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.

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

I. IDPH License ID Number: 0051557

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: 7/1/11

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 07/01/11 to 12/31/11 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' PREPARATION 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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 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	37,904	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	37,904	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	436	129	3,358	3,923	8
9	SNF/PED					9
10	ICF	20,503	10,220		30,723	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,939	10,349	3,358	34,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.40%

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 7/1/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/11 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 3,358

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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	269,799	19,760	5,977	295,536		295,536		295,536			1
2	Food Purchase		295,642		295,642		295,642	135	295,777			2
3	Housekeeping	144,129	51,154		195,283		195,283	81	195,364			3
4	Laundry	60,418	13,560		73,978		73,978		73,978			4
5	Heat and Other Utilities			65,550	65,550		65,550	1,027	66,577			5
6	Maintenance	65,187	39,030	11,950	116,167		116,167	403	116,570			6
7	Other (specify):*											7
8	TOTAL General Services	539,533	419,146	83,477	1,042,156		1,042,156	1,646	1,043,802			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,726,939	107,697	16,851	1,851,487		1,851,487		1,851,487			10
10a	Therapy			462,170	462,170		462,170		462,170			10a
11	Activities	73,619	10,251	4,000	87,870		87,870		87,870			11
12	Social Services	61,846			61,846		61,846		61,846			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,862,404	117,948	493,021	2,473,373		2,473,373		2,473,373			16
	C. General Administration											
17	Administrative			320,889	320,889		320,889	(50,356)	270,533			17
18	Directors Fees											18
19	Professional Services			44,526	44,526		44,526	(16,886)	27,640			19
20	Dues, Fees, Subscriptions & Promotions			2,846	2,846		2,846	1,682	4,528			20
21	Clerical & General Office Expenses	261,268		48,398	309,666		309,666	41,718	351,384			21
22	Employee Benefits & Payroll Taxes			392,819	392,819		392,819		392,819			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,184	8,184		8,184	16	8,200			24
25	Other Admin. Staff Transportation			11,567	11,567		11,567	1,602	13,169			25
26	Insurance-Prop.Liab.Malpractice			8,790	8,790		8,790	292	9,082			26
27	Other (specify):* Mgmt Alloc of Benefit							12,747	12,747			27
28	TOTAL General Administration	261,268		838,019	1,099,287		1,099,287	(9,185)	1,090,102			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,663,205	537,094	1,414,517	4,614,816		4,614,816	(7,539)	4,607,277			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER #0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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			18,263	18,263		18,263	(15,182)	3,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,857	12,857		12,857		12,857			32
33	Real Estate Taxes			50,427	50,427		50,427	8,550	58,977			33
34	Rent-Facility & Grounds			600,000	600,000		600,000		600,000			34
35	Rent-Equipment & Vehicles			7,880	7,880		7,880	794	8,674			35
36	Other (specify):*											36
37	**TOTAL Ownership**			689,427	689,427		689,427	(5,838)	683,589			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,401	1,339	113,740		113,740	(1,339)	112,401			39
40	Barber and Beauty Shops			170	170		170		170			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,856	59,856		59,856		59,856			42
43	Other (specify):* **Non-Allow Costs**			39,529	39,529		39,529	(39,529)				43
44	**TOTAL Special Cost Centers**		112,401	100,894	213,295		213,295	(40,868)	172,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,663,205	649,495	2,204,838	5,517,538		5,517,538	(54,245)	5,463,293			45

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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	(17,743)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(675)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,876)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(707)	43		24
25	Fund Raising, Advertising and Promotional	(24,382)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(14,160)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,543)		$	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)	14,637		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,637		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,906)		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

TOWER HILL HEALTHCARE CENTER

ID# 0051557

Report Period Beginning: 07/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense - Med A	$ (7,858)	43	1
2	X Ray Expense - Med A	(5,907)	43	2
3	Chamber of Commerce Dues	(395)	20	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				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**	(14,160)		49

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jeremy Amster	49%	Rosewood Health and Rehab Center	Independence, MO	S.W. Management Co.	Skokie	Bookkeeping
Stuart Milstein	16%			Groves Community H	Independence. MO	Hospice
Ari Milstein	16%			Forest View Senior Re	Independence. MO	Independent Living
Elana Minkove	16%			White Oak Living Cen	Independence. MO	Residential Care
David Zuckerman	2%					
Albert Milstein	1%					

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			$			$	$	1
2	V								2
3	V		NA						3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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. (July - August)		$ 45	$ 45	15
16	V	3	Housekeeping		SW Management Co. (July - August)		27	27	16
17	V	5	Heat and Other Utilities		SW Management Co. (July - August)		342	342	17
18	V	6	Maintenance		SW Management Co. (July - August)		134	134	18
19	V	17	Administrative	21,296	SW Management Co. (July - August)		6,766	(14,530)	19
20	V	19	Professional Services		SW Management Co. (July - August)		327	327	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (July - August)		29	29	21
22	V	21	Clerical & General Office Expense		SW Management Co. (July - August)		13,906	13,906	22
23	V	24	Travel and Seminar		SW Management Co. (July - August)		5	5	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (July - August)		534	534	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co. (July - August)		97	97	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (July - August)		4,249	4,249	26
27	V	30	Depreciation		SW Management Co. (July - August)		854	854	27
28	V	32	Interest		SW Management Co. (July - August)				28
29	V	33	Real Estate Taxes		SW Management Co. (July - August)		850	850	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (July - August)		265	265	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			$ 21,296			$ 28,430	$ * 7,134	39

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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.(September thru December)		$ 90	$ 90	15
16	V	3	Housekeeping		SW Management Co.(September thru December)		54	54	16
17	V	5	Heat and Other Utilities		SW Management Co.(September thru December)		685	685	17
18	V	6	Maintenance		SW Management Co.(September thru December)		269	269	18
19	V	17	Administrative	42,593	SW Management Co.(September thru December)		6,767	(35,826)	19
20	V	19	Professional Services		SW Management Co.(September thru December)		653	653	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co.(September thru December)		58	58	21
22	V	21	Clerical & General Office Expense		SW Management Co.(September thru December)		27,812	27,812	22
23	V	24	Travel and Seminar		SW Management Co.(September thru December)		11	11	23
24	V	25	Other Admin. Staff Transport		SW Management Co.(September thru December)		1,068	1,068	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Management Co.(September thru December)		195	195	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co.(September thru December)		8,498	8,498	26
27	V	30	Depreciation		SW Management Co.(September thru December)		1,707	1,707	27
28	V	32	Interest		SW Management Co.(September thru December)				28
29	V	33	Real Estate Taxes		SW Management Co.(September thru December)		1,700	1,700	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co.(September thru December)		529	529	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			$ 42,593			$ 50,096	$ * 7,503	39

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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	Jeremy Amster	Owner	Administrator	49.00	0	50	100.00	Mgmt. Fee	$ 245,000	L17, C3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 245,000		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 # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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. (July - August)
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	101,308	10	$ 358	$	12,772	$ 45	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		12,772	27	2
3	5	Heat and Other Utilities	Bed Days Available	101,308	10	2,716		12,772	342	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		12,772	134	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		12,772	327	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	101,308	10	229		12,772	29	6
7	21	Clerical & General Office Exp	Bed Days Available	101,308	10	110,303	95,042	12,772	13,906	7
8	24	Travel and Seminar	Bed Days Available	101,308	10	42		12,772	5	8
9	25	Other Admin. Staff Transport	Bed Days Available	101,308	10	4,236		12,772	534	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	101,308	10	772		12,772	97	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		12,772	4,249	11
12	32	Interest	Bed Days Available	101,308	10			12,772	0	12
13	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		12,772	850	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	101,308	10	2,099		12,772	265	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	17
18	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	18
19	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	0	0	19
20	30	Depreciation	Direct Cost	6,938					854	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 266,571	$ 196,541		$ 28,430	25

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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.(September thru December)
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	199,348	10	$ 716	$	25,132	$ 90	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		25,132	54	2
3	5	Heat and Other Utilities	Bed Days Available	199,348	10	5,432		25,132	685	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		25,132	269	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		25,132	653	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	199,348	10	458		25,132	58	6
7	21	Clerical & General Office Exp	Bed Days Available	199,348	10	220,606	190,085	25,132	27,812	7
8	24	Travel and Seminar	Bed Days Available	199,348	10	86		25,132	11	8
9	25	Other Admin. Staff Transport	Bed Days Available	199,348	10	8,472		25,132	1,068	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	199,348	10	1,543		25,132	195	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		25,132	8,498	11
12	32	Interest	Bed Days Available	199,348	10			25,132		12
13	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		25,132	1,700	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	199,348	10	4,198		25,132	529	14
15										15
16										16
17	17	Administrative	Avg. Hours Worked	30	10	67,667	67,667	3	6,767	17
18										18
19	17	Administrative	Avg. Hours Worked	15	1	67,667	67,667			19
20	30	Depreciation	Direct Cost	13,877					1,707	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 465,476	$ 325,419		$ 50,096	25

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Varies		1,000,000	1,000,000	Demand	Varies	4,072	6
7	Shareholder's Loan	X		Working Capital	Varies		1,250,000	1,250,000	Demand	Varies	8,785	7
8												8
9	TOTAL Facility Related						$ 2,250,000	$ 2,250,000			$ 12,857	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,250,000	$ 2,250,000			$ 12,857	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.)**

**** 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 # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 50,427	2
3. Under or (over) accrual (line 2 minus line 1).		$ 50,427	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	Mgmt. Alloc	458	
		$ 6,000	5
	Allocated from Management Co.	2,092	
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.		$ 58,977	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	103,001	8
	2007	101,535	9
	2008	102,633	10
	2009	94,675	11
	2010	50,427	12

This facility does not accrue real estate taxes as it is part of the lease agreement.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TOWER HILL HEALTHCARE CENTER COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051557

CONTACT PERSON REGARDING THIS REPORT Jeremy Amster

TELEPHONE (847) 697-3310 FAX #: (847) 697-3354

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-228-012	Long term care property	$ 100,853.20	$ 50,426.60
2.	10-28-412.049-0000	SW Management Allocation	$ 33,410.00	$ 2,092.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134,263.20	$ 52,518.60

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

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					$	$		$	$	$	4
5											5
6	Allocation from Management Company		1995		26,622			761	761	12,668	6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	71	20	65	(6)	65	9
10											10
11	Allocation of SW Management - Leasehold improvement			1995	2,979			149	149	2,684	11
12	Allocation of SW Management - Leasehold improvement			1996	496			25	25	386	12
13	Allocation of SW Management - Leasehold improvement			1997	575			29	29	488	13
14	Allocation of SW Management - Leasehold improvement			1998	492			25	25	338	14
15	Allocation of SW Management - Leasehold improvement			1999	1,365			68	68	825	15
16	Allocation of SW Management - Leasehold improvement			2005	2,825			141	141	918	16
17	Allocation of SW Management - Leasehold improvement			2007	1,599			80	80	360	17
18	Allocation of SW Management - Leasehold improvement			2009	3,339			167	167	417	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

*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 # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 45,513	$ 71		$ 1,510	$ 1,439	$ 19,149	70

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

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	18,192	18,192	455	(17,737)	10	455	72
73	Fully Depreciated Assets							73
74	Mgmt. Co.	8,406		170	170		6,672	74
75	TOTALS	$ 26,598	$ 18,192	$ 625	$ (17,567)		$ 7,127	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management	2010 Infiniti	2010	$ 4,730	$	$ 946	$ 946	5	$ 1,419	76
77										77
78										78
79										79
80	TOTALS			$ 4,730	$	$ 946	$ 946		$ 1,419	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)	$ 76,841	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,263	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 3,081	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,182)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 27,695	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 # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Kane Street Property, LLC
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. [X] 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:	1963	206	07/01/2011	$ 600,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		206		$ 600,000 **			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: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/2011
Ending 06/30/2031

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$ 1,218,000
13.	/2013	$ 1,242,540
14.	/2014	$ 1,268,176

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ N/A Description:
(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	$ 7,880	17
18	Allocation from Management Co.			794	18
19					19
20					20
21	TOTAL		$ 912.96	$ 8,674	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.

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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.

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,408	$ 157,682	$	1,408	$ 157,682	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,576	72,490		1,576	72,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,224	231,339		2,224	231,339	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				112,401		112,401	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			$ 0	5,208	$ 461,511	$ 112,401	5,208	$ 573,912	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.

Facility Name & ID Number TOWER HILL HEALTHCARE CENTER # 0051557 Report Period Beginning: 07/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	39,856	39,856	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	3,213,227	3,213,227	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,591	12,591	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,266,674	$ 3,266,674	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		26,622	14
15	Leasehold Improvements, at Historical Cost	5,221	18,891	15
16	Equipment, at Historical Cost	50,819	31,328	16
17	Accumulated Depreciation (book methods)	(18,263)	(27,695)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,777	$ 49,146	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,304,451	$ 3,315,820	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (116,215)	$ (116,215)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,533	53,533	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	193,120	193,120	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,898	20,898	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,985	5,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	330,849	330,849	36
37	Accrued Management Fees	40,833	40,833	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,529,003	$ 1,529,003	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,250,000	1,250,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	340,492	340,492	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,590,492	$ 1,590,492	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,119,495	$ 3,119,495	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 184,956	$ 196,325	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,304,451	$ 3,315,820	48

***(See instructions.)**

TOWER HILL HEALTHCARE CENTER
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Schedule 17A

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued Expenses	318,849	318,849
Due to Kane for Rent	12,000	12,000
Total Line 36 - Other Current Liabilities (specify):	330,849	330,849

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		484,956	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) **Option Payment**		(300,000)	15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	184,956	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)**	$	184,956	24 *

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

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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	$ 5,575,420	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,575,420	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	410,135	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 410,135	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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment & Misc. Income	16,939	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,939	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,002,494	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,042,156	31
32	Health Care	2,473,373	32
33	General Administration	1,099,287	33
	B. Capital Expense		
34	Ownership	689,427	34
	C. Ancillary Expense		
35	Special Cost Centers	153,439	35
36	Provider Participation Fee	59,856	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,517,538	40
41	**Income before Income Taxes (line 30 minus line 40)****	484,956	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 484,956	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.**

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

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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	880	1,120	$ 45,934	$ 41.01	1
2	Assistant Director of Nursing	892	964	39,132	40.58	2
3	Registered Nurses	13,563	14,794	472,793	31.96	3
4	Licensed Practical Nurses	14,194	14,878	421,163	28.31	4
5	CNAs & Orderlies	52,864	57,623	747,917	12.98	5
6	CNA Trainees	0	0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,209	5,621	73,619	13.10	9
10	Activity Assistants					10
11	Social Service Workers	3,373	3,613	61,846	17.12	11
12	Dietician					12
13	Food Service Supervisor	960	960	25,474	26.54	13
14	Head Cook	4,306	4,702	63,941	13.60	14
15	Cook Helpers/Assistants	14,962	16,657	180,384	10.83	15
16	Dishwashers					16
17	Maintenance Workers	3,808	4,080	65,187	15.98	17
18	Housekeepers	13,063	14,434	144,129	9.99	18
19	Laundry	5,181	5,945	60,418	10.16	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,937	12,441	261,268	21.00	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)	145,191	157,832	$ 2,663,205 *	$ 16.87	34

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

** See instructions.

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	$ 5,977	L1, C3	35
36	Medical Director	Monthly	10,000	L9, C3	36
37	Medical Records Consultant	Monthly	7,092	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,759	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	659	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,000	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,487		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster	Administrator/Owner	49%	$ 0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 0

B. Administrative - Other

Description	Amount
Management Fees-Special-Rosemary Betz	$ 12,000
Central Bookkeeping Office (Eliminated on Sch. V, Col. 7)	63,889
Jeremy Amster	245,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 320,889
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Shira Balaban	Legal	$ 1,217
Stephen N Sher PC	Legal	9,876
Polsinelli Shughart	Legal	11,623
Allen A Lefkovitz & Associates	Legal	6,000
Honkamp Krueger & Co., PC	Accounting	81
McGladrey & Pullen, LLP	Accounting	14,925
Personnel Planners	U/E Consultant	804
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 44,526

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,187
Unemployment Compensation Insurance	12,623
FICA Taxes	204,722
Employee Health Insurance	86,908
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	9,701
Uniforms	5,460
Life Insurance	(695)
Miscellaneous Employee Benefits	3,913
TOTAL (agree to Schedule V, line 22, col.8)	$ 392,819

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 61)	726
Patient Background Checks	
Illinois Council on Long Term Care	
Miscellaneous Dues & Permits	735
Miscellaneous Licenses	269
Inspection Fees & Permits	721
Allocated from Management Co.	87
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,528

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,184
Allocated from Management Co.	16
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,200

**See instructions.

TOWER HILL HEALTHCARE CENTER
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	44,526
Disallow out of period legal	(9,876)
Reclass Allen A Lefkovitz & Assoc. to RE Tax Appeal	(6,000)
Reclass IDPH License Fee	(1,990)
Allocated From SW Management:	
- Accounting	857
- Legal	123
Total (agree to Schedule V, line 19, column 8)	27,640

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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		$		$	$	$	$	$	$	$	$	$

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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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **41,442** 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 fo
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 Departmen
during this cost report period. $ **59,856**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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 othe
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
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