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: 0049015

Facility Name: ALL FAITH PAVILION

Address: 3500 SOUTH GILES AVENUE (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (312) 326-2000 **Fax #** (312) 326-5753

HFS ID Number:

Date of Initial License for Current Owners: 6/5/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT		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: DARRYL BUEKER **Telephone Number:** (417) 865-8701
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 1/1/10 to 12/31/10 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)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	65,350		2,120	67,470	8
9	SNF/PED					9
10	ICF		76		76	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,350	76	2,120	67,546	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.53%

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 [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 6/5/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 2,120

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	347,622	27,870	14,968	390,460		390,460		390,460			1
2	Food Purchase		350,284		350,284		350,284		350,284			2
3	Housekeeping	105,276	35,797		141,073		141,073		141,073			3
4	Laundry	100,602	24,963	3,498	129,063		129,063		129,063			4
5	Heat and Other Utilities			247,776	247,776		247,776	6,051	253,827			5
6	Maintenance	242,163		143,458	385,621		385,621	5,677	391,298			6
7	Other (specify):*											7
8	TOTAL General Services	795,663	438,914	409,700	1,644,277		1,644,277	11,728	1,656,005			8
	B. Health Care and Programs											
9	Medical Director			48,000	48,000		48,000		48,000			9
10	Nursing and Medical Records	2,473,934	119,788	14,934	2,608,656		2,608,656		2,608,656			10
10a	Therapy	63,936		265,594	329,530		329,530		329,530			10a
11	Activities	128,229	8,524	143	136,896		136,896		136,896			11
12	Social Services	204,368		915	205,283		205,283		205,283			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,870,467	128,312	329,586	3,328,365		3,328,365		3,328,365			16
	C. General Administration											
17	Administrative	131,400		275,420	406,820		406,820	(252,311)	154,509			17
18	Directors Fees											18
19	Professional Services			319,326	319,326	(49,878)	269,448	(15,490)	253,958			19
20	Dues, Fees, Subscriptions & Promotions			52,537	52,537		52,537	(26,370)	26,167			20
21	Clerical & General Office Expenses	173,037	24,018	55,124	252,179		252,179	123,204	375,383			21
22	Employee Benefits & Payroll Taxes			697,131	697,131		697,131		697,131			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,137	2,137		2,137	535	2,672			24
25	Other Admin. Staff Transportation			18,162	18,162		18,162	7,648	25,810			25
26	Insurance-Prop.Liab.Malpractice			416,255	416,255		416,255	(24,219)	392,036			26
27	Other (specify):*							17,145	17,145			27
28	TOTAL General Administration	304,437	24,018	1,836,092	2,164,547	(49,878)	2,114,669	(169,858)	1,944,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,970,567	591,244	2,575,378	7,137,189	(49,878)	7,087,311	(158,130)	6,929,181			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: 1/1/10 Ending: 12/31/10

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			199,640	199,640		199,640	85,621	285,261			30
31	Amortization of Pre-Op. & Org.							425	425			31
32	Interest			34,077	34,077		34,077	714,484	748,561			32
33	Real Estate Taxes			190,650	190,650	49,878	240,528	32,631	273,159			33
34	Rent-Facility & Grounds			898,748	898,748		898,748	(929,375)	(30,627)			34
35	Rent-Equipment & Vehicles			45,401	45,401		45,401	317	45,718			35
36	Other (specify):*							10,524	10,524			36
37	**TOTAL Ownership**			1,368,516	1,368,516	49,878	1,418,394	(85,373)	1,333,021			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			94,034	94,034		94,034		94,034			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):*							(56,053)	(56,053)			43
44	**TOTAL Special Cost Centers**			228,172	228,172		228,172	(56,053)	172,119			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,970,567	591,244	4,172,066	8,733,877		8,733,877	(299,556)	8,434,321			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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	(108,941)	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions	(3,750)	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	(18,964)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,448)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(171,435)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (311,540)		$	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)	11,984		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 11,984		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (299,556)		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

ALL FAITH PAVILION

ID# 0049015

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (9,149)	20	1
2	MARKETING SALARIES	(47,681)	43	2
3	MARKETING EMPLOYEE BENEFITS	(8,372)	43	3
4	CONSULTANT TO COLLECT OLD A/R	(21,744)	19	4
5	INSURANCE DEDUCTIBLE	(25,000)	26	5
6	MISC INCOME	(30,627)	34	6
7	DEPR EXP-P/Y ADJ	(59,460)	30	7
8	REAL ESTATE TAX ADJ (NET)	30,598	33	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**	(171,435)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALL FAITH PAVILION # 0049015 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	6,051	0	0	0	0	0	0	0	0	6,051	5
6	Maintenance	0	0	5,677	0	0	0	0	0	0	0	0	5,677	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	11,728	0	0	0	0	0	0	0	0	11,728	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	(252,311)	0	0	0	0	0	0	0	0	(252,311)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,744)	(3,133)	9,387	0	0	0	0	0	0	0	0	(15,490)	19
20	Fees, Subscriptions & Promotions	(28,113)	0	1,743	0	0	0	0	0	0	0	0	(26,370)	20
21	Clerical & General Office Expenses	(12,198)	0	135,402	0	0	0	0	0	0	0	0	123,204	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	535	0	0	0	0	0	0	0	0	535	24
25	Other Admin. Staff Transportation	0	0	7,648	0	0	0	0	0	0	0	0	7,648	25
26	Insurance-Prop.Liab.Malpractice	(25,000)	0	781	0	0	0	0	0	0	0	0	(24,219)	26
27	Other (specify):*	0	0	17,145	0	0	0	0	0	0	0	0	17,145	27
28	**TOTAL General Administration**	(87,055)	(3,133)	(79,670)	0	0	0	0	0	0	0	0	(169,858)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,055)	(3,133)	(67,942)	0	0	0	0	0	0	0	0	(158,130)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALL FAITH PAVILION # 0049015 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(168,401)	250,255	3,767	0	0	0	0	0	0	0	0	85,621	30
31	Amortization of Pre-Op. & Org.	0	0	425	0	0	0	0	0	0	0	0	425	31
32	Interest	(2)	710,869	3,617	0	0	0	0	0	0	0	0	714,484	32
33	Real Estate Taxes	30,598	0	2,033	0	0	0	0	0	0	0	0	32,631	33
34	Rent-Facility & Grounds	(30,627)	(898,748)	0	0	0	0	0	0	0	0	0	(929,375)	34
35	Rent-Equipment & Vehicles	0	0	317	0	0	0	0	0	0	0	0	317	35
36	Other (specify):*	0	10,524	0	0	0	0	0	0	0	0	0	10,524	36
37	**TOTAL Ownership**	(168,432)	72,900	10,159	0	0	0	0	0	0	0	0	(85,373)	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):*	(56,053)	0	0	0	0	0	0	0	0	0	0	(56,053)	43
44	**TOTAL Special Cost Centers**	(56,053)	0	0	0	0	0	0	0	0	0	0	(56,053)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(311,540)	69,767	(57,783)	0	0	0	0	0	0	0	0	(299,556)	45

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [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	34	RENTAL INCOME	$ 898,748	PHWD REALTY, LLC		$	$ (898,748)	1
2	V	30	DEPRECIATION				250,255	250,255	2
3	V	32	INTEREST				710,869	710,869	3
4	V	36	AMORTIZATION-LOAN COSTS				10,524	10,524	4
5	V								5
6	V								6
7	V	19	PROFESSIONAL FEES	57,400	PHC CONSULTANTS, LLC		54,267	(3,133)	7
8	V								8
9	V	19	PROFESSIONAL FEES	17,238	MTS CONSULTING		17,238		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 973,386			$ 1,043,153	$ * 69,767	14

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	17	HOME OFFICE	$ 275,420	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (275,420)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		6,051	6,051	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		5,677	5,677	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		23,109	23,109	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		9,387	9,387	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		1,743	1,743	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		119,664	119,664	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		15,738	15,738	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		535	535	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		7,648	7,648	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		781	781	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		17,145	17,145	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,628	1,628	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		317	317	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		425	425	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		2,139	2,139	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		3,617	3,617	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		2,033	2,033	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 275,420			$ 217,637	$ * (57,783)	39

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	28.00	SEE ATTACHED	2	6.45	Mgt Fees	$		1
2	BRIAN LEVINSON		Administrative	18.00	SEE ATTACHED	6	15.00	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: 1/1/10 Ending: 12/31/10

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: 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 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	Patient Days	581,243	18	$ 52,068	$	67,546	$ 6,051	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		67,546	5,677	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	67,546	23,109	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		67,546	9,387	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		67,546	1,743	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	67,546	119,664	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		67,546	15,738	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		67,546	535	8
9	25	Travel	Patient Days	581,243	18	65,815		67,546	7,648	9
10	26	Insurance	Patient Days	581,243	18	6,717		67,546	781	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		67,546	17,145	11
12	30	Depreciation	Patient Days	581,243	18	14,004		67,546	1,628	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		67,546	317	13
14	31	Amortization	Patient Days	581,243	18	3,657		67,546	425	14
15	30	Depreciation	Patient Days	581,243	18	18,405		67,546	2,139	15
16	32	Interest	Patient Days	581,243	18	31,121		67,546	3,617	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		67,546	2,033	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 217,637	25

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			X	MORTGAGE			$	$			$ 710,869	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GE/ML		X	LINE OF CREDIT							34,077	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 744,946	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(2)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										3,617	13
14	TOTAL Non-Facility Related						$	$			$ 3,615	14
15	TOTALS (line 9+line14)						$	$			$ 748,561	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 83,706 **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.)**

Facility Name & ID Number ALL FAITH PAVILION **#** 0049015 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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.**	$ 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.)		$ 282,805	2
3. Under or (over) accrual (line 2 minus line 1).		$ (17,195)	3
4. Real Estate Tax accrual used for 2010 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.**		$ 49,878	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** $ 92,158 **For** 06/07 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (61,557)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 271,126	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	281,102	8
2006	288,888	9
2007	285,804	10
2008	288,672	11
2009	282,805	12

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 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 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.	17-34-310-002-0000	NURSING HOME	$ 3,278.97	$ 3,278.97
2.	17-34-310-003-0000	NURSING HOME	$ 1,622.97	$ 1,622.97
3.	17-34-310-004-0000	NURSING HOME	$ 1,596.13	$ 1,596.13
4.	17-34-310-055-0000	NURSING HOME	$ 272,155.98	$ 272,155.98
5.	17-34-310-056-0000	NURSING HOME	$ 1,037.60	$ 1,037.60
6.	17-34-310-057-0000	NURSING HOME	$ 2,075.63	$ 2,075.63
7.	17-34-310-058-0000	NURSING HOME	$ 1,037.60	$ 1,037.60
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 282,804.88	$ 282,804.88

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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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? [ ] (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			2007	$ 1,522,100	1
2					2
3	TOTALS			$ 1,522,100	3

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			2007	1974	$ 4,220,000	$ 105,500	40	$ 105,500	$	$ 378,042	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGN (2010 removed $95)			2007	13,650		10	1,365	1,365	4,687	9
10	WALK IN COOLER REPAIRS			2007	8,349		15	557	557	1,902	10
11	REMODELING-LOBBY, RECEPTION, ADMISSIONS			2007	10,000		15	667	667	2,223	11
12	FIRE ALARM SYSTEM			2007	5,026		10	503	503	1,634	12
13	SPRINKLER SYSTEM REPAIR			2007	12,793		25	512	512	1,578	13
14	DOORS--GLASS TINTING (REMOVED $1,850 PER 2010 CAP COST A			2008			10				14
15	HEAT/AIR WORK			2008	11,775		15	785	785	2,028	15
16	LAMINATED GLASS (REMOVED $850 PER 2010 CAP COST AUDIT)			2008			10				16
17	ELEVATOR-REPAIR STOP SWITCH			2008	2,632		20	132	132	318	17
18	NEW GENERATOR			2009	169,750		5	33,950	33,950	48,096	18
19	GENERATOR REPLACEMENT FEES			2009	2,400		5	480	480	640	19
20	VINYL FLOORING - BPAT CORP			2009	200,046		10	20,005	20,005	20,005	20
21	MILLWORK			2009	42,995		15	2,866	2,866	2,866	21
22	REPLACE TWO OLD TRANSFER SWITCHES			2009	14,850		15	990	990	1,073	22
23	PAINTING-INTERIOR-CONTRACT-RED FEATHER GROUP			2009	72,212		15	4,814	4,814	5,215	23
24	MILLWORK 5 FLOORS			2010	57,595		15	3,520	3,520	3,520	24
25	NEW FLOORING - 5 FLOORS			2010	17,543		10	1,462	1,462	1,462	25
26	INSTALL GENERATOR, LIGHTS			2010	4,325		5	577	577	577	26
27	HANDICAP RAMP			2010	70,739		10	589	589	589	27
28						74,066			(74,066)		28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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: 1/1/10 Ending: 12/31/10

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	LAB/MAT TO REPAIR WATER DAMAGE-THYSSENDRUPP E	2009	$ 4,689	$	15	$ 313	$ 313	$ 600	37
38	RM 208 GLASS (REMOVED $675 PER 2010 CAP COST AUDIT	2009			15				38
39	RM 311 GLASS (REMOVED $675 PER CAP COST AUDIT)	2009			15				39
40	3RD FLOOR DAY ROOM GLASS (REMOVED $725 PER 2010 C	2009			15				40
41	REPLACE PIPING GAS	2009	4,121		15	275	275	390	41
42	SWITCH HEAT TO COLLING SYSTEM	2009	5,997		15	400	400	600	42
43	SET UP GUAGES, CHG COMPORESSORS, OTHER REPAIRS	2009	2,938		15	196	196	261	43
44	REPAIR WALK IN FREEZER (REMOVE $1,086 PER 2010 CAP	2009			10				44
45	CONVENTIONAL OVEN REPAIR (REMOVED $1,076 PER 201	2009			10				45
46	ENVIRONMENTAL SERVICES-ASBESTOS INSPECTION (RE	2009			15				46
47	HOT WATER SYSTEM REPLACEMENT	2009	6,034		10	603	603	804	47
48	GENERATOR IMPROVEMENTS	2009	5,000		5	1,000	1,000	1,250	48
49									49
50	COMPRESSOR REPAIR (REMOVED $1,660 PER 2010 CAP CO	2009			15				50
51	A/C - TOWER FAN REPAIR/REPLACEMENT	2009	11,500		15	767	767	959	51
52	REPLACE ALTERNATOR FLOAT SWITCH (REMOVE $1,146	2009			15				52
53	CAMERAS, RECORDERS, MONITORS, ETC. (SECURITY)	2009	38,767		5	7,753	7,753	9,691	53
54	DIRECTTV HEADEND SYSTEM INC. WIRING PMT 1 (MOVE	2009	11,875		5	2,375	2,375	2,969	54
55	INSTALL PIPE/WIRE TO NEW SECURITY EQUIP (REMOVE	2009			15				55
56	INSTALL DUCT & DIFFUSERS	2009	3,644		15	243	243	283	56
57	DIRECTTV HEADEND SYSTEM INC. WIRING PMT 2	2009	11,875		5	2,375	2,375	2,375	57
58	NEW SEWAGE PUMP	2010	3,532		10	353	353	353	58
59	NEW FLOORING 5 FLOORS	2010	70,172		10	5,848	5,848	5,848	59
60	PHONE SYSTEM DEPOSIT (MOVED TO EQUIP PER 2010 CA	2010			10				60
61	COMDIAL DXP SYSTEM (WILL MOVE TO EQUIP WITH DE	2010			10				61
62	EXTERIOR PATIO AND GAZEBO	2010	6,801		10	340	340	340	62
63	FLOOR PLANS AND MASTER PLAN	2010	3,426		10	171	171	171	63
64	PAINTING-INTERIOR-CONTRACT-RED FEATHER GROUP	2010	23,285		15	1,552	1,552	1,552	64
65				98,142			(98,142)		65
66									66
67									67
68	Allocation from Platinum			1,625		1,625			68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,150,336	$ 279,333		$ 205,463	$ (73,870)	$ 504,901	70

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 665,850	$ 76,548	$ 71,516	$ (5,032)		$ 254,398	71
72	Current Year Purchases	99,104	36,179	6,140	(30,039)		6,140	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,142	2,142				74
75	TOTALS	$ 764,954	$ 114,869	$ 79,798	$ (35,071)		$ 260,538	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)	$ 7,437,390	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 394,202	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 285,261	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (108,941)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 765,439	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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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:				$			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: *

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: $ $25,861 Description: Printer/copier $15,966; Storage $1,715; Postage meter $3,112; Generator $2,000: Medical $3,068
    (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	$	$ 14,400	17
18		2006 Volkswagon GTI	500.00	1,500	18
19		Auto allowance		3,640	19
20					20
21	TOTAL		$ 500.00	$ 19,540	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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	10a-03	hrs	$		$ 132,233	$		$ 132,233	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			13,697			13,697	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			119,664			119,664	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 prescrpts				89,459		89,459	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab and X-ray	39-02					4,575		4,575	13
14	TOTAL			$		$ 265,594	$ 94,034		$ 359,628	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 ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 131,744	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,277,708		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	238,836		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)**	$ 1,648,288	$	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	210,067		15
16	Equipment, at Historical Cost	47,846		16
17	Accumulated Depreciation (book methods)	(219,914)		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)**	$ 37,999	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,686,287	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 398,450	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,033		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	31,063		36
37	Due Others, Adv Billing	290,090		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,170,636	$	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)**	$ 1,170,636	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 515,651	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,686,287	$	48

***(See instructions.)**

Facility Name & ID Number ALL FAITH PAVILION # 0049015 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (168,375)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (168,374)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	684,025	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)**	$ 684,025	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)**	$ 515,651	24 *

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 8,521,144	1
2	Discounts and Allowances for all Levels	124,976	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,646,120	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	638,837	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 638,837	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	96,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,598	19
20	Radiology and X-Ray	1,250	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,316	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	30,627	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 30,627	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,417,902	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,644,277	31
32	Health Care	3,328,365	32
33	General Administration	2,164,547	33
	B. Capital Expense		
34	Ownership	1,368,516	34
	C. Ancillary Expense		
35	Special Cost Centers	94,034	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)***	$ 8,733,877	40
41	**Income before Income Taxes (line 30 minus line 40)****	684,025	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 684,025	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: 1/1/10 Ending: 12/31/10

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	1,960	2,256	$ 89,192	$ 39.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,491	10,040	291,237	29.01	3
4	Licensed Practical Nurses	42,690	44,512	1,081,416	24.29	4
5	CNAs & Orderlies	75,368	98,928	983,052	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,156	7,346	63,936	8.70	8
9	Activity Director	2,480	2,784	39,360	14.14	9
10	Activity Assistants	9,220	9,647	88,869	9.21	10
11	Social Service Workers	10,280	11,074	204,368	18.45	11
12	Dietician					12
13	Food Service Supervisor	3,308	4,377	57,746	13.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,719	32,073	289,876	9.04	15
16	Dishwashers					16
17	Maintenance Workers	19,844	23,187	242,163	10.44	17
18	Housekeepers	9,923	11,206	105,276	9.39	18
19	Laundry	9,021	11,840	100,602	8.50	19
20	Administrator	1,864	2,529	131,400	51.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,016	11,052	173,037	15.66	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	2,802	3,000	29,037	9.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,142	285,851	$ 3,970,567 *	$ 13.89	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	301	$ 13,540	01-03	35
36	Medical Director	Monthly	48,000	09-03	36
37	Medical Records Consultant	Quarterly	1,920	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		13,014	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	915	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	315	$ 77,389		49

C. CONTRACT NURSES

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

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LAURIE DECKARD	ADMINISTRATOR		$ 72,907
EARL VAN DUSEN	ADMINISTRATOR		58,493
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,400

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 319,326
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 319,326

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,633
Unemployment Compensation Insurance	101,653
FICA Taxes	299,211
Employee Health Insurance	169,884
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	200
EMPLOYEE BENEFITS-OTHER	15,257
EMPLOYEE PHYSICAL EXAM	293
TOTAL (agree to Schedule V, line 22, col.8)	$ 697,131

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	
Health Care Worker Background Check	3,680
(Indicate # of checks performed 56)	
Patient Background Checks 379	
ADVERTISING & MARKETING	18,964
DUES & SUBSCRIPTIONS	14,573
LICENSES	6,171
ALLOCATION FROM PLATINUM	1,743
Less: Public Relations Expense	( )
Non-allowable advertising	(18,964)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,167

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,137
ALLOCATION FROM PLATINUM	535
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,672

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALL FAITH PAVILION # 0049015 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ALL FAITH PAVILION **#** 0049015 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 $21,756**

(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? **10-15 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,670** 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?
g. Does the facility transport residents to and from day training? 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 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.