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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/12 to 12/31/12 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) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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: 01/01/12 Ending: 12/31/12

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	75,396	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,396	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	581	465	6,913	7,959	8
9	SNF/PED					9
10	ICF	40,917	20,162		61,079	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,498	20,627	6,913	69,038	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

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 6,913

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

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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	537,326	46,969	12,655	596,950		596,950		596,950			1
2	Food Purchase		592,735		592,735		592,735	419	593,154			2
3	Housekeeping	305,255	166,092		471,347		471,347	86	471,433			3
4	Laundry	124,970	36,321		161,291		161,291		161,291			4
5	Heat and Other Utilities			144,793	144,793		144,793	2,023	146,816			5
6	Maintenance	138,430	89,217	23,153	250,800		250,800	681	251,481			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,105,981	931,334	180,601	2,217,916		2,217,916	3,209	2,221,125			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	3,519,071	246,231	38,884	3,804,186		3,804,186		3,804,186			10
10a	Therapy											10a
11	Activities	127,242	33,470	5,000	165,712		165,712	300	166,012			11
12	Social Services	195,505			195,505		195,505		195,505			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,841,818	279,701	64,884	4,186,403		4,186,403	300	4,186,703			16
	C. General Administration											
17	Administrative			641,778	641,778		641,778	(425,734)	216,044			17
18	Directors Fees											18
19	Professional Services			37,488	37,488		37,488	(4,594)	32,894			19
20	Dues, Fees, Subscriptions & Promotions			13,601	13,601		13,601	(72)	13,529			20
21	Clerical & General Office Expenses	496,439		127,748	624,187		624,187	64,333	688,520			21
22	Employee Benefits & Payroll Taxes			738,507	738,507		738,507		738,507			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,643	7,643		7,643	(300)	7,343			24
25	Other Admin. Staff Transportation			23,877	23,877		23,877	3,372	27,249			25
26	Insurance-Prop.Liab.Malpractice			20,074	20,074		20,074	6,619	26,693			26
27	Other (specify):* Mgmt Alloc of Benefi							24,562	24,562			27
28	**TOTAL General Administration**	496,439		1,610,716	2,107,155		2,107,155	(331,814)	1,775,341			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,444,238	1,211,035	1,856,201	8,511,474		8,511,474	(328,305)	8,183,169			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:** 01/01/12 **Ending:** 12/31/12

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			69,726	69,726		69,726	(52,023)	17,703			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			81,037	81,037		81,037	(12,270)	68,767			32
33	Real Estate Taxes			100,853	100,853		100,853	494	101,347			33
34	Rent-Facility & Grounds			1,218,000	1,218,000		1,218,000		1,218,000			34
35	Rent-Equipment & Vehicles			11,279	11,279		11,279	1,457	12,736			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,480,895	1,480,895		1,480,895	(62,342)	1,418,553			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,451	1,045,303	1,233,754		1,233,754		1,233,754			39
40	Barber and Beauty Shops			428	428		428		428			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			490,097	490,097		490,097		490,097			42
43	Other (specify):* **Non-Allowable Cos**			64,655	64,655		64,655	(64,655)				43
44	**TOTAL Special Cost Centers**		188,451	1,600,483	1,788,934		1,788,934	(64,655)	1,724,279			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,444,238	1,399,486	4,937,579	11,781,303		11,781,303	(455,302)	11,326,001			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: 01/01/12 Ending: 12/31/12

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	(56,761)	30		9
10	Interest and Other Investment Income	(12,270)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(611)	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	(1,627)	43		18
19	Entertainment				19
20	Contributions	(4,666)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(232)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,550)	43		24
25	Fund Raising, Advertising and Promotional	(34,972)	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	(30,169)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (143,858)		$	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)	(311,444)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (311,444)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (455,302)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense - Med A	$ (10,156)	43	1
2	X Ray Expense - Med A	(5,393)	43	2
3	Chamber of Commerce Dues	(395)	20	3
4	Offset Miscelaneous Income Against Office Exp.	(6,067)	21	4
5	Disallow Unreconciled Real Estate Tax	(3,339)	33	5
6	Managed Care Cost	(4,680)	43	6
7	Out of Period Seminars	(139)	24	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**	(30,169)		49

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. Financial Service	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. [ ] YES [X] 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								3
4	V				N/A				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: 01/01/12 Ending: 12/31/12

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 Financial Services Company	100.00%	$ 419	$ 419	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	86	86	16
17	V	5	Heat and Other Utilities		SW Financial Services Company	100.00%	2,023	2,023	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	681	681	18
19	V	17	Administrative	432,678	SW Financial Services Company	100.00%	6,944	(425,734)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,638	1,638	20
21	V	20	Dues, Fees, Subs & Promotions		SW Financial Services Company	100.00%	323	323	21
22	V	21	Clerical & General Office Expense		SW Financial Services Company	100.00%	70,400	70,400	22
23	V	24	Travel and Seminar		SW Financial Services Company	100.00%	139	139	23
24	V	25	Other Admin. Staff Transport		SW Financial Services Company	100.00%	3,372	3,372	24
25	V	26	Insurance-Prop.Liab.Malpractice		SW Financial Services Company	100.00%	619	619	25
26	V	27	Mgmt. Allocation of Benefits		SW Financial Services Company	100.00%	24,562	24,562	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	4,738	4,738	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	3,833	3,833	28
29	V	35	Rent-Equipment & Vehicles		SW Financial Services Company	100.00%	1,457	1,457	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			$ 432,678			$ 121,234	$ * (311,444)	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: 01/01/12 Ending: 12/31/12

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	N/A	50	100.00	Wages	$ 209,100	L17(7)	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	$ 209,100		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: 01/01/12 Ending: 12/31/12

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	609,314	12	$ 3,388	$	75,396	$ 419	1
2	3	Housekeeping	Bed Days Available	609,314	12	696		75,396	86	2
3	5	Heat and Other Utilities	Bed Days Available	609,314	12	16,350		75,396	2,023	3
4	6	Maintenance	Bed Days Available	609,314	12	5,506		75,396	681	4
5	19	Professional Services	Bed Days Available	609,314	12	13,244		75,396	1,638	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	609,314	12	2,612		75,396	323	6
7	21	Clerical & General Office Exp	Bed Days Available	609,314	12	568,945	495,892	75,396	70,400	7
8	24	Travel and Seminar	Bed Days Available	609,314	12	1,122		75,396	139	8
9	25	Other Admin. Staff Transport	Bed Days Available	609,314	12	27,251		75,396	3,372	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	609,314	12	4,999		75,396	619	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	609,314	12	198,498		75,396	24,562	11
12	33	Real Estate Taxes	Bed Days Available	609,314	12	30,980		75,396	3,833	12
13	35	Rent-Equipment & Vehicles	Bed Days Available	609,314	12	11,766		75,396	1,457	13
14										14
15								75,396		15
16										16
17	17	Administrative	Avg. Hours Worked	45	12	209,100	209,100	1	4,647	17
18	17	Administrative	Avg. Hours Worked	45	12	103,345	103,345	1	2,297	18
19										19
20	30	Depreciation	Direct Cost	38,287					4,738	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,197,802	$ 808,337		$ 121,234	25

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	1,950,000	Demand	Varies	55,799	6
7	Shareholder's Loan	X		Working Capital	Varies		1,250,000	584,334	Demand	Varies	25,238	7
8												8
9	TOTAL Facility Related						$ 2,250,000	$ 2,534,334			$ 81,037	9
	B. Non-Facility Related*											
10												10
11								Intrest income offset			(12,270)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,270)	14
15	TOTALS (line 9+line14)						$ 2,250,000	$ 2,534,334			$ 68,767	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: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)	2011	$ 97,514	2
3. Under or (over) accrual (line 2 minus line 1).		$ 97,514	3
4. Real Estate Tax accrual used for 2012 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 C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
	Allocated from Management Co.	3,833	
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.		$ 101,347	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	101,535	8
	2008	102,633	9
	2009	94,675	10
	2010	100,853	11
	2011	97,514	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 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 97,514.00	$ 97,514.00
2.	10-28-412.049-0000	SW Financial Services Co. Allocation	$ 30,980.00	$ 3,833.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 128,494.00	$ 101,347.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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 [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

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			Allocated from Management Co.		49,258			1,407	1,407	24,847	6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	190	20	261	71	326	9
10											10
11	Remodel			2012	187,645	4,833	20	4,691	(142)	4,691	11
12	New Therapy Room & Restroom										12
13	Flooring for Dish Room										13
14	Flooring, Wall Coverings for Beauty Shop										14
15	Flooring, Wall Coverings, Hand Rails for Lower Level Corridor										15
16	Flooring, Wall Covering for Lower Level Conference Room										16
17											17
18											18
19											19
20											20
21											21
22	Hot Water Heater - Basement			2012	20,418	31	20	510	479	510	22
23	Ceiling Tiles throughout the facility			2012	6,196	66	20	155	89	155	23
24	Replace Defective 4" Cast Iron Pipe & Fittings - Kitchen			2012	5,660	60	20	142	82	142	24
25	Flower Islands - Parking Lot			2012	9,314	4,890	15	310	(4,580)	310	25
26											26
27											27
28	Allocated from Management Co.			1995	5,513			277	277	5,241	28
29	Allocated from Management Co.			1996	918			46	46	760	29
30	Allocated from Management Co.			1997	1,064			53	53	956	30
31	Allocated from Management Co.			1998	910			46	46	671	31
32	Allocated from Management Co.			1999	2,526			126	126	1,653	32
33	Allocated from Management Co.			2005	5,226			261	261	1,960	33
34	Allocated from Management Co.			2007	2,959			148	148	814	34
35	Allocated from Management Co.			2009	6,177			309	309	1,081	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: 01/01/12 Ending: 12/31/12

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)		$ 309,005	$ 10,070		$ 8,742	$ (1,328)	$ 44,117	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: 01/01/12 Ending: 12/31/12

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	$ 18,192	$ 34,417	$ 1,819	$ (32,598)	10	$ 2,274	71
72	Current Year Purchases	101,518	25,239	5,077	(20,162)	10	5,077	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.	15,553		315	315		12,661	74
75	TOTALS	$ 135,263	$ 59,656	$ 7,211	$ (52,445)		$ 20,012	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 Mgmt. Co.	2010 Infiniti	2010	$ 8,751	$	$ 1,750	$ 1,750		$ 4,376	76
77										77
78										78
79										79
80	TOTALS			$ 8,751	$	$ 1,750	$ 1,750		$ 4,376	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)	$ 453,019	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,703	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (52,023)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 68,505	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: 01/01/12 Ending: 12/31/12

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	$ 1,218,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		206		$ 1,218,000 **			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.	/2013	$ ########
13.	/2014	$ ########
14.	/2015	$ ########

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: N/A
(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	$ 940.00	$ 11,279	17
18	Allocation from Management Co.			1,457	18
19					19
20					20
21	TOTAL		$ 940.00	$ 12,736	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: 01/01/12 Ending: 12/31/12

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

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	39(3)	hrs	$	3,705	$ 414,958	$	3,705	$ 414,958	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,032	93,487		2,032	93,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,162	536,858		5,162	536,858	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				188,451		188,451	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			$	10,899	$ 1,045,303	$ 188,451	10,899	$ 1,233,754	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.

STATE OF ILLINOIS

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 204,481	$ 204,481	1
2	Cash-Patient Deposits	52,734	52,734	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,251)	4,962,296	4,962,296	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,108	17,108	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	47,830	47,830	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,284,449	$ 5,284,449	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		49,258	14
15	Leasehold Improvements, at Historical Cost	234,454	259,747	15
16	Equipment, at Historical Cost	119,710	144,014	16
17	Accumulated Depreciation (book methods)	(87,989)	(68,505)	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): HUD Expense for Option	27,700	27,700	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 293,875	$ 412,214	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,578,324	$ 5,696,663	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 344,410	$ 344,410	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,517	64,517	28
29	Short-Term Notes Payable	1,950,000	1,950,000	29
30	Accrued Salaries Payable	234,058	234,058	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,486	25,486	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,267	1,267	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	761,227	761,227	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,380,965	$ 3,380,965	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	584,334	584,334	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	110,252	110,252	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 694,586	$ 694,586	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,075,551	$ 4,075,551	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,502,773	$ 1,621,112	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,578,324	$ 5,696,663	48

***(See instructions.)**

Tower Hill Rehabilitation, LLC
0051557

12/31/2012

Schedule 17A

	Operating	After Consolidation
Other Crrent Assets		
Due from State - Interest	11,980	11,980
Due From IL Dept of Healthcare & Family Services	15,877	15,877
Employee Loans	3,275	3,275
Reiimbursement Due - MCR Bad Debts	16,698	16,698
Total Line 9 - Other Current Assets	47,830	47,830

Other Current Liabilities (specify):		
Accrued Expenses	720,453	720,453
Insurance Premiums Accrued	4,774	4,774
Due to Kane for Rent	36,000	36,000
Total Line 36 - Other Current Liabilities (specify):	761,227	761,227

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 184,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 184,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,817,818	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**	(500,000)	15
16	Other (describe) **Rounding**	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,317,817	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,502,773	24 *

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,623,838	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,623,838	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	855,646	6
7	Oxygen	46,520	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 902,166	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***	12,270	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,270	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustment & Misc. Income	60,847	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 60,847	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,599,121	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,217,916	31
32	Health Care	4,186,403	32
33	General Administration	2,107,155	33
	B. Capital Expense		
34	Ownership	1,480,895	34
	C. Ancillary Expense		
35	Special Cost Centers	1,298,837	35
36	Provider Participation Fee	490,097	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,781,303	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,817,818	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,817,818	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,232,049	44
45	Private Pay - Net Inpatient Revenue	2,019,257	45
46	Medicare - Net Inpatient Revenue	3,241,923	46
47	Other-(specify) Hospice	130,609	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,623,838	49

* **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.**

*** **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.**

^ - This entity is a cash basis taxpayer.

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 81,577	$ 39.22	1
2	Assistant Director of Nursing	1,912	2,152	83,647	38.87	2
3	Registered Nurses	32,070	33,797	1,012,416	29.96	3
4	Licensed Practical Nurses	29,624	31,230	830,006	26.58	4
5	CNAs & Orderlies	117,660	127,136	1,511,425	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,990	12,022	127,242	10.58	10
11	Social Service Workers	9,818	10,039	195,505	19.47	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,080	50,679	24.36	13
14	Head Cook	10,496	11,499	135,889	11.82	14
15	Cook Helpers/Assistants	32,508	35,432	350,758	9.90	15
16	Dishwashers					16
17	Maintenance Workers	8,057	8,992	138,430	15.39	17
18	Housekeepers	28,760	32,041	305,255	9.53	18
19	Laundry	11,534	12,846	124,970	9.73	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,385	26,639	496,439	18.64	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)	322,966	347,985	$ 5,444,238 *	$ 15.65	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	$ 12,655	L1, C3	35
36	Medical Director	Monthly	21,000	L9, C3	36
37	Medical Records Consultant	Monthly	16,204	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	22,680	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,000	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Activity Consultant-Special Prog.	6	300	L11, C3	47
48					48
49	TOTAL (lines 35 - 48)	6	$ 77,839		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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster *	Administrator/Owner	49	$ 209,100
* Administrator's wages reported on Sch V, L17 C7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 209,100

B. Administrative - Other

Description	Amount
Management Fees-Special-Rosemary Betz	$ 24,000
Central Bookkeeping Office (Eliminated on Sch. V, Col. 7)	127,778
Jeremy Amster (Eliminated on Sch. V, Col. 7)	490,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 641,778
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Shira Balaban	Legal	$ 550
Polsinelli Shughart	Legal	21,993
Honkamp Krueger & Co, PC	Accounting	975
McGladrey LLP	Accounting	12,613
Personnel Planners	U/E Consultant	1,357
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 37,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,435
Unemployment Compensation Insurance	67,077
FICA Taxes	425,582
Employee Health Insurance	120,657
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	9,429
Uniforms	12,777
Life Insurance	
Miscellaneous Employee Benefits	550
TOTAL (agree to Schedule V, line 22, col.8)	$ 738,507

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	$
Advertising: Employee Recruitment	629
Health Care Worker Background Check	
(Indicate # of checks performed 205)	2,454
Patient Background Checks	
Miscellaneous Dues & Permits	1,145
Miscellaneous Licenses	2,701
Inspection Fees	6,672
Allocated from Management Co.	323
Disallow Chamber of Commerce	(395)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,529

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,204
Allocated from Management Co.	139
See Attached Schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,343

* Attach copy of IMRF notifications

**See instructions.

Tower Hill Rehabilitation, LLC
0051557
12/31/12

Schedule 21C

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	37,488
Disallow out of period legal	(232)
Reclass settlement to insurance	(6,000)
Allocated From SW Management:	
- Accounting	1,444
- Legal	194
Total (agree to Schedule V, line 19, column 8)	32,894

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 political 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. $ **86,493** 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. $ **490,097**
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. $ **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 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.