

Facility Name & ID Number Tabor Hills Health Care Facility

0040543 Report Period Beginning: 10/1/06 Ending: 09/30/07

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 N/A

	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	192	Skilled (SNF)	192	70,080	1
2		Skilled Pediatric (SNF/PED)			2
3	19	Intermediate (ICF)	19	6,935	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,009	7,252	7,326	16,587	8
9	SNF/PED					9
10	ICF	22,806	33,229	17	56,052	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,815	40,481	7,343	72,639	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.32%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 04/28/95

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 04/28/95 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 52 and days of care provided 7,173

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/07 Fiscal Year: 09/30/07

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

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/06 Ending: 09/30/07

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	424,348	26,931	10,812	462,091		462,091	462,091			1
2	Food Purchase		364,278		364,278		364,278	364,278			2
3	Housekeeping	353,583	96,696	71,411	521,690		521,690	521,690			3
4	Laundry	163,821	51,587	4,371	219,779		219,779	219,779			4
5	Heat and Other Utilities			313,653	313,653		313,653	313,653			5
6	Maintenance	158,975	45,454	182,866	387,295		387,295	387,295			6
7	Other (specify):*										7
8	TOTAL General Services	1,100,727	584,946	583,113	2,268,786		2,268,786	2,268,786			8
	B. Health Care and Programs										
9	Medical Director			27,075	27,075		27,075	27,075			9
10	Nursing and Medical Records	4,697,181	523,116	1,459,531	6,679,828		6,679,828	6,679,828			10
10a	Therapy	306,115	1,079	58,844	366,038		366,038	366,038			10a
11	Activities	156,960	2,671	5,339	164,970		164,970	164,970			11
12	Social Services	104,268	389	2,328	106,985		106,985	106,985			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,264,524	527,255	1,553,117	7,344,896		7,344,896	7,344,896			16
	C. General Administration										
17	Administrative	181,406			181,406		181,406	181,406			17
18	Directors Fees										18
19	Professional Services			126,871	126,871		126,871	(7,211)	119,660		19
20	Dues, Fees, Subscriptions & Promotions			78,758	78,758		78,758	78,758			20
21	Clerical & General Office Expenses	373,988	62,886	45,751	482,625		482,625	482,625			21
22	Employee Benefits & Payroll Taxes			2,477,177	2,477,177		2,477,177	2,477,177			22
23	Inservice Training & Education			480	480		480	480			23
24	Travel and Seminar			8,376	8,376		8,376	8,376			24
25	Other Admin. Staff Transportation			15,913	15,913		15,913	15,913			25
26	Insurance-Prop.Liab.Malpractice			336,420	336,420		336,420	336,420			26
27	Other (specify):*										27
28	TOTAL General Administration	555,394	62,886	3,089,746	3,708,026		3,708,026	(7,211)	3,700,815		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,920,645	1,175,087	5,225,976	13,321,708		13,321,708	(7,211)	13,314,497		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Tabor Hills Health Care Facility

#0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			536,062	536,062		536,062	5,383	541,445			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			435,278	435,278		435,278	(7,867)	427,411			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			971,340	971,340		971,340	(2,484)	968,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,375		183,375		183,375		183,375			39
40	Barber and Beauty Shops			48,878	48,878		48,878		48,878			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,067	114,067		114,067		114,067			42
43	Other (specify):* Non-allowable Cos			162,698	162,698		162,698	(162,698)				43
44	TOTAL Special Cost Centers		183,375	325,643	509,018		509,018	(162,698)	346,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,920,645	1,358,462	6,522,959	14,802,066		14,802,066	(172,393)	14,629,673			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	5,383	30		9
10	Interest and Other Investment Income	(7,867)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(88,381)	43		24
25	Fund Raising, Advertising and Promotional	(8,576)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(72,952)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (172,393)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (172,393)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/1/06

Ending: 09/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Resident Physicians	\$ (5,277)	43	1
2	Disallow Miscellaneous Expense	(6,939)	43	2
3	Disallow X-Ray Expense	(19,978)	43	3
4	Disallow Lab Expense	(32,513)	43	4
5	Disallow Non-allowable Legal Fees	(7,211)	19	5
6	Disallow Travel & Entertainment	(1,034)	43	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	(72,952)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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

	Operating Expenses	PAGES	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	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,211)	0	0	0	0	0	0	0	0	0	0	(7,211)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,211)	0	0	0	0	0	0	0	0	0	0	(7,211)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,211)	0	0	0	0	0	0	0	0	0	0	(7,211)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tabor Hills Health Care Facility# 0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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	5,383	0	0	0	0	0	0	0	0	0	0	5,383	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,867)	0	0	0	0	0	0	0	0	0	0	(7,867)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,484)	0	0	0	0	0	0	0	0	0	0	(2,484)	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):*	(162,698)	0	0	0	0	0	0	0	0	0	0	(162,698)	43
44	TOTAL Special Cost Centers	(162,698)	0	0	0	0	0	0	0	0	0	0	(162,698)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(172,393)	0	0	0	0	0	0	0	0	0	0	(172,393)	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
Bohemian Home for the Aged	100%			Bohemian Home for the Aged	Naperville	Townhomes

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V			N/A				3
4	V							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		\$			\$	\$ *	14

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

Tabor Hills Health Care Facility, Inc.
Provider #: 0040543
10/1/06 to 9/30/07

Schedule 6A

Officers/Board of Directors

President

Stanley D. Loula
15 Spinning Wheel Road
Suite 416
Hinsdale, IL 60521

Vice President

Walter Wlodek
15 Spinning Wheel Road
Suite 416
Hinsdale, IL 60521

Secretary & Administrator

Gloria J. Pindiak
1347 Crystal Avenue
Naperville, IL 60563

Treasurer

Charles Capek
1432 Crystal
Naperville, IL 60563

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/06 Ending: 09/30/07

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	Gloria Pindiak	Administrator	Administrative	0.00	0	40+	100.00	Salary	\$ 110,542	L17,C1	1
2											2
3	See attached schedule of Board of Directors										
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 110,542		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending: 09/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4				N/A					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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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**		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	Northwest Bank of Wisconsin		X	Mortgage	Principal and interest due	3/31/98	\$ 8,095,000	\$	12/22/06	varies	\$ 204,683	1								
2					Semi-annually							2								
3												3								
4	Illinois Revenue Authority		X	Mortgage	P & I due upon presentment	11/22/06	4,970,670	4,970,670	11/15/36	varies	57,601	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 13,065,670	\$ 4,970,670			\$ 262,284	9								
B. Non-Facility Related*																				
10	Interest Income Offset										(7,867)	10								
11	Amortization of Loan Fees										3,200	11								
12	Bond Costs										169,794	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 165,127	14								
15	TOTALS (line 9+line14)						\$ 13,065,670	\$ 4,970,670			\$ 427,411	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	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.)	2006	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tabor Hills Health Care Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0040543

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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).

Bohemian Home for the Aged d/b/a Tabor Hills Adult Community provides housing to seniors through an adult living community.

There are 104 townhomes and a total of 1,267,596 square feet of land.

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>264,519</u>	<u>1995</u>	<u>\$ 574,693</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	264,519		\$ 574,693	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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	211	1995	1995	\$ 10,039,753	\$ 249,936	40	\$ 249,932	\$ (4)	\$ 3,135,826	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Land Improvements		1995	36,958	2,464	15	2,464		30,799	9
10	Improvements		1995	1,421		40	36	36	579	10
11	Sign		1997	500	13	40	13		136	11
12	Electric		1996	656	16	40	16		168	12
13	Humidistats		1996	1,378	34	40	34		357	13
14	Door alarm		1996	854	21	40	21		228	14
15	Plumbing		1996	1,050	26	40	26		273	15
16	Install lights, water heater		1997	2,345	59	40	59		612	16
17	Pipe		1997	618	15	40	15		165	17
18	Electric		1997	3,121	78	40	78		819	18
19	Signs & outlets		1997	2,504	63	40	63		654	19
20	Wall hugging overbed lights		1997	27,302	683	40	683		7,099	20
21	Air compressor		1997	2,078	52	40	52		546	21
22	Roof repair		1997	3,154	79	40	79		822	22
23	Deco-gard products		1997	738	18	40	18		190	23
24	Shelving units		1998	2,317	58	40	58		551	24
25	Chimney cap		1998	945	24	40	24		228	25
26	Access door		1998	2,061	52	40	52		494	26
27	Bumper guards		1998	3,687	92	40	92		874	27
28	Land improvement - survey		1998	800		10	80	80	760	28
29	Carpeting		1999	67,303	6,730	10	6,730		56,645	29
30	Miniblinds		1999	3,501	350	10	350		2,829	30
31	Vertical blinds		1999	1,974	197	10	197		1,741	31
32	Swingmaster door		1999	2,357	236	10	236		2,084	32
33	Security lock		1999	2,779	278	10	278		2,386	33
34	WanderGuard code alert system		1999	16,182	1,618	10	1,618		13,753	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting</u>	2000	\$ 225	\$ 23	10	\$ 23		\$ 160	37
38	<u>Railing & bumper</u>	2000	3,275	82	40	82		617	38
39	<u>Carpeting</u>	2000	41,999	4,200	10	4,200		29,050	39
40	<u>Tile</u>	2001	6,493	162	40	162		1,108	40
41	<u>Courtyard improvements</u>	2001	15,673	392	40	392		2,383	41
42	<u>Architect Fees - Dining Room</u>	2002	58,322	5,832	10	5,832		23,328	42
43	<u>Carpet</u>	2002	3,341	334	10	334		1,670	43
44	<u>Door Alarm</u>	2003	8,254	825	10	825		3,781	44
45	<u>Fountain</u>	2003	2,278	228	10	228		1,007	45
46	<u>Carpet</u>	2003	4,545	455	10	455		1,820	46
47	<u>Therapeutic Garden</u>	2003	135,525	3,388	40	3,388		12,090	47
48	<u>Windows</u>	2003	600	15	40	15		60	48
49	<u>Braille Room Signs</u>	2003	3,156	79	40	79		277	49
50	<u>Flooring & Ceiling Tile</u>	2004	12,755	319	40	319		1,117	50
51	<u>Architect Fees - Dining Room</u>	2004	17,405	435	40	435		1,523	51
52	<u>Air Conditioning</u>	2004	32,155	3,216	10	3,216		11,256	52
53	<u>Plumbing</u>	2004	30,619	765	40	765		2,761	53
54	<u>Doors</u>	2004	12,160	1,216	10	1,216		4,256	54
55	<u>Water Box</u>	2004	1,996	200	10	200		700	55
56	<u>Fire Alarm</u>	2004	8,965	897	10	897		3,139	56
57	<u>Driveway</u>	2004	2,750	275	10	275		963	57
58	<u>Electric Work & Lighting</u>	2004	213,367	5,334	40	5,334		16,553	58
59	<u>Entryway Renovation</u>	2004	761	19	40	19		57	59
60	<u>Sprinkler System</u>	2004	1,798	45	40	45		135	60
61	<u>Dining Room Renovation</u>	2004	1,915,627	44,311	40	47,891	3,580	139,981	61
62	<u>Bathroom Renovation</u>	2005	2,000	50	40	50		125	62
63	<u>Automatic Door System</u>	2005	3,551	89	40	89		223	63
64	<u>Signs</u>	2006	21,716	543	40	543		814	64
65	<u>Door Sensor Locks</u>	2006	18,597	465	40	465		697	65
66	<u>Asphalt Parking Lots</u>	2006	7,156	716	10	716		1,073	66
67	<u>Wall Mirrors Therapy Room</u>	2006	2,940	74	40	74		110	67
68	<u>Electrical Work</u>	2006	25,507	638	40	638		957	68
69	<u>Wiring</u>	2006	68,676	1,717	40	1,717		2,575	69
70	TOTAL (lines 4 thru 69)		\$ 12,912,523	\$ 340,531		\$ 344,223	\$ 3,692	\$ 3,527,984	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,912,523	\$ 340,531		\$ 344,223	\$ 3,692	\$ 3,527,984	1
2	Lighting	2006	21,943	549	40	549		823	2
3	Exhaust Fans	2006	28,060	702	40	702		1,052	3
4	Heaters	2006	28,826	721	40	721		1,081	4
5	HVAC	2006	71,252	1,781	40	1,781		2,672	5
6	Fountain	2006	39,594	2,640	15	2,640		2,860	6
7	Wall Coverings	2007	6,058	303	10	303		303	7
8	Fire Prevention	2007	5,464	273	10	273		273	8
9	Exterior Work	2007	7,440	372	10	372		372	9
10	Naperville Room improvements								10
11	- Remove interior partition wall, remove required ceiling								11
12	grid & tile to new demising wall, construct new interior								12
13	demising wall attaching to underside of pan desk, remove								13
14	existing ceiling panels, provided required fire stopping								14
15	for perimeter walls & ceiling	2007	17,034	213	40	213		213	15
16	Exercise Room improvements								16
17	- Removed wallpaper, patched damaged areas, replaced								17
18	& repaired all required drywall. Install new insulation								18
19	install new fire rated metal door frame & door	2007	18,807	235	40	235		235	19
20	Exterior Doors & Frames	2007	8,292	104	40	104		104	20
21	Interior Doors	2007	2,490	31	40	31		31	21
22	1 North Kitchen improvements								22
23	- Removed cabinets, walls, ceiling & flooring - concrete								23
24	floor to install new plumbing drain	2007	8,754	109	40	109		109	24
25	Finance Office improvements								25
26	- Replaced door and walls, taped off and painted	2007	2,622	33	40	33		33	26
27	Carpeting	2007	12,371	619	10	619		619	27
28	Electrical work	2007	30,630	383	40	383		383	28
29	Duct work	2007	18,266	228	40	228		228	29
30	Smoke detectors	2007	7,966	398	10	398		398	30
31	Electrical work	2007	13,558	169	40	169		169	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,261,950	\$ 350,394		\$ 354,086	\$ 3,692	\$ 3,539,942	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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	\$ 1,137,750	\$ 142,214	\$ 143,902	\$ 1,688	5-10 Years	\$ 671,413	71
72	Current Year Purchases	227,319	15,967	15,967		5-10 Years	15,967	72
73	Fully Depreciated Assets	1,652,513	2,457	2,457			1,652,513	73
74								74
75	TOTALS	\$ 3,017,582	\$ 160,638	\$ 162,326	\$ 1,688		\$ 2,339,893	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	See schedule 13a			\$ 237,038	\$ 25,030	\$ 25,033	\$ 3	5	\$ 180,249	76
77										77
78										78
79										79
80	TOTALS			\$ 237,038	\$ 25,030	\$ 25,033	\$ 3		\$ 180,249	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)	\$ 17,091,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 536,062	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 541,445	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,383	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,060,084	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	Non-care related bus	\$ 38,750	\$	\$ 38,750	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 38,750	\$	\$ 38,750	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility, Inc.
 IDPH Facility # 0040543
 9.30.07

Schedule 13A

Schedule XI - D Vehicle Depreciation

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Facility Use	1997 Ford Eldorado Bus	1997	44,290.00			-	5	44,290.00
Medical Transportation	1988 Ford Van	1988	23,216.00			-	5	23,216.00
Facility Use	2000 Chrysler Van	2000	31,930.00	-	-	-	5	31,930.00
Administrative Use	2003 Van	2003	41,902.00	8,380.50	8,380.50	-	5	37,014.50
Facility Use	2004 Van	2004	70,823.00	14,162.00	14,164.67	2.67	5	41,310.34
	Pickup truck	2007	21,500.00	2,150.00	2,150.00	-	5	2,150.00
	Vehicle Parts	2007	3,377.00	338.00	338.00	-	5	338.00
			<u>237,038.00</u>	<u>25,030.50</u>	<u>25,033.17</u>	<u>2.67</u>		<u>180,248.84</u>

See Accountants' Compilation Report

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:				\$ <u>N/A</u>			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. N/A

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease _____.

9. Option to Buy: YES NO Terms: N/A *

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: \$ N/A Description: N/A

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* 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>It is the policy of this facility to only hire certified nurses aides. 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A(1),(3)	3855 hrs	\$ 103,145	261	\$ 19,210		4,116	\$ 122,355	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		545	33,104		545	33,104	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1),(2),(3)	7587 hrs	202,970	102	6,530	1,079	7,689	210,579	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				183,375		183,375	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 306,115	908	\$ 58,844	\$ 184,454	12,350	\$ 549,413	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning: 10/1/06

Ending:

09/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 37,442	\$ 37,442	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	1,574,736	1,574,736	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,863	3,863	5
6	Prepaid Insurance	309,242	309,242	6
7	Other Prepaid Expenses	34,422	34,422	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,959,705	\$ 1,959,705	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,693	574,693	13
14	Buildings, at Historical Cost	9,997,265	10,039,753	14
15	Leasehold Improvements, at Historical Cost	3,207,038	3,222,197	15
16	Equipment, at Historical Cost	3,322,051	3,254,620	16
17	Accumulated Depreciation (book methods)	(5,947,217)	(6,060,084)	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 (spec Finance Fee/Net)	37,760		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,191,590	\$ 11,031,179	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,151,295	\$ 12,990,884	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,444,873	\$ 1,444,873	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	74,388	74,388	29
30	Accrued Salaries Payable	589,563	589,563	30
31	Accrued Taxes Payable (excluding real estate taxes)	(178)	(178)	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	106,252	106,252	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch17A	173,046	173,046	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,387,944	\$ 2,387,944	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,896,282	4,896,282	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)	\$ 4,896,282	\$ 4,896,282	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,284,226	\$ 7,284,226	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,867,069	\$ 5,706,658	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,151,295	\$ 12,990,884	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.06 to 9.30.07

Schedule 17A

XV. Balance Sheet

C. Current Liabilities - Line 36

	Operating	After Consolidation
Resident Credit Balances	\$ (55,990.00)	\$ (55,990.00)
Accrued Wage Assignment	\$ (651.00)	\$ (651.00)
Other Liabilities	\$ (77,411.00)	\$ (77,411.00)
Refunds(Residents/Family)	\$ (38,994.00)	\$ (38,994.00)
Total	\$ (173,046.00)	\$ (173,046.00)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,629,039	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,629,039	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(965,014)	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)	\$ (965,014)	17
	B. Transfers (Itemize):		
18	Interorganization Transfers	2,203,044	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2,203,044	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,867,069	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 12,782,697	1
2	Discounts and Allowances for all Levels	(976,170)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,806,527	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	956,271	6
7	Oxygen	24,227	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 980,498	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	46,307	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	355	15
16	Rental of Facility Space		16
17	Sale of Drugs	286,611	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,321	19
20	Radiology and X-Ray	15,415	20
21	Other Medical Services	659,439	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,040,448	23
	D. Non-Operating Revenue		
24	Contributions	85	24
25	Interest and Other Investment Income***	7,867	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,952	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activities Income	1,564	28
28a	Miscellaneous Income	63	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,627	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,837,052	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,268,786	31
32	Health Care	7,344,896	32
33	General Administration	3,708,026	33
	B. Capital Expense		
34	Ownership	971,340	34
	C. Ancillary Expense		
35	Special Cost Centers	394,951	35
36	Provider Participation Fee	114,067	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,802,066	40
41	Income before Income Taxes (line 30 minus line 40)**	(965,014)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (965,014)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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	1,926	2,126	\$ 74,417	\$ 35.00	1
2	Assistant Director of Nursing	1,917	2,086	69,128	33.14	2
3	Registered Nurses	26,644	71,413	2,051,201	28.72	3
4	Licensed Practical Nurses	16,189	17,674	307,630	17.41	4
5	CNAs & Orderlies	111,335	119,073	1,579,621	13.27	5
6	CNA Trainees					6
7	Licensed Therapist	10,579	11,442	306,115	26.75	7
8	Rehab/Therapy Aides	7,041	7,817	97,077	12.42	8
9	Activity Director	1,758	2,019	29,060	14.39	9
10	Activity Assistants	22,274	23,732	127,900	5.39	10
11	Social Service Workers	7,663	8,411	104,268	12.40	11
12	Dietician					12
13	Food Service Supervisor	1,946	2,178	48,209	22.13	13
14	Head Cook	3,976	4,465	68,293	15.30	14
15	Cook Helpers/Assistants	29,156	32,366	283,657	8.76	15
16	Dishwashers	2,330	2,410	24,189	10.04	16
17	Maintenance Workers	7,805	8,510	158,975	18.68	17
18	Housekeepers	36,303	39,423	353,583	8.97	18
19	Laundry	16,732	18,117	163,821	9.04	19
20	Administrator	3,051	3,611	165,234	45.76	20
21	Assistant Administrator	424	560	16,172	28.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,491	21,378	373,988	17.49	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	6,149	6,909	100,543	14.55	31
32	Other Health C: <u>See PG 20A</u>	19,820	21,543	417,564	19.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	354,509	427,263	\$ 6,920,645 *	\$ 16.20	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	501	\$ 10,812	Ln 1, Col 3	35
36	Medical Director	30	27,075	Ln 9, Col 3	36
37	Medical Records Consultant	25	1,504	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	152	6,600	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	3,024	Ln 11, Col 3	44
45	Social Service Consultant	43	2,328	Ln 12, Col 3	45
46	Other(specify)				46
47	<u>Medical Consultant</u>	Monthly	2,000	Ln 10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	793	\$ 53,343		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	14,238	\$ 591,105	Ln 10, Col 3	50
51	Licensed Practical Nurses	5,483	159,206	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	33,042	698,511	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	52,763	\$ 1,448,822		53

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.06 to 9.30.07

Schedule 20A

XVIII. Staffing and Salary Costs

Line 32 Other Healthcare (specify):

Description	Hours Worked	Hours Paid	Wages	Average Wages
Ward Clerk	3,124	3,395	61,457	18.10
Care Plan Coordinator	4,800	5,218	127,213	24.38
Special Care Unit Manager	1,684	1,831	41,193	22.50
Restorative Services	7,210	7,836	127,343	16.25
Quality Assurance	3,002	3,263	60,358	18.50
	19,820	21,543	417,564	19.38

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning: 10/1/06

Ending: 09/30/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gloria Pindiak	CEO	0	\$ 110,542	Workers' Compensation Insurance	\$ 122,856	IDPH License Fee	\$	
Clara Leonard	Administrator	0	70,864	Unemployment Compensation Insurance	172	Advertising: Employee Recruitment	32,811	
				FICA Taxes	514,457	Health Care Worker Background Check		
				Employee Health Insurance	347,830	(Indicate # of checks performed 86)	1,030	
				Employee Meals		Patient Background Checks	500	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	16,798	
				Uniforms	4,112	Miscellaneous Dues	4,265	
				Employee Appreciation	17,587	Life Services Network of Illinois	10,995	
				401(k) Expense	31,155	Miscellaneous Subscriptions	1,570	
				Employee Pension	1,385,292	Claims Processing Fees	5,289	
				Life/Disability Insurance	41,617	Less: Public Relations Expense	()	
				Other Employee Benefits	12,099	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 181,406	TOTAL (agree to Schedule V, line 22, col.8)		\$ 78,758		
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							See Attached Schedule 21B	8,376
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
See Attached Schedule 21A			\$ 126,871					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 126,871					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Tabor Hills Health Care Facility, Inc.

Provider #: 0040543

10/01/06 to 09/30/07

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vopenka & Associates	Computer	37,125
HDSI	Computer	7,446
Ivans	Computer	778
Accu-Med Services	Computer	3,270
Comcast	Computer	798
Nebo Systems, Inc.	Computer	160
RSM McGladrey	Audit & Accounting	62,112
Wessels & Pautsch	Legal	675
Erickson Papanek Peterson Erickson	Legal	1,638
Duane Morris	Legal	6,333
Foley & Lardner LLP	Legal	500
Smith, Hemmesch, Burke, Brannigan, & Guerin	Legal	6,000
Hovell & Associates	Legal	36
Total (agree to Schedule V, line 19, column 3)		<u>126,871</u>
Non-Allowable Legal Fees		(7,211)
Total (agree to Schedule V, line 19, column 8)		<u><u>119,660</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/06

Ending:

09/30/07

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. Life Services Network of Illinois - \$10,995
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 120,320 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 114,067
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? No Indicate the amount. \$ N/A
- (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? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (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