

Facility Name & ID Number ALL FAITH PAVILION

0049015 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	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	62,535		1,412	63,947	8
9	SNF/PED					9
10	ICF		425		425	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,535	425	1,412	64,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.98%

D. How many bed-hold days during this year were paid by the Department? NONE (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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 6/5/07

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/5/07 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 245 and days of care provided 1,412

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	316,098	30,124	22,017	368,239		368,239		368,239		1
2	Food Purchase		319,655		319,655		319,655	(1)	319,654		2
3	Housekeeping	60,615	43,080		103,695		103,695		103,695		3
4	Laundry	108,218	29,558	8,825	146,601		146,601		146,601		4
5	Heat and Other Utilities			262,933	262,933		262,933	5,371	268,304		5
6	Maintenance	221,774		76,394	298,168		298,168	5,450	303,618		6
7	Other (specify):*										7
8	TOTAL General Services	706,705	422,417	370,169	1,499,291		1,499,291	10,820	1,510,111		8
	B. Health Care and Programs										
9	Medical Director			47,000	47,000		47,000		47,000		9
10	Nursing and Medical Records	2,556,125	127,701	11,503	2,695,329		2,695,329		2,695,329		10
10a	Therapy	53,940	1,024	282,432	337,396		337,396		337,396		10a
11	Activities	125,351	10,025	1,264	136,640		136,640		136,640		11
12	Social Services	201,560		852	202,412		202,412		202,412		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,936,976	138,750	343,051	3,418,777		3,418,777		3,418,777		16
	C. General Administration										
17	Administrative	119,326		271,920	391,246		391,246	(199,218)	192,028		17
18	Directors Fees										18
19	Professional Services			247,706	247,706		247,706	(33,935)	213,771		19
20	Dues, Fees, Subscriptions & Promotions			58,293	58,293		58,293	(37,141)	21,152		20
21	Clerical & General Office Expenses	339,729	28,739	106,098	474,566		474,566	50,837	525,403		21
22	Employee Benefits & Payroll Taxes			734,823	734,823		734,823		734,823		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,602	2,602		2,602	406	3,008		24
25	Other Admin. Staff Transportation			15,087	15,087		15,087	12,991	28,078		25
26	Insurance-Prop.Liab.Malpractice			275,726	275,726		275,726	946	276,672		26
27	Other (specify):*							26,517	26,517		27
28	TOTAL General Administration	459,055	28,739	1,712,255	2,200,049		2,200,049	(178,597)	2,021,452		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,102,736	589,906	2,425,475	7,118,117		7,118,117	(167,777)	6,950,340		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 Number

ALL FAITH PAVILION

#0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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			20,274	20,274		20,274	186,398	206,672			30
31	Amortization of Pre-Op. & Org.							250	250			31
32	Interest			71,520	71,520		71,520	615,363	686,883			32
33	Real Estate Taxes			288,672	288,672		288,672	2,315	290,987			33
34	Rent-Facility & Grounds			1,414,459	1,414,459		1,414,459	(1,414,459)				34
35	Rent-Equipment & Vehicles			65,434	65,434		65,434	827	66,261			35
36	Other (specify):*							82,459	82,459			36
37	TOTAL Ownership			1,860,359	1,860,359		1,860,359	(526,847)	1,333,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			43,355	43,355		43,355		43,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):*							(36,319)	(36,319)			43
44	TOTAL Special Cost Centers			177,493	177,493		177,493	(36,319)	141,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,102,736	589,906	4,463,327	9,155,969		9,155,969	(730,943)	8,425,026			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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				9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(39,980)	21		18
19	Entertainment				19
20	Contributions	(1,508)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,052)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,007)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(86,871)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,422)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(561,521)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (561,521)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (730,943)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	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

BHF USE ONLY							
48		49		50		51	52

ALL FAITH PAVILION

ID# 0049015

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC-COPE	\$ (7,937)	20	1
2	MARKETING SALARIES	(30,802)	43	2
3	MARKETING EMPLOYEE BENEFITS	(5,517)	43	3
4	CONSULTANT TO COLLECT OLD A/R	(42,615)	19	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	(86,871)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALL FAITH PAVILION# 0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1)	0	0	0	0	0	0	0	0	0	0	(1)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	5,371	0	0	0	0	0	0	0	0	5,371	5
6	Maintenance	0	0	5,450	0	0	0	0	0	0	0	0	5,450	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1)	0	10,821	0	10,820	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	0	(199,218)	0	0	0	0	0	0	0	0	(199,218)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(42,615)	0	8,680	0	0	0	0	0	0	0	0	(33,935)	19
20	Fees, Subscriptions & Promotions	(37,989)	0	848	0	0	0	0	0	0	0	0	(37,141)	20
21	Clerical & General Office Expenses	(52,495)	0	103,332	0	0	0	0	0	0	0	0	50,837	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	406	0	0	0	0	0	0	0	0	406	24
25	Other Admin. Staff Transportation	0	0	12,991	0	0	0	0	0	0	0	0	12,991	25
26	Insurance-Prop.Liab.Malpractice	0	0	946	0	0	0	0	0	0	0	0	946	26
27	Other (specify):*	0	0	26,517	0	0	0	0	0	0	0	0	26,517	27
28	TOTAL General Administration	(133,099)	0	(45,498)	0	(178,597)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(133,100)	0	(34,677)	0	(167,777)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALL FAITH PAVILION# 0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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)	
	D. Ownership													
30	Depreciation	0	183,203	3,195	0	0	0	0	0	0	0	0	186,398	30
31	Amortization of Pre-Op. & Org.	0	0	250	0	0	0	0	0	0	0	0	250	31
32	Interest	(3)	611,842	3,524	0	0	0	0	0	0	0	0	615,363	32
33	Real Estate Taxes	0	0	2,315	0	0	0	0	0	0	0	0	2,315	33
34	Rent-Facility & Grounds	0	(1,414,459)	0	0	0	0	0	0	0	0	0	(1,414,459)	34
35	Rent-Equipment & Vehicles	0	0	827	0	0	0	0	0	0	0	0	827	35
36	Other (specify):*	0	82,459	0	0	0	0	0	0	0	0	0	82,459	36
37	TOTAL Ownership	(3)	(536,955)	10,111	0	(526,847)	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):*	(36,319)	0	0	0	0	0	0	0	0	0	0	(36,319)	43
44	TOTAL Special Cost Centers	(36,319)	0	0	0	0	0	0	0	0	0	0	(36,319)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(169,422)	(536,955)	(24,566)	0	(730,943)	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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	34 RENTAL INCOME	\$ 1,414,459	PHWD REALTY, LLC		\$	(1,414,459)	1
2	V	30 DEPRECIATION				183,203	183,203	2
3	V	32 INTEREST				611,842	611,842	3
4	V	36 AMORTIZATION-LOAN COSTS				82,459	82,459	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,414,459			\$ 877,504	\$ * (536,955)	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	17 Home Office	\$ 271,920	Platinum Health Care, LLC	100.00%	\$	\$ (271,920)
16	V	5 Utilities		Platinum Health Care, LLC		5,371	5,371
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		5,450	5,450
18	V	17 Administrative Salary		Platinum Health Care, LLC		72,702	72,702
19	V	19 Professional Fees		Platinum Health Care, LLC		8,680	8,680
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		848	848
21	V	21 Clerical Salaries		Platinum Health Care, LLC		90,234	90,234
22	V	21 Office Expenses		Platinum Health Care, LLC		13,098	13,098
23	V	24 Education & Seminars		Platinum Health Care, LLC		406	406
24	V	25 Travel		Platinum Health Care, LLC		12,991	12,991
25	V	26 Insurance		Platinum Health Care, LLC		946	946
26	V	27 Employee Benefits		Platinum Health Care, LLC		26,517	26,517
27	V	30 Depreciation		Platinum Health Care, LLC		1,240	1,240
28	V	35 Equipment Rental		Platinum Health Care, LLC		827	827
29	V	31 Amortization		Platinum Health Care, LLC		250	250
30	V	30 Depreciation		Platinum Health Care, LLC		1,955	1,955
31	V	32 Interest		Platinum Health Care, LLC		3,524	3,524
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,315	2,315
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 271,920			\$ 247,354	\$ * (24,566)

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	BEN KLEIN		Administrative	28.00	SEE ATTACHED	2	5.00	Mgt Fees	\$	1
2	BRIAN LEVINSON		Administrative	18.00	SEE ATTACHED	7	17.50	Mgt Fees		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending: 12/31/09

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 Platinum Health Care, LLC
 Street Address 7444 Long Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-7652

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	Patient Days	606,157	15	\$ 50,576	\$ 64,372	\$ 5,371	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	64,372	5,450	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	72,702	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	64,372	8,680	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	64,372	848	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	90,234	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	64,372	13,098	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	64,372	406	8
9	25	Travel	Patient Days	606,157	15	122,325	64,372	12,991	9
10	26	Insurance	Patient Days	606,157	15	8,909	64,372	946	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	64,372	26,517	11
12	30	Depreciation	Patient Days	606,157	15	11,677	64,372	1,240	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	64,372	827	13
14	31	Amortization	Patient Days	606,157	15	2,355	64,372	250	14
15	30	Depreciation	Patient Days	606,157	15	18,405	64,372	1,955	15
16	32	Interest	Patient Days	606,157	15	33,183	64,372	3,524	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	64,372	2,315	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 247,354	25

Facility Name & ID Number

ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Landcaster Pollard Mort. Co.		X	Mortgage			\$	\$		\$ 611,842	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	Merrill Lynch		X	Line of Credit						60,088	6								
7	Ben Klein/Third Firth Bank		X	Working Capital						11,432	7								
8											8								
9	TOTAL Facility Related					\$	\$			\$ 683,362	9								
B. Non-Facility Related*																			
10	Interest Income Offset									(3)	10								
11											11								
12											12								
13	Allocation from Platinum									3,524	13								
14	TOTAL Non-Facility Related					\$	\$			\$ 3,521	14								
15	TOTALS (line 9+line14)					\$	\$			\$ 686,883	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 77,609 Line # 32

* 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.		\$	300,000	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.)		\$	288,672	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(11,328)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	300,000	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.		\$	288,672	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	278,269	8	
	2005	281,102	9	
	2006	288,888	10	
	2007	285,804	11	
	2008	288,672	12	
				FOR BHF USE ONLY
	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALL FAITH PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0049015

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax Applicable to Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-34-310-002-0000</u>	<u>NURSING HOME</u>	\$ <u>3,257.16</u>	\$ <u>3,257.16</u>
2. <u>17-34-310-003-0000</u>	<u>NURSING HOME</u>	\$ <u>1,599.44</u>	\$ <u>1,599.44</u>
3. <u>17-34-310-004-0000</u>	<u>NURSING HOME</u>	\$ <u>1,552.24</u>	\$ <u>1,552.24</u>
4. <u>17-34-310-055-0000</u>	<u>NURSING HOME</u>	\$ <u>278,623.03</u>	\$ <u>278,623.03</u>
5. <u>17-34-310-056-0000</u>	<u>NURSING HOME</u>	\$ <u>909.89</u>	\$ <u>909.89</u>
6. <u>17.34-310-057-0000</u>	<u>NURSING HOME</u>	\$ <u>1,820.21</u>	\$ <u>1,820.21</u>
7. <u>17-34-310-058-0000</u>	<u>NURSING HOME</u>	\$ <u>909.89</u>	\$ <u>909.89</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>288,671.86</u>	\$ <u>288,671.86</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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 ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories _____

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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			2007	\$ 1,522,100	1
2					2
3	TOTALS			\$ 1,522,100	3

Facility Name & ID Number ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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		2007	1974	\$ 4,220,000	\$	40	\$ 105,500	\$ 105,500	\$ 272,542
5					105,500			(105,500)	
6									
7									
8									
	Improvement Type**								
9	SIGN		2007	13,745		10	1,375	1,375	3,322
10	WALK IN COOLER REPAIRS		2007	8,349		15	557	557	1,345
11	REMODELING-LOBBY, RECEPTION, ADMISSIONS		2007	10,000		15	667	667	1,556
12	FIRE ALARM SYSTEM		2007	5,026		10	503	503	1,131
13	SPRINKLER SYSTEM REPAIR		2007	12,793		25	512	512	1,066
14	DOORS--GLASS TINTING		2008	1,850		10	185	185	308
15	HEAT/AIR WORK		2008	11,775		15	785	785	1,243
16	LAMINATED GLASS		2008	850		10	85	85	127
17	ELEVATOR-REPAIR STOP SWITCH		2008	2,632		20	132	132	186
18					4,799			(4,799)	
19									
20									
21									
22	LAB/MAT TO REPAIR WATER DAMAGE-THYSSENKRUPP ELEVA		2009	4,689		15	287	287	287
23	RM 208 GLASS		2009	675		15	41	41	41
24	RM 311 GLASS		2009	675		15	30	30	30
25	3RD FLOOR DAY ROOM GLASS		2009	725		15	32	32	32
26	REPLACE PIPING GAS		2009	4,121		15	115	115	115
27	SWITCH HEAT TO COOLING SYSTEM		2009	5,997		15	200	200	200
28	SET UP GUAGES, CHG COMPRESSORS, OTHER REPAIRS		2009	2,938		15	65	65	65
29	REPAIR WALK IN FREEZER		2009	1,086		10	54	54	54
30	NEW GENERATOR		2009	169,750		5	14,146	14,146	14,146
31	CONVENTIONAL OVEN REPAIR		2009	1,076		10	45	45	45
32	ENVIRONMENTAL SERVICES-ASBESTOS INSPECTION		2009	1,570		15	35	35	35
33	GENERATOR REPLACEMENT FEES		2009	2,400		5	160	160	160
34	HOT WATER SYSTEM REPLACEMENT		2009	6,034		10	201	201	201
35	GENERATOR IMPROVEMENTS		2009	5,000		5	250	250	250
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 ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2009	\$ 1,660		15	\$ 28	\$ 28	\$ 28	37
38	2009	11,500		15	192	192	192	38
39	2009	1,146		15	19	19	19	39
40	2009	38,767		5	1,938	1,938	1,938	40
41	2009	11,875		5	594	594	594	41
42	2009	1,013		15	11	11	11	42
43	2009	3,644		15	40	40	40	43
44	2009	200,046		10				44
45	2009	42,995		15				45
46	2009	14,850		15	83	83	83	46
47	2009	72,212		15	401	401	401	47
48	2009	11,875		5				48
49			18,967			(18,967)		49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67			1,282		1,282			67
68								68
69								69
70		\$ 4,905,339	\$ 130,548		\$ 130,548	\$ (0)	\$ 301,793	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	\$ 633,457	\$ 72,904	\$ 72,904	\$		\$ 180,979	71
72	Current Year Purchases	20,518	1,307	1,307			1,307	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,913	1,913				74
75	TOTALS	\$ 653,975	\$ 76,124	\$ 76,124	\$		\$ 182,286	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)	\$ 7,081,414	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 206,672	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 206,672	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 484,079	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			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: \$ 42,636 Description: Printer/copier \$12,580; Storage \$3,073; Postage meter \$829; Copier \$6,265; Generator \$19,889

(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		2007 Ford E350 Van	\$ _____	\$ 14,473	17
18		2006 Volkswagon GTI		6,500	18
19		Auto allowance		5,142	19
20		Adjustment		(3,317)	20
21	TOTAL		\$ _____	\$ 22,798	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>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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10s-03	hrs	\$		\$ 132,479	\$		\$ 132,479	1
2	Licensed Speech and Language Development Therapist	10s-03	hrs			24,290			24,290	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10s-03	hrs			125,494			125,494	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				41,835		41,835	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Therapy</u>	10a-03				169			169	12
13	Other (specify): <u>Lab</u>	39-02					1,520		1,520	13
14	TOTAL			\$		\$ 282,432	\$ 43,355		\$ 325,787	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 ALL FAITH PAVILION

0049015

Report Period Beginning: 1/1/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ (65,772)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,965,762		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,665		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,058,655	\$	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	618,319		15
16	Equipment, at Historical Cost	20,518		16
17	Accumulated Depreciation (book methods)	(20,274)		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)	\$ 618,563	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,677,218	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 405,673	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	975,000		29
30	Accrued Salaries Payable	141,566		30
31	Accrued Taxes Payable (excluding real estate taxes)	300,000		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	Accrued Expenses	43,313		36
37	Due Others, Adv Billing	980,041		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,845,593	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,845,593	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (168,375)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,677,218	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 586,661	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 586,661	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(755,036)	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	()	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)	\$ (755,036)	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)	\$ (168,375)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ALL FAITH PAVILION

0049015

Report Period Beginning: 1/1/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,090,713	1
2	Discounts and Allowances for all Levels	(356,736)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,733,977	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	625,835	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 625,835	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	38,732	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,386	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41,118	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	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)	\$ 8,400,933	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,499,291	31
32	Health Care	3,418,777	32
33	General Administration	2,200,049	33
B. Capital Expense			
34	Ownership	1,860,359	34
C. Ancillary Expense			
35	Special Cost Centers	43,355	35
36	Provider Participation Fee	134,138	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,155,969	40
41	Income before Income Taxes (line 30 minus line 40)**	(755,036)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (755,036)	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 filed 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 ALL FAITH PAVILION

0049015

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	1,896	2,072	\$ 82,701	\$ 39.91	1
2	Assistant Director of Nursing	128	144	5,192	36.06	2
3	Registered Nurses	9,698	10,193	299,477	29.38	3
4	Licensed Practical Nurses	43,609	46,037	1,183,729	25.71	4
5	CNAs & Orderlies	80,984	90,898	946,610	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,344	4,998	53,940	10.79	8
9	Activity Director	3,768	3,832	52,778	13.77	9
10	Activity Assistants	7,739	8,188	72,573	8.86	10
11	Social Service Workers	10,679	11,296	201,560	17.84	11
12	Dietician					12
13	Food Service Supervisor	1,781	2,103	27,347	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,290	29,264	288,751	9.87	15
16	Dishwashers					16
17	Maintenance Workers	17,288	19,096	221,774	11.61	17
18	Housekeepers	7,157	7,886	60,615	7.69	18
19	Laundry	10,491	11,899	108,218	9.09	19
20	Administrator	1,928	2,201	119,326	54.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,963	15,059	339,729	22.56	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	3,763	3,934	38,416	9.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,506	269,100	\$ 4,102,736 *	\$ 15.25	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	403	\$ 20,336	01-03	35
36	Medical Director	Monthly	47,000	09-03	36
37	Medical Records Consultant	Quarterly	1,152	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,351	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	14	852	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	417	\$ 79,691		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

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0049015

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LTC \$17,922
- (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? N/A
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,562 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. \$ 134,138
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. \$ 0 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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. \$ _____
- (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.