

Facility Name & ID Number Tower Hill Healthcare Center

0045930 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 _____

	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	75,396	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	75,396	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	47,530	13,927	5,899	67,356	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,530	13,927	5,899	67,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.34%

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 7/1/02

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/1/02 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 206 and days of care provided 5,899

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	395,010	34,759	7,665	437,434		437,434		437,434	1	
2	Food Purchase		527,953		527,953		527,953	(16,280)	511,673	2	
3	Housekeeping	234,904	102,704		337,608		337,608	165	337,773	3	
4	Laundry	101,226	22,221		123,447		123,447		123,447	4	
5	Heat and Other Utilities			205,777	205,777		205,777	1,612	207,389	5	
6	Maintenance	122,533	109,619	24,211	256,363		256,363	3,556	259,919	6	
7	Other (specify):*									7	
8	TOTAL General Services	853,673	797,256	237,653	1,888,582		1,888,582	(10,947)	1,877,635	8	
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000	9	
10	Nursing and Medical Records	3,072,026	155,122	19,339	3,246,487		3,246,487	4,169	3,250,656	10	
10a	Therapy			709,375	709,375		709,375		709,375	10a	
11	Activities	149,100	47,866	5,400	202,366		202,366		202,366	11	
12	Social Services	68,606			68,606		68,606		68,606	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	3,289,732	202,988	758,114	4,250,834		4,250,834	4,169	4,255,003	16	
	C. General Administration										
17	Administrative	180,332		198,899	379,231		379,231	(100,910)	278,321	17	
18	Directors Fees									18	
19	Professional Services			54,570	54,570		54,570	5,086	59,656	19	
20	Dues, Fees, Subscriptions & Promotions			24,311	24,311		24,311	(8,223)	16,088	20	
21	Clerical & General Office Expenses	384,209		120,251	504,460		504,460	54,737	559,197	21	
22	Employee Benefits & Payroll Taxes			584,263	584,263		584,263	9,366	593,629	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			6,202	6,202		6,202	(432)	5,770	24	
25	Other Admin. Staff Transportation			12,328	12,328		12,328	1,633	13,961	25	
26	Insurance-Prop.Liab.Malpractice			19,626	19,626		19,626	772	20,398	26	
27	Other (specify):* Mgmt Alloc of Benefit							20,451	20,451	27	
28	TOTAL General Administration	564,541		1,020,450	1,584,991		1,584,991	(17,520)	1,567,471	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,707,946	1,000,244	2,016,217	7,724,407		7,724,407	(24,298)	7,700,109	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:

01/01/2008

Ending:

12/31/2008

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			121,722	121,722		121,722	48,893	170,615			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,798	30,798		30,798	233,982	264,780			32
33	Real Estate Taxes			100,035	100,035		100,035	4,805	104,840			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			27,514	27,514		27,514	1,430	28,944			35
36	Other (specify):*											36
37	TOTAL Ownership			760,069	760,069		760,069	(190,890)	569,179			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,504		221,504		221,504		221,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,094	113,094		113,094		113,094			42
43	Other (specify):* Non-allowable cost			69,438	69,438		69,438	(69,438)				43
44	TOTAL Special Cost Centers		221,504	182,532	404,036		404,036	(69,438)	334,598			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,707,946	1,221,748	2,958,818	8,888,512		8,888,512	(284,626)	8,603,886			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	(63,936)	30		9
10	Interest and Other Investment Income	(18,281)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(748)	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	(4,892)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(221)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,416)	43		24
25	Fund Raising, Advertising and Promotional	(21,460)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(557)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,901)	43		28
29	Other-Attach Schedule See Pg. 5A	(35,841)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,253)		\$	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)	(123,373)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (123,373)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (284,626)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Tower Hill Healthcare Center

ID# 0045930

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense	\$ (11,966)	43	1
2	X-Ray Expense	(15,055)	43	2
3	Lobbying expense	(7,750)	20	3
4	Chamber of Commerce dues	(620)	20	4
5	Education & Seminars	(450)	24	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				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	(35,841)		49

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 Schedule 6A		See Schedule 6B		See Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32 Amortization	\$	Kane Street Associates	100.00%	\$ 6,072	\$ 6,072	1
2	V	30 Depreciation		Kane Street Associates	100.00%	108,915	108,915	2
3	V	32 Interest		Kane Street Associates	100.00%	258,708	258,708	3
4	V	34 Rent	480,000	Kane Street Associates	100.00%		(480,000)	4
5	V	43 RT Tax		Kane Street Associates	100.00%	557	557	5
6	V	32 Interest Income	12,517	Kane Street Associates	100.00%		(12,517)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 492,517			\$ 374,252	\$ * (118,265)	14

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

Tower Hill Healthcare Center
Provider # : 0045930
12/31/2008

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 :

Beauvais Manor Healthcare & Rehab	St. Louis, MO
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%	165		165	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,612		1,612	17
18	V	6 Maintenance		SW Management Co.	100.00%	3,556		3,556	18
19	V	17 Administrative	128,750	SW Management Co.	100.00%	27,840		(100,910)	19
20	V	19 Professional Services		SW Management Co.	100.00%	5,307		5,307	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	147		147	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	54,737		54,737	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	18		18	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,633		1,633	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	772		772	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	20,451		20,451	26
27	V	30 Depreciation		SW Management Co.	100.00%	3,914		3,914	27
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	4,805		4,805	28
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,430		1,430	29
30	V								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			\$ 126,398	\$ *	(2,352)	39

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

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	\$ 24,905	S & E Medical Supply Co.	100.00%	\$ 17,980	\$ (6,925)	15
16	V	10 Medical Supplies	2,947	S & E Medical Supply Co.	100.00%	7,116	4,169	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							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		\$ 27,852			\$ 25,096	\$ * (2,756)	39

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	7.50	Salary	\$ 13,920	L17, C7	1
2	Rosemary Betz	Adm. Consultant	Administrative	10.00	See Schedule 7B	0	0.00	Facility Fees	0	L17, C3	2
3	Moshe Herman	CFO	Administrative	5.00	See Schedule 7C	3	7.50	Salary	13,920	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	\$ 27,840		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:

01/01/2008

Ending: 12/31/2008

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	657,492	12	\$ 98	\$ 75,396	\$ 11	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	75,396	165	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	75,396	1,612	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	75,396	3,556	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	75,396	5,307	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	75,396	147	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	54,737	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	75,396	18	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	75,396	1,633	9	
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	657,492	12	6,729	75,396	772	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	75,396	20,451	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	75,396	4,805	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	75,396	1,430	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	3	27,840	17
18	17	Administrative	Avg. Hours Worked	50	6	185,600	185,600	0	0	18
19									19	
20	30	Depreciation	Direct Cost					3,914	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 126,398	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning: 01/01/2008

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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		\$	\$		\$ 17,980	1
2	10	Medical Supplies	Direct Cost					7,116	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 25,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$	\$ 3,594,451	8/20/08	0.0525	\$	258,708						
2																		
3																		
4																		
5																		
Working Capital																		
6	Member Loans	X		Line of Credit	Varies	12/15/02		1,000,000				12,517						
7	N/P Stockholder	X		Working Capital		11/15/02		406,189	(52,500)			18,281						
8																		
9	TOTAL Facility Related				\$25,886.40		\$	1,406,189	\$ 3,541,951		\$	289,506						
B. Non-Facility Related*																		
10								Interest income offset				(3,563)						
11								Amortization of mortgage costs				6,072						
12								Related Party Interest Expense net of Interest Income				(14,718)						
13								Real Estate Entity Interest Income Offset				(12,517)						
14	TOTAL Non-Facility Related						\$		\$		\$	(24,726)						
15	TOTALS (line 9+line14)						\$	1,406,189	\$ 3,541,951		\$	264,780						

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>101,534.74</u>	\$ <u>101,534.74</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>4,805.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>145,035.08</u>	\$ <u>106,339.74</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? X YES 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending: 12/31/2008

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	\$ 109,220	\$ 109,220	\$ 1,519,005	4
5										5
6	Allocation from Management Company	1995		49,634		39	1,418	1,418	17,946	6
7										7
8										8
	Improvement Type**									
9	Nursing Stations		2002	10,000		5			10,000	9
10	Carpet		2002	3,239		7	463	463	2,815	10
11	Time Recorder		2002	6,505		5			6,505	11
12	Fire Alarm System		2003	2,072		7	296	296	1,727	12
13	Recooling Tower Pump		2003	2,600		5	217	217	2,600	13
14	Hot Water Heater		2004	38,024	1,383	20	1,901	518	8,555	14
15	Alarm System		2004	24,807	902	20	1,240	338	5,582	15
16	Boiler		2005	19,350	704	20	968	264	3,386	16
17	Water softener valves & filter media		2005	9,955	362	20	498	136	1,742	17
18	Hardware for 8 doors		2005	5,177	188	20	259	71	906	18
19	Wire glass in frames		2005	1,194	43	20	60	17	209	19
20	Door alarm system		2005	2,733	99	20	137	38	478	20
21	Resurface parking lot		2005	25,256	1,944	20	1,263	(681)	4,420	21
22	Elevator door edges		2005	2,400	87	20	120	33	420	22
23	Elevator pump		2005	1,450	53	20	73	20	254	23
24	Sidewalk		2006	8,700	744	20	435	(309)	1,088	24
25	Ceiling Tile & Drywall		2006	4,842	176	20	242	66	605	25
26	Sidewalks & Curbs		2006	7,600	650	20	380	(270)	950	26
27	Sprinkler System		2006	20,659	751	20	1,033	282	2,582	27
28	Boiler		2006	89,925	3,270	20	4,496	1,226	11,241	28
29	UCP II Keypad		2006	2,473	90	20	124	34	309	29
30	Plumbing-Backflow Project		2006	10,366	777	20	518	(259)	1,296	30
31	Cooling Tower & Water Chiller		2006	5,954	216	20	298	82	744	31
32	Closet Doors		2006	4,000	145	20	200	55	500	32
33	Chairrail		2006	5,980	217	20	299	82	748	33
34	Landscaping		2006	60,182	5,146	20	3,009	(2,137)	7,523	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

Facility Name & ID Number Tower Hill Healthcare Center

0045930

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Paint and Decorate Entire Facility	2007	\$ 14,600	\$	20	\$ 730	\$ 730	\$ 1,094	37
38	Fire alarm	2007	2,696	98	20	135	37	202	38
39	Boiler and valves	2007	14,191	516	20	710	194	1,064	39
40	Tile 88 bathrooms	2007	17,815	648	20	891	243	1,336	40
41	Landscaping-Retaining Wall	2007	15,979	1,538	20	799	(739)	1,198	41
42	Landscaping-Paver Walk & Fence	2007	11,475	1,133	10	1,148	15	1,721	42
43	Elevator	2008	56,650	2,127	20	1,416	(711)	1,416	43
44	Retaining wall	2008	26,000	13,650	20	650	(13,000)	650	44
45	Replace sidewalk-2 squares	2008	2,515	1,321	20	63	(1,258)	63	45
46	Valve	2008	3,300	105	20	83	(23)	83	46
47	Brick pond	2008	10,000	197	20	250	53	250	47
48	Telephone system	2008	33,796	33,796	20	845	(32,951)	845	48
49	Automatic door opener	2008	3,900	30	20	98	68	98	49
50									50
51									51
52	Allocation of SW Management - Leasehold improvement	1995	5,295		20	265	265	3,989	52
53	Allocation of SW Management - Leasehold improvement	1996	925		20	46	46	581	53
54	Allocation of SW Management - Leasehold improvement	1997	1,332		20	67	67	930	54
55	Allocation of SW Management - Leasehold improvement	1998	917		20	46	46	493	55
56	Allocation of SW Management - Leasehold improvement	1999	2,546		20	127	127	1,156	56
57	Allocation of SW Management - Leasehold improvement	2005	5,266		20	263	263	922	57
58	Allocation of SW Management - Leasehold improvement	2007	2,981		20	149	149	224	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)		\$ 4,916,851	\$ 73,106		\$ 137,944	\$ 64,838	\$ 1,632,449	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	\$ 284,230	\$ 16,759	\$ 29,545	\$ 12,786	10	\$ 84,791	71
72	Current Year Purchases	33,778	31,857	1,593	(30,264)	10	1,593	72
73	Fully Depreciated Assets	639,160					639,160	73
74	Allocation from Management Co	15,672		204	204	10	11,487	74
75	TOTALS	\$ 972,840	\$ 48,616	\$ 31,342	\$ (17,274)		\$ 737,031	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	Allocation from Management	Cadillac	2004	\$ 6,647	\$	\$ 1,329	\$ 1,329	5	\$ 5,982	76
77										77
78										78
79										79
80	TOTALS			\$ 6,647	\$	\$ 1,329	\$ 1,329		\$ 5,982	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)	\$ 6,046,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,615	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,893	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,375,462	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: _____

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: \$ 15,334 Description: Beds, Medical Equipment \$4,958(Advacare Systems), Tools \$279(Home Depot), Tables Chairs Linens \$10,097(
(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	\$ 12,180	17
18					18
19	SW Management Allocation			1,430	19
20					20
21	TOTAL		\$ 861.39	\$ 13,610	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	9,800	\$ 274,565	\$	9,800	\$ 274,565	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		258	74,504		258	74,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		13,184	342,795		13,184	342,795	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				221,504		221,504	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	23,242	\$ 691,864	\$ 221,504	23,242	\$ 913,368	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	38,307	38,307	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	2,500,476	2,500,476	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,608	5,608	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch. 17A	5,892	5,892	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,551,283	\$ 2,551,283	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		4,283,289	14
15	Leasehold Improvements, at Historical Cost	577,593	633,562	15
16	Equipment, at Historical Cost	366,634	979,487	16
17	Accumulated Depreciation (book methods)	(451,802)	(2,375,462)	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 Sch. 17A	4,708	6,304	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 497,133	\$ 3,677,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,048,416	\$ 6,228,463	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 538,803	\$ 538,803	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,481	60,481	28
29	Short-Term Notes Payable	(52,500)	(52,500)	29
30	Accrued Salaries Payable	129,006	129,006	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,089	14,089	31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,600	104,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch. 17A	517,992	180,785	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,312,471	\$ 975,264	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,594,451	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)	\$	\$ 3,594,451	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,312,471	\$ 4,569,715	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,735,945	\$ 1,658,748	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,048,416	\$ 6,228,463	48

Tower Hill Healthcare Center, LLC
 Provider #:0045930
 12/31/2008

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interst	5,702	5,702
Employee Loans	190	190
Employee Payroll Advance	-	-
Reimbursement Due / Bad Debts	-	-
Total Line 9 - Other Current Assets (specify):	5,892	5,892

Other Long Term Assets (specify):	Operating	After Consolidation
Short Term Loan Exchange	4,708	4,708
Loan Costs	-	52,721
A/A Loan costs	-	(51,125)
Total Line 23 - Other Long Term Assets (specify):	4,708	6,304

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	21,992	21,992
Credit union	225	225
Union dues	4,311	4,311
Accrued Expenses	114,537	114,537
Accrued Legal Expenses	5,000	5,000
Accrued Management fees	2,000	2,000
Due to Public Aid	(2,823)	(2,823)
Due / from Kane St. Assoc.	372,750	12,516
Due to Partners	-	23,027
Total Line 36 - Other Current Liabilities (specify):	517,992	180,785

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,149,179	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,149,179	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	986,769	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	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 586,766	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)	\$ 1,735,945	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	\$ 9,258,641	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,258,641	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	613,075	6
7	Oxygen	2	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 613,077	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***	3,563	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,563	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)	\$ 9,875,281	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,888,582	31
32	Health Care	4,250,834	32
33	General Administration	1,584,991	33
	B. Capital Expense		
34	Ownership	760,069	34
	C. Ancillary Expense		
35	Special Cost Centers	290,942	35
36	Provider Participation Fee	113,094	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,888,512	40
41	Income before Income Taxes (line 30 minus line 40)**	986,769	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 986,769	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: 01/01/2008

Ending: 12/31/2008

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	2,160	\$ 71,326	\$ 33.02	1
2	Assistant Director of Nursing	1,886	68,649	34.07	2
3	Registered Nurses	37,088	1,123,859	28.16	3
4	Licensed Practical Nurses	16,284	424,240	25.39	4
5	CNAs & Orderlies	110,890	1,383,952	11.72	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,010	25,026	11.97	9
10	Activity Assistants	9,244	124,074	12.57	10
11	Social Service Workers	4,193	68,606	15.40	11
12	Dietician				12
13	Food Service Supervisor	2,160	48,128	21.49	13
14	Head Cook	9,741	109,521	10.23	14
15	Cook Helpers/Assistants	25,990	237,361	8.40	15
16	Dishwashers				16
17	Maintenance Workers	10,375	122,533	11.04	17
18	Housekeepers	27,520	234,904	7.88	18
19	Laundry	11,358	101,226	7.96	19
20	Administrator	2,815	180,332	63.74	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	18,251	384,209	19.77	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)	291,965	\$ 4,707,946 *	\$ 15.07	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	98	\$ 7,665	L1, C3	35
36	Medical Director	255	24,000	L9, C3	36
37	Medical Records Consultant	55	3,243	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	111	16,096	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	238	17,511	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,400	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	757	\$ 73,915		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	\$ 180,332	Workers' Compensation Insurance	\$ 93,611	IDPH License Fee	\$ 105		
				Unemployment Compensation Insurance	43,052	Advertising: Employee Recruitment			
				FICA Taxes	355,936	Health Care Worker Background Check	3,424		
				Employee Health Insurance	73,571	(Indicate # of checks performed <u>285</u>)			
				Employee Meals	9,366	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	14,816		
				Uniforms	11,677	Miscellaneous Dues & Permits	1,594		
				Employee Life Insurance	600	Miscellaneous Inspections & Licenses	3,752		
				Miscellaneous Employee Benefits	5,816	Allocation from Management Co.	147		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 180,332	TOTAL (agree to Schedule V, line 22, col.8)		\$ 593,629	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,088
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			\$ 70,149	N/A			Out-of-State Travel	\$	
SW Management-Home Office & Management Fees (Eliminated in Schedule V Column 7)			128,750				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 198,899	TOTAL		\$	Seminar Expense	5,752	
C. Professional Services							Allocation from Management Co.	18	
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Ashman & Stein	Legal		\$ 21,027				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,770
Daniel Parsons	Legal		3,633						
Bradley Cahow	Legal		525						
Stone, Mcguire, Siegel	Legal		3,358						
Wellspring Partners	Legal		6,500						
Personnel Planners	U/E Consultant		1,560						
McGladrey & Pullen, LLP	Accounting		17,761						
Frost, Ruttenberg, Rothblatt	Accounting		206						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,570						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Tower Hill Healthcare Center, LLC
Provider #: 0045930
12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 54,570

Disallow out of period legal

Legal (221)

Allocated From SW Management:

Accounting 1,146

Legal 4,161

Total (agree to Schedule V, line 19, column 8) 59,656

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center

FYE: 12/31/08

Medicaid Cost Report Workpapers

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Provider Number - 0045930

Schedule of Travel and Seminar Detail

Section XIX Continued:

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost
Jeremy Amster	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Hilda Holm	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Sarah Thompson	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Michelle Valdez	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Linda Nahl	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Jeremy Amster	Customer Satisfaction	3/11/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Hilda Holm	Customer Satisfaction	3/11/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Margie Thompson	Customer Satisfaction	3/11/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Merlyn Sulana	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Margie Thompson	Be Prepared for MDS Medicaid Audits (Repeat)	2/14/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Jennifer Desmond	OSHA Safety Day	3/26/2008	Sugar Grove, IL	US Dept of Labor-OSHA	59.00
Jeremy Amster	Infection Protection-It's In Your Hands	4/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Hilda Holm	Infection Protection-It's In Your Hands	4/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Linda Nahl	Infection Protection-It's In Your Hands	4/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Monica Melo	Infection Protection-It's In Your Hands	4/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Barrie Komie	Preparing Leaders for the Future of Dementia Care	5/1/2008	Hinsdale, IL	LSN Foundation	575.00
Jeremy Amster	Wound Management	5/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Hilda Holm	Wound Management	5/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Romel Tucastacas	Wound Management	5/15/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Barry Komie	Basic Dementia Care	3/14/2008	South Elgin, IL	Alzheimer's Association	700.00
Barry Komie	Basic Dementia Care	8/20/2008	South Elgin, IL	Alzheimer's Association	700.00
Margie Thompson	Psychiatric Commitment: legal and Ethical Principles of Involuntary H	May-08	Aurora, IL	Family Counseling Service	39.00
Robin Cain	Psychiatric Commitment: legal and Ethical Principles of Involuntary H	May-08	Aurora, IL	Family Counseling Service	39.00
Hilda Holm	Psychiatric Commitment: legal and Ethical Principles of Involuntary H	May-08	Aurora, IL	Family Counseling Service	39.00
Facility Training	CPR Certification, Masks & Instruction Book	7/1 & 3/08	Elgin, IL	A-TEC Ambulance, Inc	300.00
Facility Training	CPR Certification, Masks & Instruction Book	8/21/2008	Elgin, IL	A-TEC Ambulance, Inc	75.00
Pablo Gutierrez	Serving Safe Food	9/3/2008	Elgin, IL	Elgin Community College	139.00
Juan Martinez	Serving Safe Food	9/3/2008	Elgin, IL	Elgin Community College	139.00
Roberto Chavez	Serving Safe Food	9/3/2008	Elgin, IL	Elgin Community College	139.00
Monica Alonzo	Serving Safe Food	9/3/2008	Elgin, IL	Elgin Community College	139.00
Jeremy Amster	Today's Trends in Medicare/Medicaid Billing	10/31/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Hilda Holm	Today's Trends in Medicare/Medicaid Billing	10/31/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Monica Melo	Today's Trends in Medicare/Medicaid Billing	10/31/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Kendra Johnson	Today's Trends in Medicare/Medicaid Billing	10/31/2008	Skokie, IL	Illinois Council on Long Term Care	95.00
Facility Training	CPR Certification, Masks & Instruction Book	9/23 & 25/08	Elgin, IL	A-TEC Ambulance, Inc	225.00
				Total	5,302.00
				Allocation from Management Company	18.00
				Grand Total	5,320.00

Total

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	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
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: 01/01/2008

Ending: 12/31/2008

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 Long Term Care \$14,816
- (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. \$ 66,481 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. \$ 113,094
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. \$ 9,366 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 \$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