

Facility Name & ID Number Tower Hill Healthcare Center

0045930 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,190	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	444	365	5,670	6,479	8
9	SNF/PED					9
10	ICF	34,618	11,998		46,616	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,062	12,363	5,670	53,095	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.61%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

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 07/01/02

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/02 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 20 and days of care provided 5,670

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	312,176	19,022	12,418	343,616		343,616	(1,010)	342,606		1
2	Food Purchase		335,555		335,555		335,555	(9,126)	326,429		2
3	Housekeeping	165,561	83,262		248,823		248,823	496	249,319		3
4	Laundry	83,452	19,072		102,524		102,524		102,524		4
5	Heat and Other Utilities			109,749	109,749		109,749	2,405	112,154		5
6	Maintenance	77,108	90,971	19,330	187,409		187,409	1,902	189,311		6
7	Other (specify):*										7
8	TOTAL General Services	638,297	547,882	141,497	1,327,676		1,327,676	(5,333)	1,322,343		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,366,096	95,045	22,270	2,483,411		2,483,411	885	2,484,296		10
10a	Therapy			566,613	566,613		566,613		566,613		10a
11	Activities	127,622	21,517		149,139		149,139	800	149,939		11
12	Social Services	38,840			38,840		38,840		38,840		12
13	CNA Training										13
14	Program Transportation			4,275	4,275		4,275	4,381	8,656		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,532,558	116,562	617,158	3,266,278		3,266,278	6,066	3,272,344		16
	C. General Administration										
17	Administrative	120,329		139,935	260,264		260,264	(100,275)	159,989		17
18	Directors Fees										18
19	Professional Services			45,365	45,365		45,365	10,367	55,732		19
20	Dues, Fees, Subscriptions & Promotions			27,963	27,963		27,963	(4,552)	23,411		20
21	Clerical & General Office Expenses	390,263		73,878	464,141		464,141	87,453	551,594		21
22	Employee Benefits & Payroll Taxes			532,165	532,165		532,165	5,968	538,133		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,593	2,593		2,593	(93)	2,500		24
25	Other Admin. Staff Transportation			13,758	13,758		13,758	(4,125)	9,633		25
26	Insurance-Prop.Liab.Malpractice			19,772	19,772		19,772	988	20,760		26
27	Other (specify):* Mgmt Alloc of Benefit							21,218	21,218		27
28	TOTAL General Administration	510,592		855,429	1,366,021		1,366,021	16,949	1,382,970		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,681,447	664,444	1,614,084	5,959,975		5,959,975	17,682	5,977,657		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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

Facility Name & ID Number Tower Hill Healthcare Center

#0045930

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			67,494	67,494		67,494	88,672	156,166			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,431	87,431		87,431	207,013	294,444			32
33	Real Estate Taxes			100,843	100,843		100,843	4,771	105,614			33
34	Rent-Facility & Grounds			460,000	460,000		460,000	(460,000)				34
35	Rent-Equipment & Vehicles			23,760	23,760		23,760	(1,262)	22,498			35
36	Other (specify):*											36
37	TOTAL Ownership			739,528	739,528		739,528	(160,806)	578,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,105		164,105		164,105	448	164,553			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,785	112,785		112,785		112,785			42
43	Other (specify):* Nonallowable Cost			90,371	90,371		90,371	(90,371)				43
44	TOTAL Special Cost Centers		164,105	203,156	367,261		367,261	(89,923)	277,338			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,681,447	828,549	2,556,768	7,066,764		7,066,764	(233,047)	6,833,717			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(24,565)	30		9
10	Interest and Other Investment Income	(16,806)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(495)	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	(6,203)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,198)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,115)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(202)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(36,560)	43		28
29	Other-Attach Schedule See Page 5A	(191,961)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (291,105)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	58,058		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 58,058		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (233,047)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center

ID# 0045930

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense - Med A	\$ (11,473)	43	1
2	X-Ray Expense - Med A	(14,335)	43	2
3	Bad Debt Expense	(5,375)	43	3
4	Gain/Loss on Fixed Assets	(10,615)	43	4
5	Dues and Subscriptions	(1,115)	20	5
6	Interest	(84,686)	32	6
7	Non-Allowable Dues	(3,749)	20	7
8	Office Expense	(1,575)	21	8
9	Management Fees	(53,460)	17	9
10	Management Fees	(5,483)	21	10
11	Education and Seminar	(95)	24	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	(191,961)		49

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule A		See Attached Schedule B		See Attached Schedule B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	Kane Street Associates	100.00%	\$ 4,140	\$ 4,140	1
2	V	30 Depreciation		Kane Street Associates	100.00%	108,860	108,860	2
3	V	32 Interest		Kane Street Associates	100.00%	306,256	306,256	3
4	V	34 Rent	460,000	Kane Street Associates	100.00%		(460,000)	4
5	V	43 RT Tax		Kane Street Associates	100.00%	202	202	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		\$ 460,000			\$ 419,458	\$ * (40,542)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider # : 0045930
12/31/2006

Schedule 6B

VII. Related Parties - Page 6

Related Nursing Homes

City

In State:

Cahokia Nursing & Rehab	Cahokia
Caseyville Nursing & Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing & Rehab	East St. Louis

Out of State :

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare & Rehab	St. Louis, MO
Rancho Manor Healthcare & Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 11	\$	11	15
16	V	3 Housekeeping		SW Management Co.	100.00%	496		496	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	2,405		2,405	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,902		1,902	18
19	V	17 Administrative	115,935	SW Management Co.	100.00%	69,120		(46,815)	19
20	V	19 Professional Services		SW Management Co.	100.00%	12,523		12,523	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	214		214	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	94,511		94,511	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	2		2	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	704		704	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	988		988	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	21,218		21,218	26
27	V	30 Depreciation		SW Management Co.	100.00%	4,377		4,377	27
28	V	32 Interest		SW Management Co.	100.00%	2,249		2,249	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	4,771		4,771	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,538		1,538	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 115,935			\$ 217,029	\$ *	101,094	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)
15	V	2 Food	\$ 20,516	S & E Medical Supply Co.	100.00%	\$ 17,347	\$ (3,169)
16	V	3 Housekeeping	2,714	S & E Medical Supply Co.	100.00%	2,714	
17	V	10 Medical Supplies	2,586	S & E Medical Supply Co.	100.00%	3,261	675
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 25,816			\$ 23,322	\$ * (2,494)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Sheldon Wolfe	President	Administrative	42.50	See Schedule 7A	4	9.00	Salary	\$ 15,660	L17, C7	1
2	Rosemary Betz	Adm. Consultant	Administrative	10.00	See Schedule 7B	8	13.79	Facility Fees	24,000	L17, C3	2
3	Moshe Herman	CFO	Administrative	5.00	See Schedule 7C	5.7	13.00	Salary	22,315	L21, C7	3
4											4
5											5
6											6
7	Note : All individuals work in excess of 40 hours per week.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 61,975		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SW Management Co.
 Street Address 7434 N. Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	608,840	11	\$ 89	\$ 75,190	\$ 11	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	75,190	496	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	75,190	2,405	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	75,190	1,902	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	75,190	12,523	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	75,190	214	6	
7	21	Clerical & General Office Expense	Bed Days Available	608,840	11	765,293	711,669	94,511	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	75,190	2	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	75,190	704	9	
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	608,840	11	8,000	75,190	988	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	75,190	21,218	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	75,190	2,249	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	75,190	4,771	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	608,840	11	12,454	75,190	1,538	14	
15									15	
16	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	4	69,120	16
17									17	
18									18	
19	30	Depreciation	Direct Cost					4,377	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 217,029	25	

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Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 17,347	1
2	3	Housekeeping	Direct Cost					2,714	2
3	10	Medical Supplies	Direct Cost					3,261	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				\$	\$		\$ 23,322	25

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	MB Financial Bank		X	Mortgage	\$25,886.40	08/20/03	\$	3,841,180	08/20/08	0.0525	\$ 296,035	1								
2	First Bank & Trust		X	N/P-Auto	\$741.00	09/20/02		44,459	09/20/07	0.0600	2,745	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Member Loans	X		Line of Credit	Varies	12/15/02		1,000,000	685,000	12/20/06	0.0825	64,418	6							
7	Member Loans	X		Working Capital		11/15/02		406,189	426,457	Demand	0.0600	20,268	7							
8												8								
9	TOTAL Facility Related				\$26,627.40		\$	1,450,648	\$ 4,952,637		\$	383,466	9							
B. Non-Facility Related*																				
10								Interest income offset				(16,806)	10							
11								SW Management Allocation-Mortgage				2,249	11							
12								Amortization of mortgage costs				10,221	12							
13								Related party interest				(84,686)	13							
14	TOTAL Non-Facility Related						\$		\$		\$	(89,022)	14							
15	TOTALS (line 9+line14)						\$	1,450,648	\$ 4,952,637		\$	294,444	15							

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tower Hill Healthcare Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045930

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-34-228-012</u>	<u>Long-term care property</u>	\$ <u>98,943.12</u>	\$ <u>98,943.12</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management allocation</u>	\$ <u>39,720.37</u>	\$ <u>4,771.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>138,663.49</u>	\$ <u>103,714.12</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 X NO

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,038 B. General Construction Type: Exterior Frame Number of Stories _____

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>2000</u>	<u>\$ 150,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	206	2002		\$ 4,259,595	\$	39	\$ 109,219	\$ 109,219	\$ 1,300,563	4
5										5
6	Allocation from Management Company	1995		54,104		39	1,546	1,546	18,017	6
7										7
8										8
	Improvement Type**									
9	Nursing Stations		2002	10,000	806	5	2,000	1,194	8,500	9
10	Carpet		2002	3,239	261	7	463	202	1,889	10
11	Time Recorder		2002	6,505	393	5	1,301	908	5,963	11
12	Fire Alarm System		2003	2,072		7	296	296	1,135	12
13	Recooling Tower Pump		2003	2,600		5	520	520	1,863	13
14	Hot Water Heater		2004	38,024	1,383	20	1,901	518	4,753	14
15	Alarm System		2004	24,807	902	20	1,240	338	3,101	15
16	Boiler		2005	19,350	704	20	967	263	1,451	16
17	Water softener valves & filter media		2005	9,955	362	20	498	136	747	17
18	Hardware for 8 doors		2005	5,177	188	20	259	71	388	18
19	Wire glass in frames		2005	1,194	43	20	60	17	90	19
20	Door alarm system		2005	2,733	99	20	137	38	205	20
21	Resurface parking lot		2005	25,256	2,399	20	1,263	(1,136)	1,894	21
22	Elevator door edges		2005	2,400	87	20	120	33	180	22
23	Elevator pump		2005	1,450	53	20	72	19	109	23
24	Sidewalk		2006	8,700	435	20	218	(217)	217	24
25	Ceiling Tile & Drywall		2006	4,842	51	20	121	70	121	25
26	Sidewalks & Curbs		2006	7,600	380	20	190	(190)	190	26
27	Sprinkler System		2006	20,659	470	20	516	46	516	27
28	Boiler		2006	89,925	1,227	20	2,248	1,021	2,248	28
29	UCP II Keypad		2006	2,473	64	20	62	(2)	62	29
30	Plumbing-Backflow Project		2006	10,366	32	20	259	227	259	30
31	Cooling Tower & Water Chiller		2006	5,954	117	20	149	32	149	31
32	Closet Doors		2006	4,000	18	20	100	82	100	32
33	Chairrail		2006	5,980	118	20	150	32	150	33
34	Elevator-Down Payment		2006	17,250		20				34
35	Landscaping		2006	60,182	3,009	20	1,505	(1,504)	1,505	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Allocation of SW Management - Leasehold improvement	1995	\$ 5,772	\$	20	\$ 289	\$ 289	\$ 3,771	37
38	Allocation of SW Management - Leasehold improvement	1996	1,008		20	50	50	533	38
39	Allocation of SW Management - Leasehold improvement	1997	1,452		20	73	73	869	39
40	Allocation of SW Management - Leasehold improvement	1998	999		20	50	50	437	40
41	Allocation of SW Management - Leasehold improvement	1999	2,775		20	139	139	983	41
42	Allocation of SW Management - Leasehold improvement	2005	5,741		20	287	287	431	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,724,139	\$ 13,601		\$ 128,268	\$ 114,667	\$ 1,363,389	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 96,859	\$ 20,818	\$ 12,898	\$ (7,920)	10	\$ 34,776	71
72	Current Year Purchases	156,502	31,300	7,825	(23,475)	10	7,825	72
73	Fully Depreciated Assets	621,734					621,734	73
74	Allocation from Management Co.	14,604		495	495		13,825	74
75	TOTALS	\$ 889,699	\$ 52,118	\$ 21,218	\$ (30,900)		\$ 678,160	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	Resident Care	2002 Volvo	2002	\$ 39,234	\$ 1,775	\$ 5,231	\$ 3,456	5	\$ 35,442	76
77	Disposal of Auto			(39,234)					(35,442)	77
78										78
79	Allocation from Mgmt Co.	2004 Cadillac	2004	7,245		1,449	1,449	5	3,623	79
80	TOTALS			\$ 7,245	\$ 1,775	\$ 6,680	\$ 4,905		\$ 3,623	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)	\$ 5,771,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,494	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,166	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 88,672	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,045,172	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 16,714 Description: Medical equip, beds, special mattresses-\$13,277 & Equip for resident parties-\$3,437

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2007 Lexus</u>	\$ <u>861.39</u>	\$ <u>4,246</u>	17
18					18
19					19
20	<u>SW Management Allocation</u>			<u>1,538</u>	20
21	TOTAL		\$ <u>861.39</u>	\$ <u>5,784</u>	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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	18,596	\$ 220,360	\$	18,596	\$ 220,360	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		7,602	90,083		7,602	90,083	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		20,099	238,377		20,099	238,377	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				164,105		164,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	46,297	\$ 548,820	\$ 164,105	46,297	\$ 712,925	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits	27,886	27,886	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,958,479	1,958,479	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,511	5,511	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	26,336	26,336	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,019,212	\$ 2,019,212	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		4,287,759	14
15	Leasehold Improvements, at Historical Cost	379,275	436,380	15
16	Equipment, at Historical Cost	284,561	896,944	16
17	Accumulated Depreciation (book methods)	(146,505)	(2,045,172)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>See Schedule 17A</u>	4,065	19,476	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 521,396	\$ 3,745,387	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,540,608	\$ 5,764,599	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 261,199	\$ 261,199	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,695	32,695	28
29	Short-Term Notes Payable	1,111,457	1,111,457	29
30	Accrued Salaries Payable	217,467	217,467	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,047	26,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,900	101,900	32
33	Accrued Interest Payable	4,700	4,700	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	272,790	108,130	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,028,255	\$ 1,863,595	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		3,841,180	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)	\$	\$ 3,841,180	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,028,255	\$ 5,704,775	46
47	TOTAL EQUITY(page 18, line 24)	\$ 512,353	\$ 59,824	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,540,608	\$ 5,764,599	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Towerhill Healthcare Center LLC
 Provider #:0045930
 12/31/2006

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interst	16,620	16,620
Due from Prior Owner	2,902	2,902
Employee Loans	550	550
Reimbursement Due / Bad Debts	6,165	6,165
Due to Public Aid	99	99
Total Line 9 - Other Current Assets (specify):	26,336	26,336

Other Long Term Assets (specify):	Operating	After Consolidation
Short Term Loan Exchange	4,065	4,065
Loan Costs	-	51,107
A/A Loan costs	-	(35,696)
Total Line 23 - Other Long Term Assets (specify):	4,065	19,476

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	1,497	1,497
Credit union	975	975
Union dues	9,150	9,150
Accrued Expenses	71,481	71,481
Accrued Management fees	2,000	2,000
Due / from Kane St. Assoc.	187,687	-
Due to Partners	-	23,027
Total Line 36 - Other Current Liabilities (specify):	272,790	108,130

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 144,004	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 144,004	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	368,347	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) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 368,349	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)	\$ 512,353	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,029,910	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,029,910	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,804	6
7	Oxygen	5,016	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 386,820	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,806	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,806	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,575	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,575	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,435,111	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,327,676	31
32	Health Care	3,266,278	32
33	General Administration	1,366,021	33
	B. Capital Expense		
34	Ownership	739,528	34
	C. Ancillary Expense		
35	Special Cost Centers	254,476	35
36	Provider Participation Fee	112,785	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,066,764	40
41	Income before Income Taxes (line 30 minus line 40)**	368,347	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 368,347	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,080	2,080	\$ 65,661	\$ 31.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,735	35,615	985,926	27.68	3
4	Licensed Practical Nurses	10,188	10,388	273,726	26.35	4
5	CNAs & Orderlies	82,052	87,278	1,040,783	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	160	160	3,585	22.41	9
10	Activity Assistants	9,556	10,253	124,037	12.10	10
11	Social Service Workers	2,275	2,275	38,840	17.07	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	43,318	20.83	13
14	Head Cook	7,950	8,427	87,049	10.33	14
15	Cook Helpers/Assistants	22,403	24,040	181,809	7.56	15
16	Dishwashers					16
17	Maintenance Workers	5,746	6,208	77,108	12.42	17
18	Housekeepers	20,445	21,966	165,561	7.54	18
19	Laundry	9,930	10,745	83,452	7.77	19
20	Administrator	2,080	2,080	120,329	57.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,247	22,179	390,263	17.60	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,927	245,774	\$ 3,681,447 *	\$ 14.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	119	\$ 11,408	L1, C3	35
36	Medical Director	244	24,000	L9, C3	36
37	Medical Records Consultant	79	3,534	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	133	18,736	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	139	17,793	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	800	L11, C7	44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	2	210	L10, C7	46
47					47
48					48
49	TOTAL (lines 35 - 48)	724	\$ 76,481		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jeremy Amster	Administrator	0	\$ 120,329	Workers' Compensation Insurance	\$ 74,657	IDPH License Fee	\$ 35		
				Unemployment Compensation Insurance	82,143	Advertising: Employee Recruitment			
				FICA Taxes	280,641	Health Care Worker Background Check	6,478		
				Employee Health Insurance	42,732	(Indicate # of checks performed <u>540</u>)			
				Employee Meals	5,968	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	16,618		
				Employee Retirement	39,551	Miscellaneous Dues & Permits	937		
				Miscellaneous Employee Benefits	12,441	Miscellaneous Inspections & Licenses	2,878		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,329	TOTAL (agree to Schedule V, line 22, col.8)		\$ 538,133	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,411	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Rose Betz-Management Fees			\$ 24,000	N/A			Out-of-State Travel	\$	
SW Management-Home Office & Management Fees			115,935				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 139,935	TOTAL		\$	Seminar Expense	2,498	
C. Professional Services							Allocation from Management Co.		2
Vendor/Payee	Type		Amount				Entertainment Expense		()
Winston & Strawn	Legal		\$ 3,811				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,500
Ashman & Stein	Legal		25,435						
Foley & Lardner LLP	Legal		540						
RSM McGladrey	Accounting		14,149						
Personal Planners, Inc.	Unemployment Consultant		1,332						
Notary Public	Notary		98						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 45,365						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Towerhill Healthcare Center LLC
Provider #: 0045930
12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	45,365
Out-of-period legal expenses	(6,198)
Reclass to Licenses	(98)
Allocated From Kane Street Associates	
Accounting	1,350
Legal	2,790
Allocated From SW Management:	
Accounting	2,206
Legal	10,317
Total (agree to Schedule V, line 19, column 8)	<u>55,732</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning: 01/01/06

Ending: 12/31/06

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. Illinois Council on LTC - \$12,869
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,737 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. \$ 112,785
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. \$ 5,968 Has any meal income been offset against related costs? N/A 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? N/A
- 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? Yes
- 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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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