L. BUILDING & IMP				652,864	652,864	18
19	V	30	DEPR. S.L. EQUIP & FURN				76,485	76,485	19
20	V	32	INTEREST				990,206	990,206	20
21	V	33	REAL ESTATE TAXES				738,708	738,708	21
22	V	36	M.I.P. INSURANCE				88,700	88,700	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,089,400			$ 2,584,520	$ * 495,120	39

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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	ADMINISTRATIVE							$ 26,268	17-7	1
2											2
3					SEE						3
4	PHILIP ESFORMES	ADMINISTRATIVE			ATTACHED				320,000	17-3	4
5					SCHEDULE						5
6											6
7	AVRUM WEINFELD	CFO							15,488	17-7	7
8											8
9											9
10											10
11											11
12	MICHAEL ROSEN	ADMINISTRATOR	JANUARY THRU JUNE						81,890	17-1	12
13								TOTAL	$ 443,646		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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	845,281	14	$ 39,600	$ 39,600	113,868	$ 5,335	1
2	17	OFFICER SALARY	PATIENT DAYS	845,281	14	195,000	195,000	113,868	26,268	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	113,868	8,642	3
4	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		113,868	879	4
5	21	OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	113,868	14,936	5
6	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		113,868	308	6
7	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		113,868	1,408	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		113,868	16,807	8
9	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		113,868	650	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					$ 558,472	$ 357,308		$ 75,233	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 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	3	HOUSEKEEPING SALARIES	PATIENT DAYS	845,281	14	$ 12,000	$ 12,000	113,868	$ 1,617	1
2	6	PAINTERS' SALARIES	PATIENT DAYS	845,281	14	47,580	47,580	113,868	6,410	2
3	7	SCAVENGER	PATIENT DAYS	845,281	14	441		113,868	59	3
4	17	CFO SALARY -	PATIENT DAYS	845,281	14	114,971	114,971	113,868	15,488	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	66,116	113,868	10,586	5
6	20	WANT ADS / BACKGR CKS	PATIENT DAYS	845,281	14	37,500		113,868	5,052	6
7	21	OFFICE EXPENSE	PATIENT DAYS	845,281	14	405,027	295,327	113,868	54,561	7
8	23	SEMINAR	PATIENT DAYS	845,281	14	175		113,868	24	8
9	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		113,868	1,607	9
10	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		113,868	684	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		113,868	8,288	11
12	30	DEPRECIATION S.L	PATIENT DAYS	845,281	14	1,536		113,868	207	12
13	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		113,868	3,919	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					$ 805,444	$ 535,994		$ 108,502	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	15	$ 5,775	$	25,584	$ 790	1
2	6	PAINTERS FEES	INCOME	187,059	15	6,152		25,584	841	2
3	6	REPAIRS / MAINT	INCOME	187,059	15	14,941		25,584	2,043	3
4	7	ALARM SERVICE	INCOME	187,059	15	601		25,584	82	4
5	19	PROFESSIONAL FEES	INCOME	187,059	15	998		25,584	136	5
6	20	LICENSES & PERMITS	INCOME	187,059	15	971		25,584	133	6
7	21	OFFICE EXPENSE	INCOME	187,059	15	274		25,584	37	7
8	26	INSURANCE	INCOME	187,059	15	1,211		25,584	166	8
9	30	DEPRECIATION S/L	INCOME	187,059	15	17,356		25,584	2,374	9
10	32	INTEREST	INCOME	187,059	15	30,039		25,584	4,108	10
11	33	RE TAX	INCOME	187,059	15	24,313		25,584	3,325	11
12	35	STORAGE FEES	INCOME	187,059	15	7,961		25,584	1,089	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					$ 110,592	$		$ 15,124	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 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	19	PROFESSIONAL FEES	DIRECT	1	1	$ 12,000	$	1	$ 12,000	1
2	26	INSURANCE	DIRECT	1	1	25,557		1	25,557	2
3	30	DEPR. S.L. BUILDING & IMP	DIRECT	1	1	652,864		1	652,864	3
4	30	DEPR. S.L. EQUIP	DIRECT	1	1	76,485		1	76,485	4
5	32	INTEREST	DIRECT	1	1	990,206		1	990,206	5
6	33	REAL ESTATE TAXES	DIRECT	1	1	738,708		1	738,708	6
7	36	M.I.P. INSURANCE	DIRECT	1	1	88,700		1	88,700	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					$ 2,584,520	$		$ 2,584,520	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD (BEVERLY)		X	MORTGAGE	$99,236.00	3/10/05	$ 18,706,800	$ 17,512,230	3/10/40	0.0540	$ 950,913	1
2												2
3	WEDGEWOOD RLTY (BEVERLY		X	MORTGAGE	$15,000.00	3/10/05	1,650,600	796,436	12/10/15	0.0459	39,293	3
4												4
5	RELATED PARTY - IME		X								4,108	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	400,000				3,958	6
7	INSURANCE FINANCING										6,261	7
8												8
9	TOTAL Facility Related				$114,236.00		$ 20,757,400	$ 18,308,666			$ 1,004,533	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,757,400	$ 18,308,666			$ 1,004,533	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 88,700 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.)**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 392,471	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.)		$ 560,054	2
3. Under or (over) accrual (line 2 minus line 1).		$ 167,583	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 571,125	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.		$ 738,708	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	337,493	8
	2006	392,766	9
	2007	388,573	10
	2008	392,472	11
	2009	560,054	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 560,054.00	$ 560,054.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 560,054.00	$ 560,054.00

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [X] (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).

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			2006	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		2005		$ 17,449,000	$ 634,509	27.5	$ 634,509	$	$ 3,674,865	4
5											5
6											6
7	RELATED PARY										7
8	IME OFFICE				75,472	2,281	39	2,281			8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		3,486	9
10	FENCE			2001	2,100	140	15	140		1,278	10
11	ELEVATOR			2001	18,340	667	27.5	667		6,086	11
12	ALARM			2001	5,686	207	27.5	207		1,889	12
13	WINDOWS			2001	4,149	151	27.5	151		1,378	13
14	BOILER			2001	3,000	109	27.5	109		777	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953		5			12,953	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		839	16
17	DOORS			2001	15,100	549	27.5	549		4,999	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		72,918	18
19	FENCE			2002	3,100	207	15	207		1,760	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		7,020	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		1,410	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		3,581	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		4,403	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		965	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494		5			91,494	25
26	ELEVATIR			2003	110,562	4,020	27.5	4,020		31,323	26
27	PARKING LOT			2003	64,182	4,279	15	4,279		32,093	27
28	FIRE ALARM SYSTEM			2003	25,000	909	27.5	909		6,855	28
29	ROOF			2003	26,500	964	27.5	964		7,190	29
30	EXTERIOR WALL			2003	9,796	356	27.5	356		2,626	30
31	SINKS			2003	3,146	114	27.5	114		860	31
32	BUILT IN WARDROBE			2003	19,398	705	27.5	705		5,141	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700	171	27.5	171		1,176	33
34	FIRE ALARM SYSTEM			2004	13,201	480	27.5	480		3,260	34
35	BUILT IN WARDROBE			2004	21,807	793	27.5	793		5,188	35
36	MASONRY REPAIRS			2004	61,620	2,241	27.5	2,241		14,100	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	$ 2,995	$ 109	27.5	$ 109	$	$ 677	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		1,244	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		1,690	39
40	FLOOR TILING	2004	5,326	194	27.5	194		1,172	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		1,225	41
42	DOORS	2005	4,506	164	27.5	164		909	42
43	FLOOR TILING	2005	1,536	56	27.5	56		310	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		19,061	44
45	CONCRETE PATIO	2005	3,015	201	15	201		1,131	45
46	SHOWER	2006	3,040	111	27.5	111		504	46
47	DUCT WORK	2006	5,600	204	27.5	204		927	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		1,696	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		34,812	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		15,515	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		1,547	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		1,382	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		740	53
54	SHOWERS - BEVERLY	2008	9,120	333	27.5	333		910	54
55	DOORS - BEVERLY	2008	4,520	164	27.5	164		485	55
56	BOLIER - BEVERLY	2008	5,295	193	27.5	193		474	56
57	FLOORS - BEVERLY	2008	6,260	228	27.5	228		523	57
58	ROOFING - BEVERLY	2008	3,800	138	27.5	138		305	58
59	EXTERIOR WALL - BEVERLY	2008	20,000	727	27.5	727		1,484	59
60	ROOFING - BEVERLY	2009	10,333	375	27.5	375		634	60
61	CAULK JOINTS - BEVERLY	2010	28,450	561	27.5	561		561	61
62	MECHANICAL ROOM - BEVERLY	2010	19,450	206	27.5	206		206	62
63	WELDING - BEVERLY	2010	3,587	16	27.5	16		16	63
64	ROOF - BEVERLY	2010	2,925	13	27.5	13		13	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,025,139	$ 688,576		$ 688,576	$	$ 4,092,066	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: 01/01/2010 Ending: 12/31/2010

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	$ 2,952	$ 59,649	$ 56,697	10 YRS	$ 506,909	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PART Y-	767,107	76,785	76,785		10 YRS		74
75	TOTALS	$ 1,363,595	$ 79,737	$ 136,434	$ 56,697		$ 506,909	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)	$ 21,888,734	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 768,313	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 825,010	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 56,697	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,598,975	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.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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? ☐ YES ☐ NO
   If NO, see instructions.

		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		$ 2,089,400			3
4	Additions							4
5								5
6								6
7	TOTAL		328		$ 2,089,400 **			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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 12,401 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	ADMINISTRATOR	2007 BMW 530 XL	$ #######	$ 12,237	17
18	OFFICE	2009 TOYOTA AVALON	741.52	8,898	18
19	FACILITY	2010 FORD VAN	745.22	8,943	19
20					20
21	TOTAL		$ #######	$ 30,078	21

* 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.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number PRESIDENTIAL PAVILION

STATE OF ILLINOIS
0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 344,716	$		$ 344,716	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,522			4,522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			167,207			167,207	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				66,336		66,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): supplies.therapy					77,000	1,350		78,350	13
14	TOTAL			$		$ 593,445	$ 67,686		$ 661,131	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.

STATE OF ILLINOIS

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,264,958	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250,000))	1,319,222		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	170,404		6
7	Other Prepaid Expenses	58,233		7
8	Accounts Receivable (owners or related parties)	401,081		8
9	Other(specify): IL INCOME TAX DEPOSIT	25,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,238,898	$	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)	(944,230)		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)**	$ 615,635	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,854,533	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,673,048	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	241,602		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,677		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)**	$ 1,943,327	$	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)**	$ 2,331,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,523,513	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,854,533	$	48

***(See instructions.)**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,827,550	1
2	Restatements (describe):		2
3	ROUNDING	7	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,827,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(509,044)	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	(795,000)	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)**	$ (1,304,044)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,523,513	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,729,512	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,729,512	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	314,192	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 314,192	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***	50,461	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50,461	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)**	$ 13,094,165	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,409,990	31
32	Health Care	4,625,531	32
33	General Administration	3,488,499	33
	B. Capital Expense		
34	Ownership	2,204,065	34
	C. Ancillary Expense		
35	Special Cost Centers	661,131	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,568,796	40
41	**Income before Income Taxes (line 30 minus line 40)****	(474,631)	41
42	**Income Taxes**	(34,413)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (509,044)	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: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,150	3,311	$ 175,085	$ 52.88	1
2	Assistant Director of Nursing	1,926	2,086	67,785	32.50	2
3	Registered Nurses	10,258	11,932	344,791	28.90	3
4	Licensed Practical Nurses	57,103	60,958	1,371,739	22.50	4
5	CNAs & Orderlies	132,893	144,180	1,490,110	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,376	11,460	138,143	12.05	8
9	Activity Director	2,014	2,086	38,857	18.63	9
10	Activity Assistants	16,186	17,371	158,190	9.11	10
11	Social Service Workers	18,696	19,697	260,043	13.20	11
12	Dietician					12
13	Food Service Supervisor	1,966	2,086	31,285	15.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,350	35,493	342,983	9.66	15
16	Dishwashers					16
17	Maintenance Workers	8,656	9,093	127,846	14.06	17
18	Housekeepers	41,581	45,093	425,105	9.43	18
19	Laundry	15,978	17,856	169,673	9.50	19
20	Administrator	2,027	2,102	132,439	63.01	20
21	Assistant Administrator	1,221	1,221	33,410	27.36	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,351	31,342	375,272	11.97	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	4,013	4,181	47,080	11.26	31
32	Other Health C: mds. Ward clerk	12,317	12,726	282,344	22.19	32
33	Other(specify) SECURITY	21,824	23,301	207,226	8.89	33
34	TOTAL (lines 1 - 33)	424,886	457,575	$ 6,219,406 *	$ 13.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 14,648	1-3	35
36	Medical Director	O	9,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	20,932	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		0	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	1,467	12-3	45
46	Other(specify) PHYSICIANS	S	3,500	10-3	46
47	DENTAL		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 60,455		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ROSEN	ADMINISTRATOR	3	$ 81,890
PHILIP BIRN	ADMINISTRATOR		50,549
ANDREW BRONFELD	ASST ADMIN		33,410
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,849

B. Administrative - Other

Description	Amount
MANAGEMENT FEE - EMI	$ 320,000
PHILIP ESFORMES LTD	320,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 640,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		133,164
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 133,164

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 144,627
Unemployment Compensation Insurance	58,736
FICA Taxes	452,361
Employee Health Insurance	290,325
Employee Meals	21,024
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,854
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	65,212
CHICAGO HEAD TAX	10,860
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,044,999

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	1,930
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	12,027
MARKETING/ADV/PROMO	14,611
LICENSES/DUES/SUBSCRIPTIONS	19,979
MGMT CO ALLOC	5,185
TRUST/FRANCHISE/CONTRIB/ETC	(12,027)
Less: Public Relations Expense	(0)
Non-allowable advertising	(14,611)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,094

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRESIDENTIAL PAVILION **#** 0045526 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 $14,712**

(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. $ **NO** 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. $ **21,024** 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.