

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

I. IDPH License ID Number: 0040543

Facility Name: Tabor Hills Health Care Facility

Address: 1347 Crystal Court Naperville 60563
 Number City Zip Code

County: DuPage

Telephone Number: (630) 778-6077 Fax # (630) 778-6680

HFS ID Number: 36386746001

Date of Initial License for Current Owners: 4/25/95

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: Michael W. Martin Telephone Number: (217) 258-8888
 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 10/1/08 to 9/30/09 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____

(Print Name and Title) _____

(Firm Name & Address) McGladrey & Pullen, LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173

(Telephone) (847) 413-6400 Fax # (847) 517-7067

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543 Report Period Beginning: 10/1/08 Ending: 9/30/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	211	Skilled (SNF)	211	77,015	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	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	1,019	4,640	8,363	14,022	8
9	SNF/PED					9
10	ICF	23,905	30,737	10	54,652	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,924	35,377	8,373	68,674	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.17%

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

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 4/28/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/28/95 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 7,953

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/09 Fiscal Year: 9/30/09

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

Facility Name & ID Number

Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/08

Ending:

9/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	443,052	30,691	11,077	484,820		484,820	484,820			1
2	Food Purchase		377,666		377,666		377,666	377,666			2
3	Housekeeping	341,959	121,708	72,411	536,078		536,078	536,078			3
4	Laundry	141,051	49,866		190,917		190,917	190,917			4
5	Heat and Other Utilities			318,161	318,161		318,161	318,161			5
6	Maintenance	190,310	51,518	152,020	393,848		393,848	393,848			6
7	Other (specify):*										7
8	TOTAL General Services	1,116,372	631,449	553,669	2,301,490		2,301,490	2,301,490			8
	B. Health Care and Programs										
9	Medical Director			29,175	29,175		29,175	29,175			9
10	Nursing and Medical Records	5,451,229	527,922	740,151	6,719,302		6,719,302	6,719,302			10
10a	Therapy	287,767	1,107	160,745	449,619		449,619	449,619			10a
11	Activities	167,550	1,881	4,791	174,222		174,222	174,222			11
12	Social Services	93,782	932	5,108	99,822		99,822	99,822			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,000,328	531,842	939,970	7,472,140		7,472,140	7,472,140			16
	C. General Administration										
17	Administrative	138,572			138,572		138,572	138,572			17
18	Directors Fees										18
19	Professional Services			210,136	210,136		210,136	(2,313)	207,823		19
20	Dues, Fees, Subscriptions & Promotions			27,469	27,469		27,469		27,469		20
21	Clerical & General Office Expenses	361,221	66,312	56,920	484,453		484,453	(11,564)	472,889		21
22	Employee Benefits & Payroll Taxes			2,770,588	2,770,588		2,770,588		2,770,588		22
23	Inservice Training & Education			2,305	2,305		2,305		2,305		23
24	Travel and Seminar			9,890	9,890		9,890		9,890		24
25	Other Admin. Staff Transportation			20,607	20,607		20,607		20,607		25
26	Insurance-Prop.Liab.Malpractice			373,866	373,866		373,866		373,866		26
27	Other (specify):*										27
28	TOTAL General Administration	499,793	66,312	3,471,781	4,037,886		4,037,886	(13,877)	4,024,009		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,616,493	1,229,603	4,965,420	13,811,516		13,811,516	(13,877)	13,797,639		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:

10/1/08

Ending:

9/30/09

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			568,358	568,358	568,358	4,980	573,338				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			250,288	250,288	250,288	(9,352)	240,936				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			818,646	818,646	818,646	(4,372)	814,274				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,550		262,550	262,550		262,550				39
40	Barber and Beauty Shops			40,318	40,318	40,318		40,318				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523	115,523		115,523				42
43	Other (specify):* Non-allowable cost	64,166		109,132	173,298	173,298	(173,298)					43
44	TOTAL Special Cost Centers	64,166	262,550	264,973	591,689	591,689	(173,298)	418,391				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,680,659	1,492,153	6,049,039	15,221,851	15,221,851	(191,547)	15,030,304				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

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning: 10/1/08

Ending: 9/30/09

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	4,980	30		9
10	Interest and Other Investment Income	(9,352)	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	(36,354)	43		24
25	Fund Raising, Advertising and Promotional	(5,085)	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 PG5A	(145,736)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (191,547)		\$	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))	\$ (191,547)		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						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	

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/1/08

Ending: 9/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Resident Physicians	\$ (7,040)	43 1
2	Miscellaneous Expense	(7,650)	43 2
3	X-Ray Expense	(14,333)	43 3
4	Lab Expense	(35,285)	43 4
5	Travel & Entertainment	(1,630)	43 5
6	Penalties	(1,755)	43 6
7	Telephone	(11,564)	21 7
8	Non-Allowable Legal	(2,313)	19 8
9	Marketing Salary	(64,166)	43 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	(145,736)	49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/08

Ending:

9/30/09

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			N/A				2
3	V							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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/08 Ending: 9/30/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Gloria Pindiak	Administrator	CEO	0.00	0	40+	100.00	Salary	\$ 74,771	L17,C1
2										
3	See attached schedule of Board of Directors									
4										
5										
6										
7										
8										
9										
10										
11										
12										
13								TOTAL	\$ 74,771	

* 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:

10/1/08

Ending: 9/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3				N/A					3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/08 Ending: 9/30/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Illinois Revenue Authority		X	Mortgage	Principal and interest due	11/22/06	\$ 4,970,670	\$ 4,890,731	11/15/36	varies	\$ 250,288					
2					upon											
3					presentment											
4																
5																
Working Capital																
6																
7																
8																
9	TOTAL Facility Related						\$ 4,970,670	\$ 4,890,731			\$ 250,288					
B. Non-Facility Related*																
10								Interest Income			(9,352)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$ (9,352)					
15	TOTALS (line 9+line14)						\$ 4,970,670	\$ 4,890,731			\$ 240,936					

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.)

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tabor Hills Health Care Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0040543

CONTACT PERSON REGARDING THIS REPORT Frances Salinas

TELEPHONE (630) 778-6077 FAX #: (630) 778-6680

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. <u>Facility is a not-for-profit and exempt from real estate tax.</u>	_____	\$ _____	\$ _____
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 N/A NO

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

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543 Report Period Beginning:

10/1/08 Ending:

9/30/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

10/1/08

Ending:

9/30/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211		1995	1995	\$ 10,039,753	\$ 249,932	40	\$ 249,932	\$	\$ 3,635,690	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements		1995	1995	36,958	2,464	15	2,464		35,727	9
10	Improvements		1995	1995	1,421		40	36	36	651	10
11	Sign		1997	1997	500	13	40	13		162	11
12	Electric		1996	1996	656	16	40	16		200	12
13	Humidistats		1996	1996	1,378	34	40	34		425	13
14	Door alarm		1996	1996	854	21	40	21		270	14
15	Plumbing		1996	1996	1,050	26	40	26		325	15
16	Install lights, water heater		1997	1997	2,345	59	40	59		730	16
17	Pipe		1997	1997	618	15	40	15		195	17
18	Electric		1997	1997	3,121	78	40	78		975	18
19	Signs & outlets		1997	1997	2,504	63	40	63		780	19
20	Wall hugging overbed lights		1997	1997	27,302	683	40	683		8,465	20
21	Air compressor		1997	1997	2,078	52	40	52		650	21
22	Roof repair		1997	1997	3,154	79	40	79		980	22
23	Deco-gard products		1997	1997	738	18	40	18		226	23
24	Shelving units		1998	1998	2,317	58	40	58		667	24
25	Chimney cap		1998	1998	945	24	40	24		276	25
26	Access door		1998	1998	2,061	52	40	52		598	26
27	Bumper guards		1998	1998	3,687	92	40	92		1,058	27
28	Land improvement - survey		1998	1998	800		10			800	28
29	Carpeting		1999	1999	67,303	3,928	10	3,928		67,303	29
30	Miniblinds		1999	1999	3,501	322	10	322		3,501	30
31	Vertical blinds		1999	1999	1,974	36	10	36		1,974	31
32	Swingmaster door		1999	1999	2,357	37	10	37		2,357	32
33	Security lock		1999	1999	2,779	115	10	115		2,779	33
34			1999	1999	16,182	811	10	811		16,182	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/08

Ending:

9/30/09

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpeting	2000	\$ 225	\$ 23	10	\$ 23		\$ 206	37
38	Railing & bumper	2000	3,275	82	40	82		781	38
39	Carpeting	2000	41,999	4,200	10	4,200		37,450	39
40	Tile	2001	6,493	162	40	162		1,432	40
41	Courtyard improvements	2001	15,673	392	40	392		3,167	41
42	Architect Fees - Dining Room	2002	58,322	5,832	10	5,832		34,992	42
43	Carpet	2002	3,341	334	10	334		2,338	43
44	Door Alarm	2003	8,254	825	10	825		5,431	44
45	Fountain	2003	2,278	228	10	228		1,463	45
46	Carpet	2003	4,545	455	10	455		2,730	46
47	Therapeutic Garden	2003	135,525	3,388	40	3,388		18,866	47
48	Windows	2003	600	15	40	15		90	48
49	Braille Room Signs	2003	3,156	79	40	79		435	49
50	Flooring & Ceiling Tile	2004	12,755	319	40	319		1,755	50
51	Architect Fees - Dining Room	2004	17,405	435	40	435		2,393	51
52	Air Conditioning	2004	32,155	3,216	10	3,216		17,688	52
53	Plumbing	2004	30,619	765	40	765		4,291	53
54	Doors	2004	12,160	1,216	10	1,216		6,688	54
55	Water Box	2004	1,996	200	10	200		1,100	55
56	Fire Alarm	2004	8,965	897	10	897		4,933	56
57	Driveway	2004	2,750	275	10	275		1,513	57
58	Electric Work & Lighting	2004	213,367	5,334	40	5,334		27,221	58
59	Entryway Renovation	2004	761	19	40	19		95	59
60	Sprinkler System	2004	1,798	45	40	45		225	60
61	Dining Room Renovation	2004	1,915,627	42,911	40	47,891	4,980	230,707	61
62	Bathroom Renovation	2005	2,000	50	40	50		225	62
63	Automatic Door System	2005	3,551	89	40	89		401	63
64	Signs	2006	21,716	543	40	543		1,900	64
65	Door Sensor Locks	2006	18,597	465	40	465		1,627	65
66	Asphalt Parking Lots	2006	7,156	716	10	716		2,505	66
67	Wall Mirrors Therapy Room	2006	2,940	74	40	74		258	67
68	Electrical Work	2006	25,507	638	40	638		2,233	68
69	Wiring	2006	68,676	1,717	40	1,717		6,009	69
70	TOTAL (lines 4 thru 69)		\$ 12,912,523	\$ 334,967		\$ 339,983	\$ 5,016	\$ 4,207,094	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:

10/1/08

Ending:

9/30/09

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	
1	Totals from Page 12A, Carried Forward		\$ 12,912,523	\$ 334,967		\$ 339,983	\$ 5,016	\$ 4,207,094	1
2	Lighting	2006	21,943	549	40	549		1,921	2
3	Exhaust Fans	2006	28,060	702	40	702		2,456	3
4	Heaters	2006	28,826	721	40	721		2,523	4
5	HVAC	2006	71,252	1,781	40	1,781		6,234	5
6	Fountain	2006	39,594	2,640	15	2,640		8,140	6
7	Wall Coverings	2007	6,058	606	10	606		1,515	7
8	Fire Prevention	2007	5,464	546	10	546		1,366	8
9	Exterior Work	2007	7,440	744	10	744		1,860	9
10	Naperville Room improvements	2007	17,034	426	40	426		1,065	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								15
16	Exercise Room improvements	2007	18,807	470	40	470		1,175	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								19
20	Exterior Doors & Frames	2007	8,292	207	40	207		518	20
21	Interior Doors	2007	2,490	62	40	62		155	21
22	1 North Kitchen improvements	2007	8,754	219	40	219		547	22
23	- Removed cabinets, walls, ceiling & flooring - concrete								23
24	floor to install new plumbing drain								24
25	Finance Office improvements	2007	2,622	66	40	66		164	25
26	- Replaced door and walls, taped off and painted								26
27	Carpeting	2007	12,371	1,237	10	1,237		3,093	27
28	Electrical work	2007	30,630	766	40	766		1,915	28
29	Duct work	2007	18,266	457	40	457		1,142	29
30	Smoke detectors	2007	7,966	797	10	797		1,992	30
31	Electrical work	2007	13,558	339	40	339		847	31
32	Landscaping	2008	3,025	202	15	202		219	32
33	Boiler	2008	5,802	145	40	145		218	33
34	TOTAL (lines 1 thru 33)		\$ 13,270,777	\$ 348,649		\$ 353,665	\$ 5,016	\$ 4,246,159	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12B, Carried Forward		\$ 13,270,777	\$ 348,649		\$ 353,665	\$ 5,016	\$ 4,246,159	1
2	Administrative office renovations	2008	28,511	713	40	713		1,069	2
3	- New oak cabinets, closet & shelving, new ceiling tiles, install								3
4	new water cooler								4
5	Duct, fan coil & heating work	2008	12,684	317	40	317		476	5
6	Vinyl Bases	2008	4,914	491	10	491		737	6
7	Electrical work	2008	84,126	2,103	40	2,103		4,031	7
8	Mag Mile Kitchen Improvements	2008	30,844	771	40	771		1,157	8
9	- Renovate oak countertop, light fixtures, kitchen area, and								9
10	vinyl baseboard, replace old kitchen air controllers								10
11	Therapy Office Improvements - wiring, flooring, wall covering	2008	16,734	418	40	418		627	11
12	Flooring	2008	13,497	337	40	337		506	12
13	Water pump	2008	5,794	145	40	145		217	13
14	A/C Unit	2008	10,660	267	40	267		400	14
15	Coil and Freeze Thermostat	2008	5,800	145	40	145		218	15
16									16
17	Interior remodel-Electrical work, carpeting	2009	110,167	1,200	40	1,200		1,200	17
18	Landscaping	2009	2,258	138	15	138		138	18
19	Outdoor Electrical Work	2009	2,572	71	15	71		71	19
20	Landscaping	2009	23,769	264	15	264		264	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	TOTAL (lines 1 thru 33)		\$ 13,623,107	\$ 356,029		\$ 361,045	\$ 5,016	\$ 4,257,270	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:

10/1/08

Ending:

9/30/09

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	\$ 1,464,889	\$ 181,326	\$ 181,290	\$ (36)	5-10 Years	\$ 994,940	71
72	Current Year Purchases	85,389	5,289	5,289		5-10 Years	5,289	72
73	Fully Depreciated Assets	1,707,996					1,707,996	73
74								74
75	TOTALS	\$ 3,258,274	\$ 186,615	\$ 186,579	\$ (36)		\$ 2,708,225	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			\$ 273,151	\$ 25,714	\$ 25,714	\$	5	\$ 231,807	76
77										77
78										78
79										79
80	TOTALS			\$ 273,151	\$ 25,714	\$ 25,714	\$		\$ 231,807	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)	\$ 17,729,225	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 568,358	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 573,338	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,980	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,197,302	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		\$ N/A	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.

Tabor Hills Health Care Facility, Inc.
 IDPH Facility # 0040543
 9.30.09

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			-	5	44,290
Medical Transportation	1988 Ford Van	1988	23,216			-	5	23,216
Facility Use	2000 Chrysler Van	2000	31,930	-	-	-	5	31,229
Administrative Use	2003 Van	2003	41,902	-	-	-	5	41,902
Facility Use	2004 Van	2004	70,823	14,165	14,165	-	5	69,643
	Pickup truck	2007	21,500	4,300	4,300	-	5	10,750
	Vehicle Parts	2007	3,377	675	675	-	5	1,689
Administrative Use	2008 Toyota Sienna	2008	25,138	5,028	5,028	-	5	7,542
	2000 Chevy Tahoe	2009	5,000	750	750		5	750
	Truck	2009	5,975	796	796		5	796
			<u>273,151</u>	<u>25,714</u>	<u>25,714</u>	<u>-</u>		<u>231,807</u>

See Accountants' Compilation Report

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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.

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

N/A

N/A

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)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
						Units	Cost					
1	Licensed Occupational Therapist	L10A(1),(3)	1280	hrs	\$ 54,247		1,979	\$ 111,613	\$	3,259	\$ 165,860	1
2	Licensed Speech and Language Development Therapist	L10A(3)		hrs			618	42,590		618	42,590	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	L10A(1),(2),(3)	5512	hrs	233,520		94	6,542	1,107	5,606	241,169	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	L39(2)		# of prescripts					262,550		262,550	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL				\$ 287,767		2,691	\$ 160,745	\$ 263,657	9,483	\$ 712,169	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# 0040543Report Period Beginning: 10/1/08

Ending:

9/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09

(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	\$ 34,924	\$ 34,924	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>20,000</u>)	2,205,552	2,205,552	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	108,185	108,185	5
6	Prepaid Insurance	353,662	353,662	6
7	Other Prepaid Expenses	32,392	32,392	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,734,715	\$ 2,734,715	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	3,568,196	3,583,354	15
16	Equipment, at Historical Cost	3,599,396	3,531,425	16
17	Accumulated Depreciation (book methods)	(7,079,455)	(7,197,302)	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):	314,304	314,304	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,974,399	\$ 10,846,227	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,709,114	\$ 13,580,942	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,370,151	\$ 3,370,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	82,160	82,160	29
30	Accrued Salaries Payable	724,827	724,827	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	125,963	125,963	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	341,958	341,958	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,645,059	\$ 4,645,059	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,808,571	4,808,571	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)	\$ 4,808,571	\$ 4,808,571	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,453,630	\$ 9,453,630	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,255,484	\$ 4,127,312	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,709,114	\$ 13,580,942	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10/1/08-9/30/09

Schedule 17A

XV. Balance Sheet

C. Current Liabilities- Line 36

	<u>Operating</u>	<u>After Consolidation</u>
Refunds (Residents/Family)	9,852	9,852
Resident Credit Balances	251,716	251,716
Employee lock deposits	620	620
Beauty Shop Gift Certificates	227	227
Accrued Expenses	26,669	26,669
Other Liab-IDPA Audit	52,874	52,874
	<u>341,958</u>	<u>341,958</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,312,498	1
2	Restatements (describe):		2
3	Prior period adjustment	185,264	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,497,762	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,242,278)	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)	\$ (1,242,278)	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)	\$ 4,255,484	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility# 0040543Report Period Beginning: 10/1/08Ending: 9/30/09

9/30/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,759,470	1
2	Discounts and Allowances for all Levels	(993,266)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,766,204	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,123,232	6
7	Oxygen	25,874	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,149,106	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	37,863	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	301,932	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,606	19
20	Radiology and X-Ray	11,489	20
21	Other Medical Services	653,577	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,042,467	23
D. Non-Operating Revenue			
24	Contributions	130	24
25	Interest and Other Investment Income***	9,352	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,482	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	12,314	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,314	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,979,573	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,301,490	31
32	Health Care	7,472,140	32
33	General Administration	4,037,886	33
B. Capital Expense			
34	Ownership	818,646	34
C. Ancillary Expense			
35	Special Cost Centers	476,166	35
36	Provider Participation Fee	115,523	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,221,851	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,242,278)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,242,278)	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.

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
9/30/2009

Schedule XVII. Income Statement
Line 28

Schedule 19A

<u>Description</u>	<u>Amount</u>
Public Aid Application Fee	750
Resident Telephone Private	11,564
	<u>12,314</u>

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility

0040543

Report Period Beginning:

10/1/08

Ending:

9/30/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,902	2,086	\$ 75,654	\$ 36.27	1
2	Assistant Director of Nursing	1,969	2,086	73,158	35.07	2
3	Registered Nurses	69,035	74,429	2,181,108	29.30	3
4	Licensed Practical Nurses	28,865	30,663	635,969	20.74	4
5	CNAs & Orderlies	128,265	135,990	1,842,984	13.55	5
6	CNA Trainees					6
7	Licensed Therapist	6,314	6,792	287,767	42.37	7
8	Rehab/Therapy Aides	10,261	11,151	121,334	10.88	8
9	Activity Director	1,961	2,167	33,331	15.38	9
10	Activity Assistants	12,287	13,355	134,219	10.05	10
11	Social Service Workers	7,308	7,917	93,782	11.85	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,166	51,313	23.69	13
14	Head Cook	5,950	6,730	99,351	14.76	14
15	Cook Helpers/Assistants	28,356	30,491	289,547	9.50	15
16	Dishwashers	261	261	2,841	10.89	16
17	Maintenance Workers	10,687	11,312	190,310	16.82	17
18	Housekeepers	40,303	42,505	341,959	8.05	18
19	Laundry	13,710	14,335	141,051	9.84	19
20	Administrator	3,725	4,171	138,572	33.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,130	27,678	361,221	13.05	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	6,517	6,934	109,585	15.80	31
32	Other Health Care: <u>Marketing</u>	3,868	4,205	64,166	15.26	32
33	Other(specify) <u>See Sch. 20.A</u>	19,164	20,751	411,437	19.83	33
34	TOTAL (lines 1 - 33)	427,860	458,175	\$ 7,680,659 *	\$ 16.76	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	196	\$ 11,077	1(3)	35
36	Medical Director	396	29,175	9(3)	36
37	Medical Records Consultant	92	1,536	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	364	10,264	10(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	33	1,906	11(3)	44
45	Social Service Consultant	73	5,108	12(3)	45
46	Other(specify) <u>Alzheimer</u>	78	4,472	10(3)	46
47	<u>Medical Consultant</u>	Monthly	2,400	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	1,232	\$ 65,938		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,164	\$ 267,419	10(3)	50
51	Licensed Practical Nurses	2,925	90,890	10(3)	51
52	Certified Nurse Assistants/Aides	17,940	365,090	10(3)	52
53	TOTAL (lines 50 - 52)	27,029	\$ 723,399		53

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10/1/08-9/30/09

Schedule 20.A

XVIII. Staffing and Salary Costs
Line 32 Other Healthcare (specify):

Description	Hours Worked	Hours Paid	Wages	Average Wages
Ward Clerk	1,174	1,276	23,099	\$ 18.10
Care Plan Coordinator	4,602	4,922	128,834	\$ 26.18
Special Care Unit Manager	2,276	2,474	55,666	\$ 22.50
Restorative Services	8,021	8,719	141,676	\$ 16.25
Quality Assurance	3,091	3,360	62,162	\$ 18.50
	19,164	20,751	411,437	\$ 19.83

Tabor Hills Health Care Facility, Inc.
Provider # 0040543
10/1/08-9/30/09

Schedule 21C

XIX. Support Schedule
C. Professional Services

<u>Name</u>	<u>Type</u>	<u>Amount</u>
IVANS	Computer	1,513
Comcast	Computer	1,799
Accu-Med	Computer	3,025
Vopenka & Associates	Computer	78,134
Nebo Systems	Computer	266
HDSI	Computer	6,303
McGladrey & Pullen	Accounting	48,760
RSM McGladrey	Accounting	10,163
Comprehensive Business	Business Consulti	1,480
Intech Consultants, Inc.	Business Consulti	196
Prudential	Actuary	5,306
Wessels & Pautsch, P.C.	Legal	725
Dommermuth, Brestal, Cobine, & West LTD.	Legal	14,849
Duane Morris LLP	Legal	748
Polsinelli, Shalton, Flanigan, Suelthaus PC	Legal	26,128
Smith, Hemmesch, Burke, Brannigan & Guer	Legal	2,900
Erickson, Papanek Hanson	Legal	7,841
Total (agree to Schedule V, line 19, column 3)		<u>210,136</u>
		210,136
		-
Less: Out of period legal		(1,588)
Less: Non-Allowable legal		<u>(725)</u>
Total (agree to Schedule V, line 19, column 8)		<u>207,823</u>

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility

Report Period Beginning: 10/1/08

Ending:

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
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: 10/1/08

Ending: 9/30/09

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- \$12,516
- (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. \$ 102,444 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 115,523
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? 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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT