

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0040543</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Tabor Hills Health Care Facility, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/10</u> to <u>9/30/11</u> 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.																							
Address: <u>1347 Crystal Court</u> <u>Naperville</u> <u>60563</u>																									
Number City Zip Code																									
County: <u>DuPage</u>																									
Telephone Number: <u>(630) 778-6077</u> Fax # <u>(630) 778-6680</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>																								
	(Telephone) <u>(847) 517-7070</u> Fax # <u>(847) 517-7067</u>																								
Date of Initial License for Current Owners: <u>4/25/95</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code <u>501 (c)(3)</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 258-8888</u> Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility, Inc.

0040543 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	<u>192</u>	Skilled (SNF)	<u>192</u>	<u>70,080</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>19</u>	Intermediate (ICF)	<u>19</u>	<u>6,935</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>211</u>	TOTALS	<u>211</u>	<u>77,015</u>	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	<u>4,096</u>	<u>5,847</u>	<u>7,211</u>	<u>17,154</u>	8
9	SNF/PED					9
10	ICF	<u>19,219</u>	<u>29,436</u>		<u>48,655</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,315</u>	<u>35,283</u>	<u>7,211</u>	<u>65,809</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.45%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 6,929

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 9/30/11 Fiscal Year: 9/30/11

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

Facility Name & ID Number Tabor Hills Health Care Facility, Inc. # 0040543 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	466,856	30,783	11,668	509,307		509,307		509,307			1
2	Food Purchase		433,411		433,411		433,411		433,411			2
3	Housekeeping	363,351	142,647		505,998		505,998		505,998			3
4	Laundry	146,903	68,940		215,843		215,843		215,843			4
5	Heat and Other Utilities			284,361	284,361		284,361		284,361			5
6	Maintenance	219,277	42,042	280,381	541,700		541,700	(28,440)	513,260			6
7	Other (specify):*											7
8	TOTAL General Services	1,196,387	717,823	576,410	2,490,620		2,490,620	(28,440)	2,462,180			8
	B. Health Care and Programs											
9	Medical Director			30,972	30,972		30,972		30,972			9
10	Nursing and Medical Records	5,797,882	534,997	124,803	6,457,682		6,457,682		6,457,682			10
10a	Therapy	436,868	386	67,469	504,723		504,723		504,723			10a
11	Activities	292,007	363	5,014	297,384		297,384		297,384			11
12	Social Services	109,407	419	1,223	111,049		111,049		111,049			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,636,164	536,165	229,481	7,401,810		7,401,810		7,401,810			16
	C. General Administration											
17	Administrative	162,978			162,978		162,978		162,978			17
18	Directors Fees											18
19	Professional Services			236,220	236,220		236,220	(14,768)	221,452			19
20	Dues, Fees, Subscriptions & Promotions			18,411	18,411		18,411		18,411			20
21	Clerical & General Office Expenses	398,900	55,338	42,109	496,347		496,347	(17,226)	479,121			21
22	Employee Benefits & Payroll Taxes			2,268,010	2,268,010		2,268,010		2,268,010			22
23	Inservice Training & Education			2,425	2,425		2,425		2,425			23
24	Travel and Seminar			17,836	17,836		17,836		17,836			24
25	Other Admin. Staff Transportation			25,300	25,300		25,300		25,300			25
26	Insurance-Prop.Liab.Malpractice			200,648	200,648		200,648	5,157	205,805			26
27	Other (specify):*											27
28	TOTAL General Administration	561,878	55,338	2,810,959	3,428,175		3,428,175	(26,837)	3,401,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,394,429	1,309,326	3,616,850	13,320,605		13,320,605	(55,277)	13,265,328			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.

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			545,542	545,542		545,542	6,013	551,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			250,288	250,288		250,288	(10,441)	239,847			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			795,830	795,830		795,830	(4,428)	791,402			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		218,115		218,115		218,115		218,115			39
40	Barber and Beauty Shops			33,727	33,727		33,727		33,727			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):* Non-Allow Costs	69,472		167,391	236,863		236,863	(236,863)				43
44	TOTAL Special Cost Centers	69,472	218,115	316,641	604,228		604,228	(236,863)	367,365			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,463,901	1,527,441	4,729,321	14,720,663		14,720,663	(296,568)	14,424,095			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

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	6,013	30		9
10	Interest and Other Investment Income	(10,441)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(118)	43		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	(78,242)	43		24
25	Fund Raising, Advertising and Promotional	(9,916)	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	(203,864)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (296,568)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (296,568)		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

Report Period Beginning:
Ending:

ID# 0040543
10/1/10
9/30/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Resident Physicians	\$ (17,263)	43	1
2	Miscellaneous Expense	(2,226)	43	2
3	X-Ray Expense	(21,905)	43	3
4	Lab Expense	(37,295)	43	4
5	Travel & Entertainment	(426)	43	5
6	Telephone	(17,184)	21	6
7	Non-Allowable Legal	(9,611)	19	7
8	Marketing Salary	(69,472)	43	8
9	Miscellaneous Income Offset	(42)	21	9
10	Reclass from Repairs & Maintenance	(28,440)	6	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	(203,864)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	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			\$			\$	\$ *	0 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 95,457	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	\$ 95,457		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 9/30/11

()

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	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 Offset			(10,441)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (10,441)	14
15	TOTALS (line 9+line14)						\$ 4,970,670	\$ 4,890,731			\$ 239,847	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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.)		2010	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2011 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:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		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 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Tabor Hills Health Care Facility, Inc.	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 2010 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 2010.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>Facility is a not-for-profit and exempt from real estate tax.</u>		\$ <u> </u>	\$ <u> </u>
2.	<u> </u>			

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES	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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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?

☒ (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.

E. 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	Facility	264,519	1995	\$ 574,693	1
2					2
3	TOTALS	264,519		\$ 574,693	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	\$ 4,135,554
5										
6										
7										
8										
	Improvement Type**									
9	Land Improvements			1995	36,957		15			36,957
10	Improvements			1995	1,421		40	36	36	723
11	Sign			1997	500	13	40	13		188
12	Electric			1996	656	16	40	16		232
13	Humidistats			1996	1,378	34	40	34		493
14	Door alarm			1996	854	21	40	21		312
15	Plumbing			1996	1,050	26	40	26		377
16	Install lights, water heater			1997	2,345	59	40	59		848
17	Pipe			1997	618	15	40	15		225
18	Electric			1997	3,121	78	40	78		1,131
19	Signs & outlets			1997	2,504	63	40	63		906
20	Wall hugging overbed lights			1997	27,302	683	40	683		9,831
21	Air compressor			1997	2,078	52	40	52		754
22	Roof repair			1997	3,154	79	40	79		1,138
23	Deco-gard products			1997	738	18	40	18		262
24	Shelving units			1998	2,317	58	40	58		783
25	Chimney cap			1998	945	24	40	24		324
26	Access door			1998	2,061	52	40	52		702
27	Bumper guards			1998	3,687	92	40	92		1,242
28	Land improvement - survey			1998	800		10			800
29	Carpeting			1999	67,303		10			67,303
30	Miniblinds			1999	3,501		10			3,501
31	Vertical blinds			1999	1,974		10			1,974
32	Swingmaster door			1999	2,357		10			2,357
33	Security lock			1999	2,779		10			2,779
34				1999	16,182		10			16,182
35										
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

Facility Name & ID Number Tabor Hills Health Care Facility, Inc.

0040543

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpeting	2000	\$ 225	\$	10	\$		\$ 225	37
38	Railing & bumper	2000	3,275	82	40	82		945	38
39	Carpeting	2000	41,999	349	10	349		41,999	39
40	Tile	2001	6,493	162	40	162		1,756	40
41	Courtyard improvements	2001	15,673	392	40	392		3,951	41
42	Architect Fees - Dining Room	2002	58,322	5,832	10	5,832		46,656	42
43	Carpet	2002	3,341	334	10	334		3,006	43
44	Door Alarm	2003	8,254	825	10	825		7,081	44
45	Fountain	2003	2,278	228	10	228		1,919	45
46	Carpet	2003	4,545	455	10	455		3,640	46
47	Therapeutic Garden	2003	135,525	3,388	40	3,388		25,642	47
48	Windows	2003	600	15	40	15		120	48
49	Braille Room Signs	2003	3,156	79	40	79		593	49
50	Flooring & Ceiling Tile	2004	12,755	319	40	319		2,393	50
51	Architect Fees - Dining Room	2004	17,405	435	40	435		3,263	51
52	Air Conditioning	2004	32,155	3,216	10	3,216		24,120	52
53	Plumbing	2004	30,619	765	40	765		5,821	53
54	Doors	2004	12,160	1,216	10	1,216		9,120	54
55	Water Box	2004	1,996	200	10	200		1,500	55
56	Fire Alarm	2004	8,965	897	10	897		6,727	56
57	Driveway	2004	2,750	275	10	275		2,063	57
58	Electric Work & Lighting	2004	213,367	5,334	40	5,334		37,889	58
59	Entryway Renovation	2004	761	19	40	19		133	59
60	Sprinkler System	2004	1,798	45	40	45		315	60
61	Dining Room Renovation	2004	1,915,627	42,911	40	47,891	4,980	326,489	61
62	Bathroom Renovation	2005	2,000	50	40	50		325	62
63	Automatic Door System	2005	3,551	89	40	89		579	63
64	Signs	2006	21,716	543	40	543		2,986	64
65	Door Sensor Locks	2006	18,597	465	40	465		2,557	65
66	Asphalt Parking Lots	2006	7,156	716	10	716		3,937	66
67	Wall Mirrors Therapy Room	2006	2,940	74	40	74		406	67
68	Electrical Work	2006	25,507	638	40	638		3,509	68
69	Wiring	2006	68,676	1,717	40	1,717		9,443	69
70	TOTAL (lines 4 thru 69)		\$ 12,912,522	\$ 323,380		\$ 328,396	\$ 5,016	\$ 4,868,986	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, Inc.

0040543

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,912,522	\$ 323,380		\$ 328,396	\$ 5,016	\$ 4,868,986	1
2	Lighting	2006	21,943	549	40	549		3,019	2
3	Exhaust Fans	2006	28,060	702	40	702		3,860	3
4	Heaters	2006	28,826	721	40	721		3,965	4
5	HVAC	2006	71,252	1,781	40	1,781		9,796	5
6	Fountain	2006	39,594	2,640	15	2,640		13,420	6
7	Wall Coverings	2007	6,058	606	10	606		2,727	7
8	Fire Prevention	2007	5,464	546	10	546		2,458	8
9	Exterior Work	2007	7,440	744	10	744		3,348	9
10	Naperville Room improvements	2007	17,034	426	40	426		1,917	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		2,115	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		932	20
21	Interior Doors	2007	2,490	62	40	62		279	21
22	1 North Kitchen improvements	2007	8,754	219	40	219		985	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		296	25
26	- Replaced door and walls, taped off and painted								26
27	Carpeting	2007	12,371	1,237	10	1,237		5,567	27
28	Electrical work	2007	30,630	766	40	766		3,447	28
29	Duct work	2007	18,266	457	40	457		2,056	29
30	Smoke detectors	2007	7,966	797	10	797		3,586	30
31	Electrical work	2007	13,558	339	40	339		1,525	31
32	Landscaping	2008	3,025	202	15	202		623	32
33	Boiler	2008	5,802	145	40	145		508	33
34	TOTAL (lines 1 thru 33)		\$ 13,270,776	\$ 337,062		\$ 342,078	\$ 5,016	\$ 4,935,415	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, Inc.

0040543

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 13,270,776	\$ 337,062		\$ 342,078	\$ 5,016	\$ 4,935,415	1
2	Administrative office renovations	2008	28,511	713	40	713		2,495	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		1,110	5
6	Vinyl Bases	2008	4,914	491	10	491		1,719	6
7	Electrical work	2008	84,126	2,103	40	2,103		8,237	7
8	Mag Mile Kitchen Improvements	2008	30,844	771	40	771		2,699	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		1,463	11
12	Flooring	2008	13,497	337	40	337		1,180	12
13	Water pump	2008	5,794	145	40	145		507	13
14	A/C Unit	2008	10,660	267	40	267		934	14
15	Coil and Freeze Thermostat	2008	5,800	145	40	145		508	15
16									16
17	Interior remodel-Electrical work, carpeting	2009	110,167	2,754	40	2,754		6,708	17
18	Landscaping	2009	2,258	151	15	151		440	18
19	Outdoor Electrical Work	2009	2,572	171	15	171		413	19
20	Landscaping	2009	23,769	1,585	15	1,585		3,434	20
21									21
22	Repair roof leak, replace ceiling tiles & sprinkler lines	2010	3,955	100	40	100		200	22
23	Remodel reception area and admission office :	2010	8,447	211	40	211		405	23
24	Remove existing reception front glass, frame, oak hand rail,								24
25	Ceiling tile and grid, open wall and frame new door								25
26	Install new 5/8 drywall and ceiling line								26
27									27
28	Remodel work for Admission office :	2010	4,973	124	40	124		217	28
29	Install new "B" label metal frame, solid Oak door								29
30	Install new acoustical ceiling grid and tile, patch, prime and								30
31	Paint, Install new vinyl base, Install solid blocking in East								31
32	Wall to facilitate installation								32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,640,481	\$ 347,865		\$ 352,881	\$ 5,016	\$ 4,968,083	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, Inc.

0040543

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 13,640,481	\$ 347,865		\$ 352,881	\$ 5,016	\$ 4,968,083	1
2	Remodel new storage space and office for Therapy office :	2010	13,253	331	40	331		486	2
3	Supply and install new storage units for Physical Therapy								3
4	Open existing wall and install solid blocking for new cabinets								4
5	Supply and install new oak cabinets, laminate work surface,								5
6	Keyboard drawers, supply new wall covering								6
7									7
8	Remodel exercise room & kitchen in Financial service :	2010	9,774	244	40	244		346	8
9	Install new TV cabinet with support wall, oak jamb, door, VCT								9
10	Tile floor, install customer supplied kitchen cabinets, new								10
11	shelf in closet, Install new ceiling mounted curtain track,								11
12	Hangers, and rods								12
13									13
14	Roof concrete repair	2010	7,926	198	40	198		248	14
15	Remodel beauty shop (remove & replace wallcover)	2010	3,904	98	40	98		122	15
16	Remodel Elevator lobby & adjacent corridor :	2010	12,662	317	40	317		370	16
17	Install new flooring and wall covering for elev lobby & adj corridor								17
18	Painted and decorated walls								18
19	Remodel new ceiling for beauty shop and remove existing hand rail	2010	4,469	112	40	112		131	19
20	Remodel new ceiling front hallway and Admission office	2010	17,957	449	40	449		524	20
21	Remodel front entry, ice cream parlor & building permits :	2010	37,734	943	40	943		1,022	21
22	Install cherry trim, reframe new opening in soffit								22
23	install new cased opening between foyer and elevator lobby								23
24	Remove existing wallpaper, skim coat walls, sand and prime								24
25	Supply and install new sinks, corian tops, vinyl ceiling tiles								25
26	Built new base for freezer,install new angle stops, supply new								26
27	water lines								27
28	Electrical Maintenance	2010	3,348	84	40	84		91	28
29	Interior Design - Remodel Elevator lobby & adjacent corridor	2010	6,682	167	40	167		251	29
30	Carpenter - remodel CEO office & Garden dining room	2010	162,053	4,051	40	4,051		4,389	30
31	Carpenter - remodel beauty parlor	2010	3,943	99	40	99		148	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,924,186	\$ 354,958		\$ 359,974	\$ 5,016	\$ 4,976,211	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

9/30/11

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,399,719	\$ 157,446	\$ 157,446	\$	5-10 Years	\$ 1,057,149	71
72	Current Year Purchases	49,871	3,564	3,564		5-10 Years	3,564	72
73	Fully Depreciated Assets	1,978,160					1,978,160	73
74								74
75	TOTALS	\$ 3,427,750	\$ 161,010	\$ 161,010	\$		\$ 3,038,873	75

D. Vehicle Costs. (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			\$ 422,701	\$ 26,911	\$ 26,911	\$	5	\$ 274,596	76
77										77
78										78
79										79
80	TOTALS			\$ 422,701	\$ 26,911	\$ 26,911	\$		\$ 274,596	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)	\$ 18,428,872	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 545,542	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 551,555	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,013	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,293,340	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
9.30.11

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			-	5	70,823
	Pickup truck	2007	21,500	4,300	4,300	-	5	19,350
	Vehicle Parts	2007	3,377	675	675	-	5	3,039
Administrative Use	2008 Toyota Sienna	2008	25,138	5,028	5,028	-	5	17,598
	2000 Chevy Tahoe	2009	5,000	1,000	1,000	-	5	2,750
	Truck	2009	5,975	1,195	1,195	-	5	3,186
Facility Use	Van	2010	25,000	5,000	5,000	-	5	7,500
Facility Use	2011 Ford Elkhart Bus	2011	40,054	3,338	3,338	-	5	3,338
Facility Use	2010 Ford Elkhart Bus	2011	44,539	3,712	3,712	-	5	3,712
Facility Use	2011 Honda Odyssey Van	2011	39,957	2,664	2,664	-	5	2,664
			422,701	26,911	26,911	-		274,596

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:				\$ 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.
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)

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

	1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	L10A(1),(3)	3879	hrs	\$ 158,710	223	\$ 14,220	\$	4,102	\$ 172,930	1
2	Licensed Speech and Language Development Therapist	L10A(3)		hrs		676	45,179		676	45,179	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10A(1),(2),(3)	6799	hrs	278,158	123	8,070	386	6,922	286,614	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				218,115		218,115	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				\$ 436,868	1,022	\$ 67,469	\$ 218,501	11,700	\$ 722,838	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,061	\$ 42,061	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,297,603	1,297,603	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	109,040	109,040	5
6	Prepaid Insurance	433,099	433,099	6
7	Other Prepaid Expenses	30,505	30,505	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,912,308	\$ 1,912,308	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	3,901,019	3,963,975	15
16	Equipment, at Historical Cost	3,937,298	3,850,451	16
17	Accumulated Depreciation (book methods)	(8,165,176)	(8,293,340)	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	1,311,915	1,311,915	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,557,014	\$ 11,447,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,469,322	\$ 13,359,755	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,525,374	\$ 2,525,374	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	89,932	89,932	29
30	Accrued Salaries Payable	481,514	481,514	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	65,294	65,294	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	337,484	337,484	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,499,598	\$ 3,499,598	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,800,799	4,800,799	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)	\$ 4,800,799	\$ 4,800,799	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,300,397	\$ 8,300,397	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,168,925	\$ 5,059,358	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,469,322	\$ 13,359,755	48

Schedule 17A

XV. Balance Sheet

B. Other Long-Term Assets- Line 22

	<u>Operating</u>	<u>After Consolidation</u>
Due To/Fr SLC	1,275,451	1,275,451
Unamortized Bond Premium & Fees	36,464	36,464
	<u>1,311,915</u>	<u>1,311,915</u>

XV. Balance Sheet

C. Other Current Liabilities- Line 36

	<u>Operating</u>	<u>After Consolidation</u>
Refunds (Residents/Family)	33,221	33,221
Resident Credit Balances	119,896	119,896
HDSI Transfer Account	(204)	(204)
FICA	97	97
State Income Tax W/H	46	46
Employee lock deposits	705	705
Beauty Shop Gift Certificates	(774)	(774)
Accrued Expenses	523	523
Employee Life Insurance Premiums	(3,198)	(3,198)
Other Liab-IDPA Audit	182,036	182,036
PA Resident Pharmacy	6,628	6,628
Accrued Wage Assignments	(1,492)	(1,492)
	<u>337,484</u>	<u>337,484</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,092,796	1
2	Restatements (describe):		2
3	Equity - Other Entities	682,897	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,775,693	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(606,768)	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)	\$ (606,768)	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)	\$ 5,168,925	24 *

* This must agree with page 17, line 47.

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	\$ 12,520,562	1
2	Discounts and Allowances for all Levels	(703,115)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,817,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,285,143	6
7	Oxygen	32,250	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,317,393	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	33,858	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	250,832	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,218	19
20	Radiology and X-Ray	16,059	20
21	Other Medical Services	605,294	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 945,261	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,441	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,441	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	23,353	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,353	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,113,895	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,490,620	31
32	Health Care	7,401,810	32
33	General Administration	3,428,175	33
	B. Capital Expense		
34	Ownership	795,830	34
	C. Ancillary Expense		
35	Special Cost Centers	488,705	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)*	\$ 14,720,663	40
41	Income before Income Taxes (line 30 minus line 40)**	(606,768)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (606,768)	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
9/30/2011

Schedule XVII. Income Statement
Line 28

Schedule 19A

<u>Description</u>	<u>Amount</u>
Admin. Influenza Vac	3,870
Public Aid Application Fee	900
Resident Telephone Private	17,184
Misc. Income	42
Unclaimed Property	1,357
	<u>23,353</u>

See Accountants' Compilation Report

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	1,891	2,110	\$ 85,353	\$ 40.45	1
2	Assistant Director of Nursing	1,803	1,919	63,128	32.90	2
3	Registered Nurses	71,025	77,423	2,380,331	30.74	3
4	Licensed Practical Nurses	23,750	25,761	632,291	24.54	4
5	CNAs & Orderlies	127,450	138,845	1,889,910	13.61	5
6	CNA Trainees					6
7	Licensed Therapist	10,230	10,678	436,868	40.91	7
8	Rehab/Therapy Aides	10,118	11,092	148,145	13.36	8
9	Activity Director	1,774	2,088	33,206	15.90	9
10	Activity Assistants	21,621	23,812	258,801	10.87	10
11	Social Service Workers	7,007	7,564	109,407	14.46	11
12	Dietician					12
13	Food Service Supervisor	2,210	2,458	51,465	20.94	13
14	Head Cook	6,299	6,942	109,814	15.82	14
15	Cook Helpers/Assistants	27,753	31,757	305,577	9.62	15
16	Dishwashers					16
17	Maintenance Workers	12,481	13,379	219,277	16.39	17
18	Housekeepers	40,300	44,044	363,351	8.25	18
19	Laundry	14,126	15,560	146,903	9.44	19
20	Administrator	2,738	3,098	162,978	52.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,544	26,963	398,900	14.79	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	5,799	6,521	103,838	15.92	31
32	Other Health C; See Sch 20A	20,710	22,475	494,886	22.02	32
33	Other(specify) Marketing	3,612	3,947	69,472	17.60	33
34	TOTAL (lines 1 - 33)	437,241	478,436	\$ 8,463,901 *	\$ 17.69	34

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	248	\$ 11,668	1(3)	35
36	Medical Director	365	30,972	9(3)	36
37	Medical Records Consultant	62	1,552	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	455	11,956	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	21	1,570	11(3)	44
45	Social Service Consultant	18	1,223	12(3)	45
46	Other(specify) Alzheimer	2	120	10(3)	46
47	Medical Consultant	Monthly	2,400	10(3)	47
48	See Sch 20A	Monthly	2,406	10(3)	48
49	TOTAL (lines 35 - 48)	1,171	\$ 63,867		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	249	\$ 10,568	10(3)	50
51	Licensed Practical Nurses	2,678	95,801	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,928	\$ 106,369		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
10/1/10-9/30/11

Schedule 20A

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

Description	Hours Worked	Hours Paid	Wages	Average Wages
Ward Clerk	1,754	1,943	24,649	\$ 12.69
Care Plan Coordinator	9,738	10,426	297,572	\$ 28.54
Special Care Unit Manager	1,334	1,458	32,813	\$ 22.51
Restorative Services	2,364	2,584	41,982	\$ 16.25
Quality Assurance	3,300	3,606	66,697	\$ 18.50
Nursing Staff Scheduler	2,219	2,458	31,173	\$ 12.68
	20,710	22,475	494,886	\$ 22.02

XVIII. B. Consultant Services
Line 48 Other Healthcare (specify):

Description	Hours Pd	Cost	Reference
MDS/Care Plan Consultant Monthly		1,126	10(3)
Destruction of Old Records Monthly		1,280	10(3)
		2,406	

See Accountants' Compilation Report

STATE OF ILLINOIS

Facility Name & ID NumberTabor Hills Health Care Facility, Inc.# 0040543Report Period Beginning:10/1/10Ending:9/30/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Rodriquez	Administrator	0	\$ 67,521
Gloria Pindiak	CEO	0	95,457
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 162,978

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		\$ 236,220
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 236,220

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 218,619	
Unemployment Compensation Insurance		
FICA Taxes	621,762	
Employee Health Insurance	524,250	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Uniforms	4,724	
Employee Appreciation	11,476	
401(k) Expense	45,195	
Employee Pension	764,305	
Life/Disability Insurance	45,001	
Other Employee Benefits	32,678	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,268,010

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	\$ 3,980	
Advertising: Employee Recruitment	3,393	
Health Care Worker Background Check (Indicate # of checks performed 121)	1,452	
Patient Background Checks 333	4,000	
Miscellaneous Licenses & Fees	875	
Miscellaneous Dues	1,945	
Life Service Network of Illinois	2,142	
Miscellaneous Subscriptions	624	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,411

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	17,836
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 17,836

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility, Inc.
Provider # 0040543
10/1/10-9/30/11

Schedule 21C

XIX. Support Schedule
C. Professional Services

<u>Name</u>	<u>Type</u>	<u>Amount</u>
ACCU-MED SERVICES	Computer	5,400
COMCAST CABLE	Computer	1,799
HEALTH DATA SYSTEMS, INC	Computer	7,049
IVANS	Computer	1,286
VOPENKA & ASSOCIATES	Computer	97,686
McGladrey & Pullen	Accounting	41,431
Crowe Horwath LLP	Accounting	11,938
United States Treasury	Financial Services	300
Chubb Specialty	Insurance	3,480
Crowe Horwath	Legal	1,766
Duane Morris	Legal	28,805
Erickson Papanek	Legal	4,408
LSN Reciprocal	Legal	5,157
Polsinelli, Shughart	Legal	25,041
Wessels & Sherman	Legal	675
Total (agree to Schedule V, line 19, column 3)		<u>236,220</u>
Less: Out of period legal (MCD 1)		(7,966)
Less: Non-Allowable legal (MCD 1)		(1,645)
Less: Reclass to Insurance (MCD 5)		<u>(5,157)</u>
Total (agree to Schedule V, line 19, column 8)		<u>221,452</u>

See Accountants' Compilation Report

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	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

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-\$2,142
- (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.

\$108,993

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.
- (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 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