FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0045930

Facility Name: Tower Hill Healthcare Center

Address: 759 Kane Street (Number) South Elgin (City) 60177 (Zip Code)

County: Kane

Telephone Number: (847) 697-3310 **Fax #** (847) 697-3354

HFS ID Number:

Date of Initial License for Current Owners: 10/25/02

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	52,013	9,889	6,835	68,737	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,013	9,889	6,835	68,737	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.42%

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/02

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 206 and days of care provided 6,835

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

* 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: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	486,713	25,711	10,723	523,147		523,147		523,147			1
2	Food Purchase		611,326		611,326		611,326	(11,146)	600,180			2
3	Housekeeping	276,247	136,484		412,731		412,731	114	412,845			3
4	Laundry	116,517	26,611		143,128		143,128		143,128			4
5	Heat and Other Utilities			162,359	162,359		162,359	1,722	164,081			5
6	Maintenance	140,008	140,881	22,359	303,248		303,248	735	303,983			6
7	Other (specify):*											7
8	TOTAL General Services	1,019,485	941,013	195,441	2,155,939		2,155,939	(8,575)	2,147,364			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	3,391,066	237,644	6,704	3,635,414		3,635,414	(2,297)	3,633,117			10
10a	Therapy			764,283	764,283		764,283		764,283			10a
11	Activities	167,824	34,081	6,251	208,156		208,156		208,156			11
12	Social Services	74,857			74,857		74,857		74,857			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,633,747	271,725	802,238	4,707,710		4,707,710	(2,297)	4,705,413			16
	C. General Administration											
17	Administrative	170,000		287,846	457,846		457,846	(133,857)	323,989			17
18	Directors Fees											18
19	Professional Services			158,962	158,962		158,962	(3,142)	155,820			19
20	Dues, Fees, Subscriptions & Promotions			31,597	31,597		31,597	(7,565)	24,032			20
21	Clerical & General Office Expenses	521,667		138,233	659,900		659,900	62,149	722,049			21
22	Employee Benefits & Payroll Taxes			778,168	778,168		778,168	11,273	789,441			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,417	12,417		12,417	(1,190)	11,227			24
25	Other Admin. Staff Transportation			20,543	20,543		20,543	1,335	21,878			25
26	Insurance-Prop.Liab.Malpractice			21,377	21,377		21,377	622	21,999			26
27	Other (specify):* Mgmt Alloc of Benefit							17,777	17,777			27
28	TOTAL General Administration	691,667		1,449,143	2,140,810		2,140,810	(52,598)	2,088,212			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,344,899	1,212,738	2,446,822	9,004,459		9,004,459	(63,470)	8,940,989			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: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			129,827	129,827		129,827	70,576	200,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,101	3,101		3,101	209,781	212,882			32
33	Real Estate Taxes			88,922	88,922		88,922	3,700	92,622			33
34	Rent-Facility & Grounds			384,000	384,000		384,000	(384,000)				34
35	Rent-Equipment & Vehicles			30,392	30,392		30,392	1,260	31,652			35
36	Other (specify):*											36
37	**TOTAL Ownership**			636,242	636,242		636,242	(98,683)	537,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		251,628		251,628		251,628		251,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,785	112,785		112,785		112,785			42
43	Other (specify):* Non-Allowable Cos			233,995	233,995		233,995	(233,995)				43
44	**TOTAL Special Cost Centers**		251,628	346,780	598,408		598,408	(233,995)	364,413			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,344,899	1,464,366	3,429,844	10,239,109		10,239,109	(396,148)	9,842,961			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,719)	30		9
10	Interest and Other Investment Income	(3,101)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,919)	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	(5,520)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,601)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(157,801)	43		24
25	Fund Raising, Advertising and Promotional	(39,999)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(479)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(37,942)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (294,081)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,067)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (102,067)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (396,148)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center

ID# 0045930

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense - Med A	$ (12,401)	43	1
2	X Ray Expense - Med A	(16,355)	43	2
3	Education & Seminar	(1,250)	24	3
4	Chamber of Commerce Dues	(395)	20	4
5	Lobbying Expense	(7,541)	20	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**	(37,942)		49

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	20	Licenses	$	Kane Street Associates	100.00%	$ 250	$ 250	1
2	V	21	Clerical & General		Kane Street Associates	100.00%	1,377	1,377	2
3	V	30	Depreciation		Kane Street Associates	100.00%	108,860	108,860	3
4	V	32	Amortization		Kane Street Associates	100.00%	323	323	4
5	V	32	Interest		Kane Street Associates	100.00%	213,305	213,305	5
6	V	32	Interest Income	825	Kane Street Associates	100.00%		(825)	6
7	V	34	Rent	384,000	Kane Street Associates	100.00%		(384,000)	7
8	V	43	RT Tax				479	479	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 384,825			$ 324,594	$ * (60,231)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider # : 0045930
12/31/2010

VII. Related Parties - Page 6 **Schedule 6A**

Share Numl	Shareholder Name	Beginning Shares	Ownership Percentage
1	Sheldon Wolfe	N/A	42.5
2	Jack Rajchenbach	N/A	42.5
3	Moshe Herman	N/A	5
4	Rosemary Betz	N/A	10

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider # : 0045930
12/31/2010

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 :	
Rosewood Health and Rehab	Independence, MO
Beauvais Manor Healthcare & Rehab	St. Louis, MO
Hillside Manor Healthcare & Rehab	St. Louis, MO
Rancho Manor Healthcare & Rehab	Florissant, MO

Other Related Business Entities

	Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
	S.W. Management Co.	Skokie	Bookkeeping/Management Company
	S&E Medical Supply Co.	Skokie	Medical Supplies
*	SFO Associates	Skokie	Finance Company

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Management Co.	100.00%	$ 198	$ 198	15
16	V	3	Housekeeping		SW Management Co.	100.00%	114	114	16
17	V	5	Heat and Other Utilities		SW Management Co.	100.00%	1,722	1,722	17
18	V	6	Maintenance		SW Management Co.	100.00%	735	735	18
19	V	17	Administrative	162,000	SW Management Co.	100.00%	28,143	(133,857)	19
20	V	19	Professional Services		SW Management Co.	100.00%	2,459	2,459	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	121	121	21
22	V	21	Clerical & General Office Expense		SW Management Co.	100.00%	60,772	60,772	22
23	V	24	Travel and Seminar		SW Management Co.	100.00%	60	60	23
24	V	25	Other Admin. Staff Transport		SW Management Co.	100.00%	1,335	1,335	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	622	622	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.	100.00%	17,777	17,777	26
27	V	30	Depreciation		SW Management Co.	100.00%	3,435	3,435	27
28	V	32	Interest		SW Management Co.	100.00%	79	79	28
29	V	33	Real Estate Taxes		SW Management Co.	100.00%	3,700	3,700	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.	100.00%	1,260	1,260	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			$ 162,000			$ 122,532	$ * (39,468)	39

* 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: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 16,984	S & E Medical Supply Co.	100.00%	$ 16,913	$ (71)	15
16	V	3	Housekeeping	2,936	S & E Medical Supply Co.	100.00%	2,936		16
17	V	10	Medical Supplies	4,939	S & E Medical Supply Co.	100.00%	2,642	(2,297)	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			$ 24,859			$ 22,491	$ * (2,368)	39

* 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: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	42.50	See Schedule 7A	3	7.00	Salary	$ 14,071	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	7.00	Salary	14,071	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	$ 52,142		13

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

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	742,930	12	$ 1,959	$	75,190	$ 198	1
2	3	Housekeeping	Bed Days Available	742,930	12	1,125		75,190	114	2
3	5	Heat and Other Utilities	Bed Days Available	742,930	12	17,016		75,190	1,722	3
4	6	Maintenance	Bed Days Available	742,930	12	7,264		75,190	735	4
5	19	Professional Services	Bed Days Available	742,930	12	24,293		75,190	2,459	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	742,930	12	1,198		75,190	121	6
7	21	Clerical & General Office Exp	Bed Days Available	742,930	12	600,468	509,094	75,190	60,772	7
8	24	Travel and Seminar	Bed Days Available	742,930	12	594		75,190	60	8
9	25	Other Admin. Staff Transport	Bed Days Available	742,930	12	13,194		75,190	1,335	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	742,930	12	6,148		75,190	622	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	742,930	12	175,644		75,190	17,777	11
12	32	Interest	Bed Days Available	742,930	12	778		75,190	79	12
13	33	Real Estate Taxes	Bed Days Available	742,930	12	36,555		75,190	3,700	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	742,930	12	12,454		75,190	1,260	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	84	12	394,000	394,000	6	28,143	17
18	17	Administrative	Avg. Hours Worked	50	6	197,000	197,000		0	18
19										19
20	30	Depreciation	Direct Cost	33,940					3,435	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,489,690	$ 1,100,094		$ 122,532	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 16,913	1
2	3	Housekeeping	Direct Cost						2,936	2
3	10	Medical Supplies	Direct Cost						2,642	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					$	$		$ 22,491	25

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial Bank		X	Mortgage	$25,886.40	8/20/03	$	$ 3,276,303	8/20/09	0.0525	$ 213,305	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/P Stockholder	X		Working Capital	Varies	11/15/02	557,500	(577,500)	Demand	0.0400	3,101	6
7												7
8												8
9	TOTAL Facility Related				$25,886.40		$ 557,500	$ 2,698,803			$ 216,406	9
	B. Non-Facility Related*											
10							Interest income offset				(3,926)	10
11							Amortization of mortgage costs				323	11
12							Allocated from Management Co.				79	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,524)	14
15	TOTALS (line 9+line14)						$ 557,500	$ 2,698,803			$ 212,882	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 106,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 94,675	2
3. Under or (over) accrual (line 2 minus line 1).		$ (12,025)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 95,000	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.		5,947	
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	Mgmt. Alloc	$ 502	5
	Allocated from Management Co.	3,198	
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.		$ 92,622	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	98,943	8
2006	103,001	9
2007	101,535	10
2008	102,633	11
2009	94,675	12

2010 Tax Accrual = 94,675 X 1.03 = 97,515. Use 95,000

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-228-012	Long term care property	$ 94,674.78	$ 94,674.78
2.	10-28-412-049-0000	SW Management Allocation	$ 33,634.00	$ 3,198.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 128,308.78	$ 97,872.78

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2000	$ 150,000	1
2					2
3	TOTALS			$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	206		2002		$ 4,259,594	$	39	$ 109,220	$ 109,220	$ 1,737,446	4
5											5
6	Allocation from Management Company		1995		43,806		39	1,252	1,252	19,594	6
7											7
8											8
	Improvement Type**										
9	Nursing Stations			2002	10,000		5			10,000	9
10	Carpet			2002	3,239		7			3,239	10
11	Time Recorder			2002	6,505		5			6,505	11
12	Fire Alarm System			2003	2,072		7	48	48	2,072	12
13	Recooling Tower Pump			2003	2,600		5			2,600	13
14	Hot Water Heater			2004	38,024	1,383	20	1,901	518	12,350	14
15	Alarm System			2004	24,807	902	20	1,240	338	8,062	15
16	Boiler			2005	19,350	704	20	968	264	5,322	16
17	Water softener valves & filter media			2005	9,955	362	20	498	136	2,738	17
18	Hardware for 8 doors			2005	5,177	188	20	259	71	1,424	18
19	Wire glass in frames			2005	1,194	43	20	60	17	329	19
20	Door alarm system			2005	2,733	99	20	137	38	752	20
21	Resurface parking lot			2005	25,256	1,574	20	1,263	(311)	6,946	21
22	Elevator door edges			2005	2,400	87	20	120	33	660	22
23	Elevator pump			2005	1,450	53	20	73	20	399	23
24	Sidewalk			2006	8,700	603	20	435	(168)	1,958	24
25	Ceiling Tile & Drywall			2006	4,842	176	20	242	66	1,089	25
26	Sidewalks & Curbs			2006	7,600	527	20	380	(147)	1,710	26
27	Sprinkler System			2006	20,659	751	20	1,033	282	4,648	27
28	Boiler			2006	89,925	3,270	20	4,496	1,226	20,233	28
29	UCP II Keypad			2006	2,473	90	20	124	34	557	29
30	Plumbing-Backflow Project			2006	10,366	777	20	518	(259)	2,332	30
31	Cooling Tower & Water Chiller			2006	5,954	216	20	298	82	1,340	31
32	Closet Doors			2006	4,000	145	20	200	55	900	32
33	Chairrail			2006	5,980	217	20	299	82	1,346	33
34	Landscaping			2006	60,182	4,171	20	3,009	(1,162)	13,541	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Paint and Decorate Entire Facility	2007	$ 14,600	$	20	$ 730	$ 730	$ 2,555	37
38	Fire alarm	2007	2,696	98	20	135	37	472	38
39	Boiler and valves	2007	14,191	516	20	710	194	2,484	39
40	Tile 88 bathrooms	2007	17,815	648	20	891	243	3,118	40
41	Landscaping-Retaining Wall	2007	15,979	1,246	20	799	(447)	2,796	41
42	Landscaping-Paver Walk & Fence	2007	11,475	918	10	1,148	230	4,017	42
43	Elevator	2008	56,650	2,687	20	2,833	146	7,082	43
44	Retaining wall	2008	26,000	1,112	20	1,300	188	3,250	44
45	Replace sidewalk-2 squares	2008	2,515	108	20	126	18	315	45
46	Valve	2008	3,300	120	20	165	45	413	46
47	Brick pond	2008	10,000	364	20	500	136	1,250	47
48	Telephone system	2008	33,796		20	1,690	1,690	4,225	48
49	Automatic door opener	2008	3,900	142	20	195	53	488	49
50	Boiler Heater	2009	3,100	113	20	155	42	233	50
51	2" Pipe at Water Heater	2009	3,525	128	20	176	48	264	51
52	Hot Water Heater	2009	3,003	109	20	150	41	225	52
53	Flooring and Ceiling Tiles	2009	31,023	1,128	20	1,551	423	2,327	53
54	Flooring	2009	68,677	2,497	20	3,434	937	5,151	54
55	Flooring	2010	17,623	1,251	20	441	(810)	441	55
56	Relaminate nurses' stations	2010	29,340	489	20	734	245	734	56
57	Flooring	2010	10,366	236	20	259	23	259	57
58	Cooling Tower	2010	15,000	386	20	375	(11)	375	58
59	Roof work-cooling tower	2010	4,000	103	20	100	(3)	100	59
60	Wiring for wireless internet	2010	5,166	133	20	129	(4)	129	60
61	Replace motor-cooling tower	2010	3,725	62	20	93	31	93	61
62	Dampers	2010	11,412	156	20	285	129	285	62
63	Sprinklers	2010	251,873	1,908	20	6,297	4,389	6,297	63
64	Sprinkler system oversight	2010	10,100	77	20	253	176	253	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,359,693	$ 33,073		$ 153,725	$ 120,652	$ 1,919,722	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,359,693	$ 33,073		$ 153,725	$ 120,652	$ 1,919,722	1
2	Allocation of SW Management - Leasehold improvement	1995	4,902		20	245	245	4,171	2
3	Allocation of SW Management - Leasehold improvement	1996	816		20	41	41	594	3
4	Allocation of SW Management - Leasehold improvement	1997	946		20	47	47	756	4
5	Allocation of SW Management - Leasehold improvement	1998	809		20	40	40	516	5
6	Allocation of SW Management - Leasehold improvement	1999	2,247		20	112	112	1,245	6
7	Allocation of SW Management - Leasehold improvement	2005	4,648		20	232	232	1,278	7
8	Allocation of SW Management - Leasehold improvement	2007	2,631		20	132	132	460	8
9	Allocation of SW Management - Leasehold improvement	2009	5,494		20	275	275	412	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,382,186	$ 33,073		$ 154,849	$ 121,776	$ 1,929,154	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 391,734	$ 8,590	$ 40,087	$ 31,497	10	$ 155,423	71
72	Current Year Purchases	88,164	88,164	4,409	(83,755)	10	4,409	72
73	Fully Depreciated Assets	646,413					646,413	73
74	Allocated from Management Co.	13,832		280	280	10	10,699	74
75	TOTALS	$ 1,140,143	$ 96,754	$ 44,776	$ (51,978)		$ 816,944	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	Allocated from Management	2010 Infiniti	2010	$ 7,783	$	$ 778	$ 778	5	$ 778	76
77										77
78										78
79										79
80	TOTALS			$ 7,783	$	$ 778	$ 778		$ 778	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)	$ 6,680,112	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 129,827	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 200,403	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 70,576	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,746,876	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.

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 18,524 Description: Beds, Medical Equipment $12,051; Picnic Supplies $6,473
    (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	$ 912.96	$ 11,868	17
18	Allocation from Management Co.			1,260	18
19					19
20					20
21	TOTAL		$ 912.96	$ 13,128	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,066	$ 231,348	$	2,066	$ 231,348	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,048	94,203		2,048	94,203	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,973	413,231		3,973	413,231	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				251,628		251,628	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			$	8,087	$ 738,782	$ 251,628	8,087	$ 990,410	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 340,927	$ 340,927	1
2	Cash-Patient Deposits	20,186	20,186	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,695,889	2,695,889	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,895	3,895	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	43,575	43,575	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,104,472	$ 3,104,472	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		4,303,400	14
15	Leasehold Improvements, at Historical Cost	1,080,206	1,078,786	15
16	Equipment, at Historical Cost	537,698	1,147,926	16
17	Accumulated Depreciation (book methods)	(704,871)	(2,746,876)	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	41,366	42,226	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 954,399	$ 3,975,462	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,058,871	$ 7,079,934	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,559	$ 285,559	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,174	56,174	28
29	Short-Term Notes Payable	(577,500)	(577,500)	29
30	Accrued Salaries Payable	169,402	169,402	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,887	15,887	31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,000	95,000	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	805,511	957,067	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 850,033	$ 1,001,589	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,276,303	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)**	$	$ 3,276,303	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 850,033	$ 4,277,892	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,208,838	$ 2,802,042	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,058,871	$ 7,079,934	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Towerhill Healthcare Center, LLC
Provider #:0045930
12/31/2010

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interest	19,380	19,380
Employee Loans	11,074	11,074
Employee Payroll Advance	1,694	1,694
Prepaid Expenses	11,427	11,427
Total Line 9 - Other Current Assets (specify):	**43,575**	**43,575**

Other Long Term Assets (specify):	Operating	After Consolidation
Short Term Loan Exchange	41,366	41,366
Loan Costs	-	1,614
A/A Loan costs	-	(754)
Total Line 23 - Other Long Term Assets (specify):	**41,366**	**42,226**

Other Current Liabilities (specify):	Operating	After Consolidation
Due from State	158,127	158,127
Reimbursement Due / Bad Debt	384,778	384,778
Insurance Premiums Payable	1,029	1,029
Accrued Expenses	384,905	384,905
Accrued Management fees	2,000	2,000
Short Term Loan Exchange	3,300	3,300
Due to Public Aid	(99)	(99)
Due / from Kane St. Assoc.	(128,529)	-
Due to Partners	-	23,027
Total Line 36 - Other Current Liabilities (specify):	**805,511**	**957,067**

See Accountants' Compilation Report

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,116,110	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,116,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,092,728	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)**	$ 1,092,728	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)**	$ 3,208,838	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,717,386	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,717,386	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	547,821	6
7	Oxygen	11,046	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 558,867	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	(611)	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)**	$ (611)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,799	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,799	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Medicaid Income Adjustment	35,396	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,396	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,331,837	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,155,939	31
32	Health Care	4,707,710	32
33	General Administration	2,140,810	33
	B. Capital Expense		
34	Ownership	636,242	34
	C. Ancillary Expense		
35	Special Cost Centers	485,623	35
36	Provider Participation Fee	112,785	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,239,109	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,092,728	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,092,728	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: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 77,033	$ 37.04	1
2	Assistant Director of Nursing	1,803	2,037	74,439	36.54	2
3	Registered Nurses	30,996	33,326	996,577	29.90	3
4	Licensed Practical Nurses	25,002	26,446	718,852	27.18	4
5	CNAs & Orderlies	117,890	126,413	1,524,165	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	31,013	14.91	9
10	Activity Assistants	9,490	10,308	136,811	13.27	10
11	Social Service Workers	4,176	4,360	74,857	17.17	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	51,248	24.64	13
14	Head Cook	10,475	11,751	134,035	11.41	14
15	Cook Helpers/Assistants	28,236	31,127	301,430	9.68	15
16	Dishwashers					16
17	Maintenance Workers	10,403	11,244	140,008	12.45	17
18	Housekeepers	27,901	30,789	276,247	8.97	18
19	Laundry	11,346	12,738	116,517	9.15	19
20	Administrator	2,000	2,080	170,000	81.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,967	24,920	521,667	20.93	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)	309,925	333,779	$ 5,344,899 *	$ 16.01	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,723	L1, C3	35
36	Medical Director	Monthly	25,000	L9, C3	36
37	Medical Records Consultant	Monthly	3,977	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,727	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	25,501	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,251	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 74,179		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

** See instructions.

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster	Administrator	0	$ 170,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 170,000

B. Administrative - Other

Description	Amount
Management Fees-Special	$ 95,846
Central Bookkeeping Office	132,000
Management Fees-SW	60,000
(Eliminated on Schedule V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 287,846
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gallop Johnson & Neuman	Legal	$ 306
Ashman & Stein	Legal	120,646
Frederick S. Frankel	Legal	1,238
Stone McGuire & Siegel	Legal	5,329
Lamont E Stallworth	Legal	125
US Legal Support	Legal	381
Polsinelli Shughart	Legal	8,807
Bazos, Freeman, Schuster & Vanek	Legal	1,120
Cooper, Storm & Piscopo	Legal	1,000
McGladrey & Pullen LLP	Accounting	18,606
Personnel Planners	U/E Consultant	1,404
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 158,962

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,413
Unemployment Compensation Insurance	29,711
FICA Taxes	404,938
Employee Health Insurance	142,000
Employee Meals	11,273
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	26,112
Miscellaneous Employee Benefits	3,653
Uniforms	7,341
TOTAL (agree to Schedule V, line 22, col.8)	$ 789,441

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 70
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 341)	4,084
Patient Background Checks	
Illinois Council on Long Term Care	17,407
Miscellaneous Dues & Permits	995
Miscellaneous Inspections & Licenses	9,041
Allocated from Management Co.	121
See Schedule 21A	(7,686)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,032

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,167
Allocated from Management Co.	60
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,227

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center, LLC
Provider #: 0045930
12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	158,962
Disallow out of period legal	
Legal	(5,601)
Allocated From SW Management:	
Accounting	1,370
Legal	1,089
Total (agree to Schedule V, line 19, column 8)	155,820

F. Dues, Fees, Subscriptions and Promotions

Total from Pg 21	31,718
Allocated From Kane Street Associates:	250
Less : Nonallowable Chamber of Commerce	(395)
Less : Lobbying Expense	(7,541)
Total (agree to Schedule V, line 20, column 8)	24,032

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care-$17,407**

(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. $ **89,608** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **112,785**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(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. $ **11,273** 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**

(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.

SEE ACCOUNTANTS' COMPILATION REPORT