FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0040543

Facility Name: Tabor Hills Health Care Facility

Address: 1347 Crystal Avenue (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) 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) 517-7070 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: 10/1/09 Ending: 9/30/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 6/25/2010

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	211	Skilled (SNF)	192	75,153	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	19	1,862	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,407	5,843	7,621	14,871	8
9	SNF/PED					9
10	ICF	27,022	27,656	9	54,687	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,429	33,499	7,630	69,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.32%

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 [X] 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 [X]

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 [X] Date 4/28/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 7,120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/10 Fiscal Year: 9/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	458,972	28,551	10,968	498,491		498,491		498,491			1
2	Food Purchase		422,768		422,768		422,768		422,768			2
3	Housekeeping	371,393	127,834		499,227		499,227		499,227			3
4	Laundry	134,828	56,356		191,184		191,184		191,184			4
5	Heat and Other Utilities			291,530	291,530		291,530		291,530			5
6	Maintenance	211,662	42,009	229,483	483,154		483,154		483,154			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,176,855	677,518	531,981	2,386,354		2,386,354		2,386,354			8
	B. Health Care and Programs											
9	Medical Director			30,065	30,065		30,065		30,065			9
10	Nursing and Medical Records	5,959,291	525,805	65,245	6,550,341		6,550,341		6,550,341			10
10a	Therapy	370,279	1,279	132,442	504,000		504,000		504,000			10a
11	Activities	199,403	90	3,448	202,941		202,941		202,941			11
12	Social Services	103,437	82	1,666	105,185		105,185		105,185			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,632,410	527,256	232,866	7,392,532		7,392,532		7,392,532			16
	C. General Administration											
17	Administrative	143,202			143,202		143,202		143,202			17
18	Directors Fees											18
19	Professional Services			255,230	255,230		255,230	(4,553)	250,677			19
20	Dues, Fees, Subscriptions & Promotions			25,706	25,706		25,706	(850)	24,856			20
21	Clerical & General Office Expenses	382,544	57,110	38,627	478,281		478,281	(16,052)	462,229			21
22	Employee Benefits & Payroll Taxes			1,903,953	1,903,953		1,903,953		1,903,953			22
23	Inservice Training & Education			2,785	2,785		2,785		2,785			23
24	Travel and Seminar			5,524	5,524		5,524		5,524			24
25	Other Admin. Staff Transportation			27,559	27,559		27,559		27,559			25
26	Insurance-Prop.Liab.Malpractice			134,172	134,172		134,172		134,172			26
27	Other (specify):*											27
28	**TOTAL General Administration**	525,746	57,110	2,393,556	2,976,412		2,976,412	(21,455)	2,954,957			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,335,011	1,261,884	3,158,403	12,755,298		12,755,298	(21,455)	12,733,843			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: 10/1/09 Ending: 9/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			540,179	540,179		540,179	4,304	544,483			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			250,288	250,288		250,288	(24,733)	225,555			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			790,467	790,467		790,467	(20,429)	770,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		222,783		222,783		222,783		222,783			39
40	Barber and Beauty Shops			34,203	34,203		34,203		34,203			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 Cos	67,576		133,357	200,933		200,933	(200,933)				43
44	**TOTAL Special Cost Centers**	67,576	222,783	283,083	573,442		573,442	(200,933)	372,509			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,402,587	1,484,667	4,231,953	14,119,207		14,119,207	(242,817)	13,876,390			45

***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

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,304	30		9
10	Interest and Other Investment Income	(24,733)	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	(34,095)	43		24
25	Fund Raising, Advertising and Promotional	(9,971)	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	(178,322)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (242,817)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (242,817)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/1/09

Ending: 9/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Resident Physicians	$ (9,913)	43	1
2	Miscellaneous Expense	(5,359)	43	2
3	X-Ray Expense	(19,552)	43	3
4	Lab Expense	(43,174)	43	4
5	Travel & Entertainment	(1,293)	43	5
6	Penalties	(10,000)	43	6
7	Telephone	(16,052)	21	7
8	Non-Allowable Legal	(4,553)	19	8
9	Marketing Salary	(67,576)	43	9
10	Non-Care Related License Fees	(850)	20	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**	(178,322)		49

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								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.**

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Gloria Pindiak	Administrator	CEO	0.00	0	40+	100.00	Salary	$ 77,207	L17,C1	1
2											2
3	See attached schedule of Board of Directors										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,207		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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: 10/1/09 Ending: 9/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Revenue Authority		X	Mortgage	Principal and	11/22/06	$ 4,970,670	$ 4,890,731	11/15/36	Varies	$ 250,288	1
2					interest due							2
3					upon							3
4					presentment							4
5					(semi-annually)							5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,970,670	$ 4,890,731			$ 250,288	9
	B. Non-Facility Related*											
10									Interest Income		(24,733)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (24,733)	14
15	TOTALS (line 9+line14)						$ 4,970,670	$ 4,890,731			$ 225,555	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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.)

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.) **2009**	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 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:		
2005		8
2006		9
2007		10
2008		11
2009		12

Facility is a not-for-profit entity and exempt from real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility is a not-for-profit and exempt from real estate tax.		$	$
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 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (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 [X] 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	Facility	264,519	1995	$ 574,693	1
2					2
3	TOTALS	264,519		$ 574,693	3

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 10,039,753	$ 249,932	40	$ 249,932	$	$ 3,885,622	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1995	36,958	1,231	15	1,231		36,958	9
10	Improvements			1995	1,421		40	36	36	687	10
11	Sign			1997	500	13	40	13		175	11
12	Electric			1996	656	16	40	16		216	12
13	Humidistats			1996	1,378	34	40	34		459	13
14	Door alarm			1996	854	21	40	21		291	14
15	Plumbing			1996	1,050	26	40	26		351	15
16	Install lights, water heater			1997	2,345	59	40	59		789	16
17	Pipe			1997	618	15	40	15		210	17
18	Electric			1997	3,121	78	40	78		1,053	18
19	Signs & outlets			1997	2,504	63	40	63		843	19
20	Wall hugging overbed lights			1997	27,302	683	40	683		9,148	20
21	Air compressor			1997	2,078	52	40	52		702	21
22	Roof repair			1997	3,154	79	40	79		1,059	22
23	Deco-gard products			1997	738	18	40	18		244	23
24	Shelving units			1998	2,317	58	40	58		725	24
25	Chimney cap			1998	945	24	40	24		300	25
26	Access door			1998	2,061	52	40	52		650	26
27	Bumper guards			1998	3,687	92	40	92		1,150	27
28	Land improvement - survey			1998	800		10			800	28
29	Carpeting			1999	67,303		10			67,303	29
30	Miniblinds			1999	3,501		10			3,501	30
31	Vertical blinds			1999	1,974		10			1,974	31
32	Swingmaster door			1999	2,357		10			2,357	32
33	Security lock			1999	2,779		10			2,779	33
34				1999	16,182		10			16,182	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2000	$ 225	$ 19	10	$ 19	$	$ 225	37
38	Railing & bumper	2000	3,275	82	40	82		863	38
39	Carpeting	2000	41,999	4,200	10	4,200		41,650	39
40	Tile	2001	6,493	162	40	162		1,594	40
41	Courtyard improvements	2001	15,673	392	40	392		3,559	41
42	Architect Fees - Dining Room	2002	58,322	5,832	10	5,832		40,824	42
43	Carpet	2002	3,341	334	10	334		2,672	43
44	Door Alarm	2003	8,254	825	10	825		6,256	44
45	Fountain	2003	2,278	228	10	228		1,691	45
46	Carpet	2003	4,545	455	10	455		3,185	46
47	Therapeutic Garden	2003	135,525	3,388	40	3,388		22,254	47
48	Windows	2003	600	15	40	15		105	48
49	Braille Room Signs	2003	3,156	79	40	79		514	49
50	Flooring & Ceiling Tile	2004	12,755	319	40	319		2,074	50
51	Architect Fees - Dining Room	2004	17,405	435	40	435		2,828	51
52	Air Conditioning	2004	32,155	3,216	10	3,216		20,904	52
53	Plumbing	2004	30,619	765	40	765		5,056	53
54	Doors	2004	12,160	1,216	10	1,216		7,904	54
55	Water Box	2004	1,996	200	10	200		1,300	55
56	Fire Alarm	2004	8,965	897	10	897		5,830	56
57	Driveway	2004	2,750	275	10	275		1,788	57
58	Electric Work & Lighting	2004	213,367	5,334	40	5,334		32,555	58
59	Entryway Renovation	2004	761	19	40	19		114	59
60	Sprinkler System	2004	1,798	45	40	45		270	60
61	Dining Room Renovation	2004	1,915,627	42,911	40	47,891	4,980	278,598	61
62	Bathroom Renovation	2005	2,000	50	40	50		275	62
63	Automatic Door System	2005	3,551	89	40	89		490	63
64	Signs	2006	21,716	543	40	543		2,443	64
65	Door Sensor Locks	2006	18,597	465	40	465		2,092	65
66	Asphalt Parking Lots	2006	7,156	716	10	716		3,221	66
67	Wall Mirrors Therapy Room	2006	2,940	74	40	74		332	67
68	Electrical Work	2006	25,507	638	40	638		2,871	68
69	Wiring	2006	68,676	1,717	40	1,717		7,726	69
70	TOTAL (lines 4 thru 69)		$ 12,912,523	$ 328,481		$ 333,497	$ 5,016	$ 4,540,591	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,912,523	$ 328,481		$ 333,497	$ 5,016	$ 4,540,591	1
2	Lighting	2006	21,943	549	40	549		2,470	2
3	Exhaust Fans	2006	28,060	702	40	702		3,158	3
4	Heaters	2006	28,826	721	40	721		3,244	4
5	HVAC	2006	71,252	1,781	40	1,781		8,015	5
6	Fountain	2006	39,594	2,640	15	2,640		10,780	6
7	Wall Coverings	2007	6,058	606	10	606		2,121	7
8	Fire Prevention	2007	5,464	546	10	546		1,912	8
9	Exterior Work	2007	7,440	744	10	744		2,604	9
10	Naperville Room improvements	2007	17,034	426	40	426		1,491	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		1,645	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		725	20
21	Interior Doors	2007	2,490	62	40	62		217	21
22	1 North Kitchen improvements	2007	8,754	219	40	219		766	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		230	25
26	- Replaced door and walls, taped off and painted								26
27	Carpeting	2007	12,371	1,237	10	1,237		4,330	27
28	Electrical work	2007	30,630	766	40	766		2,681	28
29	Duct work	2007	18,266	457	40	457		1,599	29
30	Smoke detectors	2007	7,966	797	10	797		2,789	30
31	Electrical work	2007	13,558	339	40	339		1,186	31
32	Landscaping	2008	3,025	202	15	202		421	32
33	Boiler	2008	5,802	145	40	145		363	33
34	TOTAL (lines 1 thru 33)		$ 13,270,777	$ 342,163		$ 347,179	$ 5,016	$ 4,593,338	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,270,777	$ 342,163		$ 347,179	$ 5,016	$ 4,593,338	1
2	Administrative office renovations	2008	28,511	713	40	713		1,782	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		793	5
6	Vinyl Bases	2008	4,914	491	10	491		1,228	6
7	Electrical work	2008	84,126	2,103	40	2,103		6,134	7
8	Mag Mile Kitchen Improvements	2008	30,844	771	40	771		1,928	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		1,045	11
12	Flooring	2008	13,497	337	40	337		843	12
13	Water pump	2008	5,794	145	40	145		362	13
14	A/C Unit	2008	10,660	267	40	267		667	14
15	Coil and Freeze Thermostat	2008	5,800	145	40	145		363	15
16									16
17	Interior remodel-Electrical work, carpeting	2009	110,167	2,754	40	2,754		3,954	17
18	Landscaping	2009	2,258	151	15	151		289	18
19	Outdoor Electrical Work	2009	2,572	171	15	171		242	19
20	Landscaping	2009	23,769	1,585	15	1,585		1,849	20
21									21
22	Repair roof leak, replace ceiling tiles & sprinkler lines	2010	3,955	100	40	100		100	22
23	Remodel reception area and admission office	2010	8,447	194	40	194		194	23
24	Remodel work for Admission office	2010	4,973	93	40	93		93	24
25	Remodel new storage space and office for Therapy office	2010	13,253	155	40	155		155	25
26	Remodel exercise room & kitchen in Financial service	2010	9,774	102	40	102		102	26
27									27
28	Roof concrete repair	2010	7,926	50	40	50		50	28
29	Remodel beauty shop (remove & replace wallcover)	2010	3,904	24	40	24		24	29
30	Remodel Elevator lobby & adjacent corridor	2010	12,662	53	40	53		53	30
31	Remodel new ceiling for beauty shop and remove existing hand rai	2010	4,469	19	40	19		19	31
32	Remodel new ceiling front hallway and Admission office	2010	17,957	75	40	75		75	32
33	Remodel front entry, ice cream parlor, & building permits	2010	37,734	79	40	79		79	33
34	TOTAL (lines 1 thru 33)		$ 13,748,161	$ 353,473		$ 358,489	$ 5,016	$ 4,615,759	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 13,748,161	$ 353,473		$ 358,489	$ 5,016	$ 4,615,759	1
2	Electrical Maintenance	2010	3,348	7	40	7		7	2
3	Interior Design - Remodel Elevator lobby & adjacent corridor	2010	6,682		40	84	84	84	3
4	Carpenter - remodel CEO office & Garden dining room	2010	162,053	338	40	338		338	4
5	Carpenter - remodel beauty parlor	2010	3,943		40	49	49	49	5
6									6
7	Miscellaneous Adjustment			845			(845)		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	TOTAL (lines 1 thru 33)		$ 13,924,186	$ 354,663		$ 358,967	$ 4,304	$ 4,616,237	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,550,278	$ 164,364	$ 164,364	$	5-10 Years	$ 1,164,593	71
72	Current Year Purchases	119,605	5,274	5,274		5-10 Years	5,274	72
73	Fully Depreciated Assets	1,707,996					1,707,996	73
74								74
75	TOTALS	$ 3,377,879	$ 169,638	$ 169,638	$		$ 2,877,863	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			$ 298,151	$ 15,878	$ 15,878	$	5	$ 247,685	76
77										77
78										78
79										79
80	TOTALS			$ 298,151	$ 15,878	$ 15,878	$		$ 247,685	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)	$ 18,174,909	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 540,179	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 544,483	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,304	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,741,785	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
9.30.10

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	1,180	1,180	-	5	70,823
	Pickup truck	2007	21,500	4,300	4,300	-	5	15,050
	Vehicle Parts	2007	3,377	675	675	-	5	2,364
Administrative Use	2008 Toyota Sienna	2008	25,138	5,028	5,028	-	5	12,570
	2000 Chevy Tahoe	2009	5,000	1,000	1,000		5	1,750
	Truck	2009	5,975	1,195	1,195		5	1,991
Facility Use	Van	2010	25,000	2,500	2,500		5	2,500
			298,151	15,878	15,878	-		247,685

See Accountants' Compilation Report

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

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 [X] 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:				$ N/A			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 *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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			$ N/A	$	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

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

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

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

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

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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A(1),(3)	2010 hrs	$ 94,518	1,257	$ 81,780	$	3,267	$ 176,298	1
2	Licensed Speech and Language Development Therapist	L10A(3)	hrs		676	44,489		676	44,489	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A(1),(2),(3)	5865 hrs	275,761	114	6,173	1,279	5,979	283,213	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 prescrpts				222,783		222,783	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			$ 370,279	2,047	$ 132,442	$ 224,062	9,922	$ 726,783	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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,673	$ 17,673	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,766,019	1,766,019	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	109,133	109,133	5
6	Prepaid Insurance	416,030	416,030	6
7	Other Prepaid Expenses	32,647	32,647	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,341,502	$ 2,341,502	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	3,869,245	3,884,433	15
16	Equipment, at Historical Cost	3,744,001	3,676,030	16
17	Accumulated Depreciation (book methods)	(7,619,634)	(7,741,785)	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 (spe See Sch 17A	854,790	854,790	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,420,360	$ 11,287,914	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,761,862	$ 13,629,416	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,801,971	$ 2,801,971	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	86,601	86,601	29
30	Accrued Salaries Payable	462,425	462,425	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	155,415	155,415	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	358,524	358,524	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,864,936	$ 3,864,936	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,804,130	4,804,130	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)**	$ 4,804,130	$ 4,804,130	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,669,066	$ 8,669,066	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,092,796	$ 4,960,350	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,761,862	$ 13,629,416	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

Schedule 17A

XV. Balance Sheet
B. Long-Term Assets- Line 22

	Operating	After Consolidation
Due To/Fr SLC	818,326	818,326
Unamortized Bond Premium & Fees	36,464	36,464
	854,790	854,790

XV. Balance Sheet
C. Current Liabilities- Line 36

	Operating	After Consolidation
Refunds (Residents/Family)	852	852
Resident Credit Balances	210,784	210,784
State Income Tax W/H	(6)	(6)
Employee lock deposits	690	690
Beauty Shop Gift Certificates	570	570
Accrued Expenses	3,402	3,402
Employee Life Insurance Premiums	(3,185)	(3,185)
Other Liab-IDPA Audit	144,323	144,323
PA Resident Pharmacy	1,094	1,094
	358,524	358,524

See Accountants' Compilation Report

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,255,484	1
2	Restatements (describe):		2
3	**Equity - Other Entities**	1,020,750	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,276,234	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(183,438)	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)**	$ (183,438)	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)**	$ 5,092,796	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,732,393	1
2	Discounts and Allowances for all Levels	(1,007,952)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,724,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,191,623	6
7	Oxygen	23,512	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,215,135	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	33,609	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	256,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,560	19
20	Radiology and X-Ray	11,410	20
21	Other Medical Services	613,729	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 954,509	23
	D. Non-Operating Revenue		
24	Contributions	60	24
25	Interest and Other Investment Income***	24,733	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,793	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	16,891	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,891	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,935,769	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,386,354	31
32	Health Care	7,392,532	32
33	General Administration	2,976,412	33
	B. Capital Expense		
34	Ownership	790,467	34
	C. Ancillary Expense		
35	Special Cost Centers	457,919	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)***	$ 14,119,207	40
41	**Income before Income Taxes (line 30 minus line 40)****	(183,438)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (183,438)	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
9/30/2010

Schedule XVII. Income Statement
Line 28

Schedule 19A

Description	Amount
Public Aid Application Fee	750
Resident Telephone Private	16,052
Misc. Income	89
	16,891

See Accountants' Compilation Report

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,856	2,214	$ 83,006	$ 37.49	1
2	Assistant Director of Nursing	1,882	2,110	75,353	35.71	2
3	Registered Nurses	76,874	82,148	2,514,400	30.61	3
4	Licensed Practical Nurses	26,404	28,356	632,726	22.31	4
5	CNAs & Orderlies	138,813	149,345	1,971,821	13.20	5
6	CNA Trainees					6
7	Licensed Therapist	7,294	7,876	370,279	47.01	7
8	Rehab/Therapy Aides	11,038	11,909	142,511	11.97	8
9	Activity Director	1,769	2,130	32,989	15.49	9
10	Activity Assistants	23,256	25,193	166,414	6.61	10
11	Social Service Workers	7,668	8,431	103,437	12.27	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,171	51,087	23.53	13
14	Head Cook	6,377	6,886	105,921	15.38	14
15	Cook Helpers/Assistants	27,855	30,566	301,965	9.88	15
16	Dishwashers					16
17	Maintenance Workers	12,411	13,477	211,662	15.71	17
18	Housekeepers	44,922	48,392	371,393	7.67	18
19	Laundry	13,347	14,532	134,828	9.28	19
20	Administrator	2,548	2,928	143,202	48.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,091	26,686	382,544	14.34	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	6,252	7,005	108,796	15.53	31
32	Other Health C: See Sch 20A	19,698	21,221	430,677	20.29	32
33	Other(specify) Marketing	3,761	4,088	67,576	16.53	33
34	TOTAL (lines 1 - 33)	460,063	497,664	$ 8,402,587 *	$ 16.88	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	263	$ 10,968	1(3)	35
36	Medical Director	364	30,065	9(3)	36
37	Medical Records Consultant	61	1,560	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	458	11,399	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	28	1,468	11(3)	44
45	Social Service Consultant	15	1,666	12(3)	45
46	Other(specify) Alzheimer	14	812	10(3)	46
47	Medical Consultant	Monthly	2,400	10(3)	47
48	See Sch 20A		(5,270)	10(3)	48
49	TOTAL (lines 35 - 48)	1,203	$ 55,068		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	36	$ 1,760	10(3)	50
51	Licensed Practical Nurses	1,439	52,584	10(3)	51
52	Certified Nurse Assistants/Aides			10(3)	52
53	TOTAL (lines 50 - 52)	1,475	$ 54,344		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

Schedule 20A

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

Description	Hours Wo	Hours Paid	Wages	Average Wages
Ward Clerk	1,236	1,344	24,319	$ 18.09
Care Plan Coordinator	4,994	5,239	151,476	$ 28.91
Special Care Unit Manager	1,335	1,451	32,647	$ 22.50
Restorative Services	8,888	9,660	156,991	$ 16.25
Quality Assurance	3,245	3,527	65,244	$ 18.50
	19,698	21,221	430,677	$ 20.29

XVIII. Staffing and Salary Costs
Line 48 Other Healthcare (specify):

Description	Hours Pd	Cost	Reference
MDS/Care Plan Consultant	Monthly	3,000	10(3)
Destruction of Old Records	Monthly	560	10(3)
Return on Accts. Payable	Monthly	(8,830)	10(3)
		(5,270)	

See Accountants' Compilation Report

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Rodriquez	Administrator	0	$ 65,995
Gloria Pindiak	CEO	0	77,207
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,202

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule 21C		$ 255,230
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 255,230

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 223,428
Unemployment Compensation Insurance	2,715
FICA Taxes	653,654
Employee Health Insurance	493,448
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	6,075
Employee Appreciation	6,729
401(k) Expense	41,258
Employee Pension	397,904
Life/Disability Insurance	44,012
Other Employee Benefits	34,730
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,903,953

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	2,505
Health Care Worker Background Check	
(Indicate # of checks performed 394)	4,731
Patient Background Checks	
Miscellaneous Licenses & Fees	2,311
Miscellaneous Dues	2,430
Life Service Network of Illinois	11,965
Miscellaneous Subscriptions	769
Less: Non-Facility Related License Fees	(850)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,856

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,524
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,524

* Attach copy of IMRF notifications

**See instructions.

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

Schedule 21C

XIX. Support Schedule
C. Professional Services

Name	Type	Amount
IVANS	Computer	1,286
Comcast	Computer	1,799
Accu-Med	Computer	4,750
Vopenka & Associates	Computer	108,554
Nebo Systems	Computer	242
HDSI	Computer	6,843
McGladrey & Pullen	Accounting	44,259
RSM McGladrey	Accounting	6,000
Crowe Horwath LLP	Accounting	22,457
Standard Insurance Company	Retirement Planning	900
Chubb Specialty	Insurance	22,500
Rosanova & Whitaker	Legal	3,715
Wessels & Pautsch, P.C.	Legal	670
Dommermuth, Brestal, Cobine, & West LTD.	Legal	60
Duane Morris LLP	Legal	1,892
Polsinelli, Shalton, Flanigan, Suelthaus PC	Legal	17,342
Smith, Hemmesch, Burke, Brannigan & Guerin	Legal	2,860
Erickson, Papanek Hanson	Legal	9,101
Total (agree to Schedule V, line 19, column 3)		255,230

Less: Out of period legal	(4,553)
Less: Non-Allowable legal	-
Total (agree to Schedule V, line 19, column 8)	250,677

See Accountants' Compilation Report

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

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								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: 10/1/09 Ending: 9/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois-$11,965**

(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. $ **101,505** 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. $ **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.

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, LLP**

(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.