

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0045930</u></p> <p>Facility Name: <u>Tower Hill Healthcare Center</u></p> <p>Address: <u>759 Kane Street</u> <u>South Elgin</u> <u>60177</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847) 697-3310</u> Fax # <u>(847) 697-3354</u></p> <p>HFS ID Number: <u>721525738001</u></p> <p>Date of Initial License for Current Owners: <u>10/25/2002</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W. Martin</u> Telephone Number: <u>(217) 789-7700</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td align="right">(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, Suite 500, Schaumburg, IL 60173</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>20 N Martingale Road, Suite 500, Schaumburg, IL 60173</u>		(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>		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
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		138	6,260	6,398	8
9	SNF/PED					9
10	ICF	40,794	12,795		53,589	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,794	12,933	6,260	59,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.78%

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 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 0701/2002

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/2002 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 6,260

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	372,537	27,350	9,322	409,209		409,209		409,209		1
2	Food Purchase		405,820		405,820		405,820	(8,754)	397,066		2
3	Housekeeping	201,654	107,044		308,698		308,698	223	308,921		3
4	Laundry	96,617	21,201		117,818		117,818		117,818		4
5	Heat and Other Utilities			164,582	164,582		164,582	2,061	166,643		5
6	Maintenance	103,274	131,794	19,299	254,367		254,367	2,654	257,021		6
7	Other (specify):*										7
8	TOTAL General Services	774,082	693,209	193,203	1,660,494		1,660,494	(3,816)	1,656,678		8
	B. Health Care and Programs										
9	Medical Director			26,000	26,000		26,000		26,000		9
10	Nursing and Medical Records	2,576,268	89,368	23,892	2,689,528		2,689,528	(175)	2,689,353		10
10a	Therapy			640,205	640,205		640,205		640,205		10a
11	Activities	148,513	32,820	4,400	185,733		185,733		185,733		11
12	Social Services	61,137			61,137		61,137		61,137		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,785,918	122,188	694,497	3,602,603		3,602,603	(175)	3,602,428		16
	C. General Administration										
17	Administrative	131,044		190,885	321,929		321,929	(83,687)	238,242		17
18	Directors Fees										18
19	Professional Services			50,138	50,138		50,138	13,843	63,981		19
20	Dues, Fees, Subscriptions & Promotions			25,391	25,391		25,391	(2,196)	23,195		20
21	Clerical & General Office Expenses	390,635		112,780	503,415		503,415	49,244	552,659		21
22	Employee Benefits & Payroll Taxes			476,020	476,020		476,020	6,929	482,949		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,949	15,949		15,949	(854)	15,095		24
25	Other Admin. Staff Transportation			18,463	18,463		18,463	921	19,384		25
26	Insurance-Prop.Liab.Malpractice			44,390	44,390		44,390	867	45,257		26
27	Other (specify):*							17,228	17,228		27
28	TOTAL General Administration	521,679		934,016	1,455,695		1,455,695	2,295	1,457,990		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,081,679	815,397	1,821,716	6,718,792		6,718,792	(1,696)	6,717,096		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tower Hill Healthcare Center

#0045930

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			97,272	97,272		97,272	68,882	166,154			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,168	32,168		32,168	249,505	281,673			32
33	Real Estate Taxes			107,201	107,201		107,201	4,817	112,018			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			28,604	28,604		28,604	1,451	30,055			35
36	Other (specify):*											36
37	TOTAL Ownership			745,245	745,245		745,245	(155,345)	589,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,700		202,700		202,700		202,700			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,830	110,830		110,830		110,830			42
43	Other (specify):* Non-allowable Cos			105,187	105,187		105,187	(105,187)				43
44	TOTAL Special Cost Centers		202,700	216,017	418,717		418,717	(105,187)	313,530			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,081,679	1,018,097	2,782,978	7,882,754		7,882,754	(262,228)	7,620,526			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(43,764)	30		9
10	Interest and Other Investment Income	(8,834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(500)	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	(5,550)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,941)	43		24
25	Fund Raising, Advertising and Promotional	(39,232)	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	(60,641)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (193,462)		\$	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	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)	(86,791)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (86,791)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (280,253)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center

ID# 0045930

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense	\$ (12,493)	43	1
2	X-Ray Expense	(12,471)	43	2
3	Real Estate Tax	(38)	43	3
4	Chamber of Commerce dues	(845)	20	4
5	Lobbying expense	(2,626)	20	5
6	Interest	(32,168)	32	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(60,641)		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%	\$ 1,275	\$ 1,275	1
2	V	20 Fees, Subscriptions, Promotions		Kane Street Associates	100.00%	250	250	2
3	V	30 Depreciation		Kane Street Associates	100.00%	108,860	108,860	3
4	V	32 Interest		Kane Street Associates	100.00%	288,503	288,503	4
5	V	34 Rent	480,000	Kane Street Associates	100.00%		(480,000)	5
6	V	43 RT Tax		Kane Street Associates	100.00%	38	38	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 398,926	\$ * (81,074)	14

* 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	\$	SW Management Co.	100.00%	\$ 37	\$	37	15
16	V	3 Housekeeping		SW Management Co.	100.00%	223		223	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	2,061		2,061	17
18	V	6 Maintenance		SW Management Co.	100.00%	2,654		2,654	18
19	V	17 Administrative	128,750	SW Management Co.	100.00%	27,038		(101,712)	19
20	V	19 Professional Services		SW Management Co.	100.00%	12,568		12,568	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	98		98	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	49,244		49,244	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	73		73	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	921		921	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	867		867	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	17,228		17,228	26
27	V	30 Depreciation		SW Management Co.	100.00%	3,786		3,786	27
28	V	32 Interest		SW Management Co.	100.00%	2,004		2,004	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	4,817		4,817	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,451		1,451	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		\$ 128,750			\$ 125,070	\$ *	(3,680)	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	\$ 20,323	S & E Medical Supply Co.	100.00%	\$ 18,461	\$ (1,862)
16	V	3 Housekeeping	516	S & E Medical Supply Co.	100.00%	516	
17	V	10 Medical Supplies	2,036	S & E Medical Supply Co.	100.00%	1,861	(175)
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		\$ 22,875			\$ 20,838	\$ * (2,037)

* 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: 01/01/2007 Ending: 12/31/2007

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	3	9.00	Salary	\$ 13,519	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	3	13.00	Salary	13,519	L17, 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	\$ 51,038		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:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	645,320	11	\$ 319	\$ 75,190	\$ 37	1
2	3	Housekeeping	Bed Days Available	645,320	11	1,918	75,190	223	2
3	5	Heat and Other Utilities	Bed Days Available	645,320	11	17,688	75,190	2,061	3
4	6	Maintenance	Bed Days Available	645,320	11	22,780	75,190	2,654	4
5	19	Professional Services	Bed Days Available	645,320	11	107,864	75,190	12,568	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	645,320	11	844	75,190	98	6
7	21	Clerical & General Office Exp	Bed Days Available	645,320	11	422,637	373,471	49,244	7
8	24	Travel and Seminar	Bed Days Available	645,320	11	625	75,190	73	8
9	25	Other Admin. Staff Transport	Bed Days Available	645,320	11	7,906	75,190	921	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	645,320	11	7,442	75,190	867	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	645,320	11	147,860	75,190	17,228	11
12	32	Interest	Bed Days Available	645,320	11	17,198	75,190	2,004	12
13	33	Real Estate Taxes	Bed Days Available	645,320	11	41,339	75,190	4,817	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	645,320	11	12,453	75,190	1,451	14
15									15
16									16
17	17	Administrative	Avg. Hours Worked	40	11	360,500	360,500	3	27,038
18	17	Administrative	Avg. Hours Worked	55		180,250	180,250		0
19									19
20	30	Depreciation	Direct Cost						3,786
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,349,623	\$ 914,221	\$ 125,070	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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		\$	\$		\$ 18,461	1
2	3	Housekeeping	Direct Cost					516	2
3	10	Medical Supplies	Direct Cost					1,861	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				\$	\$		\$ 20,838	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	8/20/03	\$	3,718,928	8/20/08	0.0525	\$	278,282						
2	First Bank & Trust		X	N/P-Auto	\$741.00	9/20/02		44,459	9/20/07	0.0600								
3																		
4																		
5																		
Working Capital																		
6	Member Loans	X		Line of Credit	Varies	12/15/02		1,000,000	75,000			21,057						
7	N/P Stockholder	X		Working Capital		11/15/02		406,189	447,514			11,111						
8																		
9	TOTAL Facility Related				\$26,627.40		\$	1,450,648	\$	4,241,442		\$	310,450					
B. Non-Facility Related*																		
10								Interest income offset				(8,834)						
11								SW Management Allocation-Mortgage				2,004						
12								Amortization of mortgage costs				10,221						
13								Related party interest				(32,168)						
14	TOTAL Non-Facility Related						\$		\$			\$	(28,777)					
15	TOTALS (line 9+line14)						\$	1,450,648	\$	4,241,442		\$	281,673					

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	101,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	103,001	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,101	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	106,100	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
	Allocation from Management Co.		4,817	
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.		\$	112,018	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	106,693	8	
	2003	96,996	9	
	2004	93,526	10	
	2005	98,943	11	
	2006	103,001	12	
2007 Tax Accrual = 103,100 X 1.03 = 106,091. Use 106,100				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006 \$		13
	14	PLUS APPEAL COST FROM LINE 5 \$		14
	15	LESS REFUND FROM LINE 6 \$		15
	16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-34-228-012</u>	<u>Long term care property</u>	\$ <u>103,000.86</u>	\$ <u>103,000.86</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>42,503.98</u>	\$ <u>4,817.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>145,504.84</u>	\$ <u>107,817.86</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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 (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with numbers 1, 2, 3. Row 1: Resident Care, 150,000, 2000, 1. Row 2: (blank), 2. Row 3: TOTALS, 150,000, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 4,259,594	\$	39	\$ 109,220	\$ 109,220	\$ 1,409,784	4
5										5
6	Allocation from Management Company	1995		50,432		39	1,441	1,441	18,235	6
7										7
8										8
	Improvement Type**									
9	Nursing Stations		2002	10,000	403	5	1,500	1,097	10,000	9
10	Carpet		2002	3,239	131	7	463	332	2,352	10
11	Time Recorder		2002	6,505	262	5	542	280	6,505	11
12	Fire Alarm System		2003	2,072		7	296	296	1,431	12
13	Recooling Tower Pump		2003	2,600		5	520	520	2,383	13
14	Hot Water Heater		2004	38,024	1,383	20	1,901	518	6,654	14
15	Alarm System		2004	24,807	902	20	1,240	338	4,341	15
16	Boiler		2005	19,350	704	20	968	264	2,419	16
17	Water softener valves & filter media		2005	9,955	362	20	498	136	1,244	17
18	Hardware for 8 doors		2005	5,177	188	20	259	71	647	18
19	Wire glass in frames		2005	1,194	43	20	60	17	149	19
20	Door alarm system		2005	2,733	99	20	137	38	342	20
21	Resurface parking lot		2005	25,256	2,159	20	1,263	(896)	3,157	21
22	Elevator door edges		2005	2,400	87	20	120	33	300	22
23	Elevator pump		2005	1,450	53	20	73	20	182	23
24	Sidewalk		2006	8,700	827	20	435	(392)	653	24
25	Ceiling Tile & Drywall		2006	4,842	176	20	242	66	363	25
26	Sidewalks & Curbs		2006	7,600	722	20	380	(342)	570	26
27	Sprinkler System		2006	20,659	751	20	1,033	282	1,549	27
28	Boiler		2006	89,925	3,270	20	4,496	1,226	6,744	28
29	UCP II Keypad		2006	2,473	90	20	124	34	185	29
30	Plumbing-Backflow Project		2006	10,366	777	20	518	(259)	777	30
31	Cooling Tower & Water Chiller		2006	5,954	216	20	298	82	447	31
32	Closet Doors		2006	4,000	145	20	200	55	300	32
33	Chairrail		2006	5,980	217	20	299	82	449	33
34	Landscaping		2006	60,183	5,717	20	3,009	(2,708)	4,514	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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	2007	\$ 14,600	\$	20	\$ 365	\$ 365	\$ 365	37
38	2007	2,696	53	20	67	14	67	38
39	2007	14,191	22	20	355	333	355	39
40	2007	17,815	405	20	445	40	445	40
41	2007	15,979	599	20	399	(200)	399	41
42	2007	11,475	144	10	574	430	574	42
43								43
44								44
45								45
46	1995	5,380		20	269	269	3,784	46
47	1996	940		20	47	47	543	47
48	1997	1,353		20	68	68	878	48
49	1998	932		20	47	47	454	49
50	1999	2,587		20	129	129	1,045	50
51	2005	5,351		20	268	268	669	51
52	2007	3,029			76	76	76	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)		\$ 4,781,798	\$ 20,907	\$ 134,643	\$ 113,736	\$ 1,496,332	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	\$ 253,901	\$ 28,072	\$ 27,654	\$ (418)	10	\$ 70,256	71
72	Current Year Purchases	47,755	48,293	2,415	(45,878)	10	2,415	72
73	Fully Depreciated Assets	621,734					621,734	73
74	Allocated from Management Co.	13,611		92	92		11,463	74
75	TOTALS	\$ 937,001	\$ 76,365	\$ 30,161	\$ (46,204)		\$ 705,868	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				\$	\$	\$	\$		\$	76
77	Allocation from Management	2004 Cadillac	2002	6,752		1,350	1,350	5	4,727	77
78										78
79										79
80	TOTALS			\$ 6,752	\$	\$ 1,350	\$ 1,350		\$ 4,727	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)	\$ 5,875,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,272	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 166,154	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 68,882	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,206,927	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:				\$			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: \$ 18,267 Description: Beds, Medical Equipment & Special Mattresses 18,267 (Advacare Systems)

(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	Facility	2007 Lexus	\$ 861.39	\$ 10,337	17
18	SW Management Allocation			1,451	18
19					19
20					20
21	TOTAL		\$ 861.39	\$ 11,788	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

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

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

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	\$	9,459	\$ 264,842	\$	9,459	\$ 264,842	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,597	95,922		1,597	95,922	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		10,355	269,224		10,355	269,224	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				202,700		202,700	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			\$	21,411	\$ 629,988	\$ 202,700	21,411	\$ 832,688	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	19,752	19,752	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	2,385,139	2,385,139	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,509	5,509	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	17,160	17,160	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,428,560	\$ 2,428,560	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		4,284,087	14
15	Leasehold Improvements, at Historical Cost	441,431	497,711	15
16	Equipment, at Historical Cost	332,855	943,753	16
17	Accumulated Depreciation (book methods)	(330,080)	(2,206,927)	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): See Schedule 17A		5,190	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 444,206	\$ 3,673,814	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,872,766	\$ 6,102,374	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 391,085	\$ 391,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,647	30,647	28
29	Short-Term Notes Payable	522,514	522,514	29
30	Accrued Salaries Payable	272,351	272,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,795	28,795	31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,100	106,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Schedule 17A	372,095	129,532	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,723,587	\$ 1,481,024	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		3,718,928	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)	\$	\$ 3,718,928	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,723,587	\$ 5,199,952	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,149,179	\$ 902,422	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,872,766	\$ 6,102,374	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Tower Hill Healthcare Center
 Provider #:0045930
 12/31/2007

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interst	10,524	10,524
Due from Prior Owner	-	-
Employee Loans	1,075	1,075
Employee Payroll Advance	1,923	1,923
Reimbursement Due / Bad Debts	7,549	7,549
Total Line 9 - Other Current Assets (specify):	21,071	21,071

Other Long Term Assets (specify):	Operating	After Consolidation
Short Term Loan Exchange	-	-
Loan Costs	-	51,107
A/A Loan costs	-	(45,917)
Total Line 23 - Other Long Term Assets (specify):	-	5,190

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	-	-
Credit union	475	475
Union dues	10,877	10,877
Accrued Expenses	93,153	93,153
Accrued Management fees	2,000	2,000
Due to Public Aid	3,911	3,911
Due / from Kane St. Assoc.	265,590	-
Due to Partners	-	23,027
Total Line 36 - Other Current Liabilities (specify):	376,006	133,443

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 512,353	1
2	Restatements (describe):		2
3	Prior period adjustment	(86,398)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 425,955	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	723,224	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)	\$ 723,224	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)	\$ 1,149,179	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,081,869	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,081,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	501,000	6
7	Oxygen	14,275	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 515,275	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***	8,834	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,834	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,605,978	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,660,494	31
32	Health Care	3,602,603	32
33	General Administration	1,455,695	33
	B. Capital Expense		
34	Ownership	745,245	34
	C. Ancillary Expense		
35	Special Cost Centers	307,887	35
36	Provider Participation Fee	110,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,882,754	40
41	Income before Income Taxes (line 30 minus line 40)**	723,224	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 723,224	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: 01/01/2007

Ending: 12/31/2007

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	\$ 66,946	\$ 32.19	1
2	Assistant Director of Nursing	388	11,263	29.03	2
3	Registered Nurses	34,511	1,059,005	28.43	3
4	Licensed Practical Nurses	9,580	261,127	26.37	4
5	CNAs & Orderlies	89,742	1,177,927	12.26	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,808	21,564	11.01	9
10	Activity Assistants	9,373	126,949	12.74	10
11	Social Service Workers	3,895	61,137	15.44	11
12	Dietician				12
13	Food Service Supervisor	2,072	52,955	25.46	13
14	Head Cook	9,436	111,397	10.88	14
15	Cook Helpers/Assistants	23,689	208,185	8.07	15
16	Dishwashers				16
17	Maintenance Workers	8,004	103,274	11.77	17
18	Housekeepers	23,505	201,654	7.91	18
19	Laundry	11,415	96,617	7.85	19
20	Administrator	2,080	131,044	63.00	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	18,737	390,635	19.79	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				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	250,315	\$ 4,081,679 *	\$ 15.23	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	97	\$ 9,322	L1, C3 35
36	Medical Director	265	26,000	L9, C3 36
37	Medical Records Consultant	104	4,691	L10, C3 37
38	Nurse Consultant			38
39	Pharmacist Consultant	139	19,201	L10, C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	80	10,217	L10A, C3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	44	4,400	L11, C3 44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	729	\$ 73,831	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$	50
51	Licensed Practical Nurses			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	\$ 131,044	Workers' Compensation Insurance	\$ 43,265	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	61,799	Advertising: Employee Recruitment		
				FICA Taxes	310,084	Health Care Worker Background Check		
				Employee Health Insurance	48,480	(Indicate # of checks performed <u>426</u>)	5,108	
				Employee Meals	6,929	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	12,051	
				Miscellaneous Employee Benefits	12,392	Miscellaneous Dues & Permits	775	
						Miscellaneous Inspections & Licenses	5,549	
						Allocation from Management Co.	348	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 131,044			Less: Non-Allowable Dues	(2,626)	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Rose Betz-Management Fees			\$ 62,135			Yellow page advertising	()	
SW Management-Home Office & Management Fees			128,750					
(Eliminated in Schedule V Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 190,885	TOTAL (agree to Schedule V, line 22, col.8)	\$ 482,949	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,195	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ashman & Stein	Legal		\$ 33,821	N/A			Out-of-State Travel	\$
Personal Planners, Inc.	U/E Consultant		1,510					
RSM McGladrey, Inc.	Accounting		14,807				In-State Travel	
							Seminar Expense	15,022
							Allocation from Management Co.	73
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 50,138	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 15,095

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	50,138
Allocated From Kane Street Associates	
Accounting	1,275
Allocated From SW Management:	
Accounting	3,405
Legal	9,163
Total (agree to Schedule V, line 19, column 8)	<u>63,981</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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
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: 01/01/2007

Ending: 12/31/2007

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. IL Council on Long Term Care = \$9,425
- (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. \$ 43,323 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. \$ 110,830
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. \$ 6,929 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? 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 \$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