FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

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 01/01/13 to 12/31/13 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: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,190	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	375	412	7,025	7,812	8
9	SNF/PED					9
10	ICF	40,131	19,523		59,654	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,506	19,935	7,025	67,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.73%

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 7,025

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	587,091	41,038	17,672	645,801		645,801		645,801			1
2	Food Purchase		616,085		616,085		616,085	(12,305)	603,780			2
3	Housekeeping	354,174	146,570		500,744		500,744		500,744			3
4	Laundry	130,702	25,318		156,020		156,020		156,020			4
5	Heat and Other Utilities			144,987	144,987		144,987		144,987			5
6	Maintenance	137,329	123,544	32,160	293,033		293,033	500	293,533			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,209,296	952,555	194,819	2,356,670		2,356,670	(11,805)	2,344,865			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,728,326	205,412	39,526	3,973,264		3,973,264		3,973,264			10
10a	Therapy											10a
11	Activities	155,028	49,335		204,363		204,363		204,363			11
12	Social Services	219,831			219,831		219,831		219,831			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,103,185	254,747	51,526	4,409,458		4,409,458		4,409,458			16
	C. General Administration											
17	Administrative			630,338	630,338		630,338		630,338			17
18	Directors Fees											18
19	Professional Services			74,260	74,260		74,260	(11,863)	62,398			19
20	Dues, Fees, Subscriptions & Promotions			52,255	52,255		52,255	(5,837)	46,418			20
21	Clerical & General Office Expenses	461,095		173,912	635,007		635,007	(218)	634,789			21
22	Employee Benefits & Payroll Taxes			760,380	760,380		760,380	12,305	772,685			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,306	13,306		13,306		13,306			24
25	Other Admin. Staff Transportation			28,206	28,206		28,206		28,206			25
26	Insurance-Prop.Liab.Malpractice			97,271	97,271		97,271	57,837	155,108			26
27	Other (specify):* Mgmt Alloc of Benefi											27
28	**TOTAL General Administration**	461,095		1,829,928	2,291,023		2,291,023	52,225	2,343,248			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,773,576	1,207,302	2,076,273	9,057,151		9,057,151	40,420	9,097,571			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: 01/01/13 Ending: 12/31/13

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			64,368	64,368		64,368	550,641	615,009			30
31	Amortization of Pre-Op. & Org.							222,564	222,564			31
32	Interest			69,991	69,991		69,991	226,569	296,560			32
33	Real Estate Taxes			100,853	100,853		100,853	100,774	201,627			33
34	Rent-Facility & Grounds			1,256,561	1,256,561		1,256,561	(1,256,561)				34
35	Rent-Equipment & Vehicles			11,304	11,304		11,304		11,304			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,503,077	1,503,077		1,503,077	(156,013)	1,347,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,069	1,003,850	1,279,919		1,279,919		1,279,919			39
40	Barber and Beauty Shops			475	475		475		475			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			478,175	478,175		478,175		478,175			42
43	Other (specify):* **Non-Allowable Cos**			105,222	105,222		105,222	(105,222)				43
44	**TOTAL Special Cost Centers**		276,069	1,587,722	1,863,791		1,863,791	(105,222)	1,758,569			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,773,576	1,483,371	5,167,072	12,424,019		12,424,019	(220,816)	12,203,203			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: 01/01/13 Ending: 12/31/13

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 Reference	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	100,853	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,711,614)	30		9
10	Interest and Other Investment Income	(2,006,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,212)	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	(40,044)	43		18
19	Entertainment				19
20	Contributions	(4,107)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,862)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,364)	43		24
25	Fund Raising, Advertising and Promotional	(27,993)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,348)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(29,883)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,741,659)		$	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)	3,520,842		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,520,842		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,817)		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: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (3,504)	43	1
2	Travel	(2,396)	43	2
3	Managed Care Costs	(12,754)	43	3
4	Utilization Review Fees	(3,500)	43	4
5	Miscellaneous	(366)	21	5
6	Unreconciled real estate tax	(1,526)	33	6
7	Lobbying Dues	(5,837)	20	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**	(29,883)		49

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [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	6	Maintenance Supplies		Tower Hill Property LLC	100.00%	500	$ 500	1
2	V	21	Bank Service Charge		Tower Hill Property LLC	100.00%	148	148	2
3	V	26	Insurance		Tower Hill Property LLC	100.00%	57,837	57,837	3
4	V	30	Depreciation		Tower Hill Property LLC	100.00%	2,262,255	2,262,255	4
5	V	30	Amortization		Tower Hill Property LLC	100.00%	222,564	222,564	5
6	V	32	Interest	170	Tower Hill Property LLC	100.00%	2,232,823	2,232,653	6
7	V	33	Real Estate Tax		Tower Hill Property LLC	100.00%	102,300	102,300	7
8	V	34	Rent	1,357,415	Tower Hill Property LLC	100.00%		(1,357,415)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,357,585			$ 4,878,427	$ * 3,520,842	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: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	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: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	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: 01/01/13 Ending: 12/31/13

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	$ 215,400	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	$ 215,400		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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Lancaster Pollard Mortgage Co.		X	Mortgage	$76,623.68	8/29/13	14,100,000	14,012,597	9/1/37	0.0405	$ 192,934	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Varies		1,000,000	1,380,000	Demand	Varies	48,918	6
7	Shareholder's Loan	X		Working Capital	Varies	6/30/12	1,250,000	329,712	Demand	Varies	21,073	7
8	Kane Street Assoc.	X		Working Capital	$30,046.78	8/29/13	2,101,608	2,045,106	9/1/23	0.0650	33,635	8
9	TOTAL Facility Related						$ 18,451,608	$ 17,767,415			$ 296,560	9
	B. Non-Facility Related*											
10								Prior year due to seller			1,816,636	10
11								Offset PY due to seller interest			(1,816,636)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 18,451,608	$ 17,767,415			$ 296,560	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: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)	2012	$ 99,327	2
3. Under or (over) accrual (line 2 minus line 1).		$ 99,327	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 102,300	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
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.		$ 201,627	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	102,633	8
	2009	94,675	9
	2010	100,853	10
	2011	97,514	11
	2012	99,327	12

Accrual : 99,327 X 1.03% = $102,207. Use $102,300

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(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	$ 99,327.36	$ 99,327.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 99,327.36	$ 99,327.36

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/13 Ending: 12/31/13

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: 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	Resident Care		2012	$ 412,000	1
2					2
3	TOTALS			$ 412,000	3

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	206		2012		$ 7,828,000	$	40	$ 97,850	$ 97,850	$ 97,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	261	20	261	(0)	587	9
10											10
11	Remodel			2012	187,645	9,382	20	4,691	(4,691)	9,382	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	Hot Water Heater - Basement			2012	20,418	1,021	20	1,021		1,531	18
19	Ceiling Tiles throughout the facility			2012	6,196	310	20	310		465	19
20	Replace Defective 4" Cast Iron Pipe & Fittings - Kitchen			2012	5,660	283	20	283		425	20
21	Flower Islands - Parking Lot			2012	9,314	621	15	621	0	931	21
22	Sidewalk Work			2013	2,560	32	40	64	32	32	22
23	Paving & Sealing			2013	7,593	95	40	190	95	95	23
24	Kitchen Door			2013	2,504	31	40	63	31	31	24
25	Install Oversized Heavy Duty Door in Basement (Center Stairwell)			2013	3,256	41	40	81	41	41	25
26	and install trim around business manager office										26
27	Replace Fire Alarm Panel			2013	2,572	32	40	64	32	32	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: 01/01/13 Ending: 12/31/13

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)		$ 8,080,939	$ 12,109		$ 105,498	$ 93,389	$ 111,402	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: 01/01/13 Ending: 12/31/13

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	$ 119,710	$ 11,971	$ 11,969	$ (2)	10	$ 19,322	71
72	Current Year Purchases	5,006,824	40,288	497,541	457,253	10	497,541	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,126,534	$ 52,259	$ 509,510	$ 457,251		$ 516,863	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				$			$		$	
77										
78										
79										
80	TOTALS			$	$	$	$		$	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)	$ 13,619,473	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 64,368	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 615,008	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 550,641	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 628,265	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: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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	$ 11,304	17
18					18
19					19
20					20
21	TOTAL		$ 940.00	$ 11,304	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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	$	3,970	$ 444,594	$	3,970	$ 444,594	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,837	84,493		1,837	84,493	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,565	474,763		4,565	474,763	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				238,589		238,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen						37,480		37,480	12
13	Other (specify):									13
14	TOTAL			$	10,372	$ 1,003,850	$ 276,069	10,372	$ 1,279,919	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: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 41,887	$ 41,887	1
2	Cash-Patient Deposits	64,944	64,944	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,665)	3,598,457	3,598,457	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,506	21,506	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,806,158	1,184,422	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,532,952	$ 4,911,216	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		412,000	13
14	Buildings, at Historical Cost		7,828,000	14
15	Leasehold Improvements, at Historical Cost	252,939	252,939	15
16	Equipment, at Historical Cost	182,534	5,126,534	16
17	Accumulated Depreciation (book methods)	(152,357)	(628,265)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		3,277,300	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)**	$ 283,116	$ 16,268,508	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,816,068	$ 21,179,724	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 254,941	$ 1,367,782	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	79,908	79,908	28
29	Short-Term Notes Payable	1,380,000	1,380,000	29
30	Accrued Salaries Payable	268,205	268,205	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,706	28,706	31
32	Accrued Real Estate Taxes(Sch.IX-B)		102,300	32
33	Accrued Interest Payable	13,215	13,215	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	403,828	403,828	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,428,803	$ 3,643,944	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	329,712	16,387,415	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	88,540	88,540	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 418,252	$ 16,475,955	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,847,055	$ 20,119,899	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,969,013	$ 1,059,825	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,816,068	$ 21,179,724	48

*(See instructions.)

Tower Hill Rehabilitation, LLC
0051557
12/31/2013

Schedule 17A

	Operating	After Consolidation
Other Current Assets		
Due from State - Interest	134,414	134,414
Escrow - Replacement Reserve		466,362
Escrow - Repairs		230,357
Escrow - Insurance		93,366
Escrow - RE Taxes		41,386
Escrow - MIP		24,823
Employee Loans	4,960	4,960
Reimbursement Due/Bad Debt	124,188	124,188
Short Term Loan Exchange	34,193	34,193
Employee Payroll Advance	326	326
Due to/From Tower Hill Pr	1,508,077	30,046
Total Line 9 - Other Current Assets	1,806,158	1,184,422

Other Current Liabilities (specify):		
Accrued Expenses	335,310	335,310
Insurance Premiums Accrued	6,428	6,428
Due to Public Aid	14,090	14,090
Due to/From Kane St Property	48,000	48,000
Total Line 36 - Other Current Liabilities (specify):	403,828	403,828

Facility Name & ID Number Tower Hill Healthcare Center **#** 0051557 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,502,773	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	799,998	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,302,771	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	666,242	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 666,242	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)**	$ 2,969,013	24	*

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 12,008,336	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,008,336	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	815,934	6
7	Oxygen	13,325	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 829,259	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***	189,449	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 189,449	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustments & Misc Income	63,217	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 63,217	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,090,261	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,356,670	31
32	Health Care	4,409,458	32
33	General Administration	2,291,023	33
	B. Capital Expense		
34	Ownership	1,503,077	34
	C. Ancillary Expense		
35	Special Cost Centers	1,385,616	35
36	Provider Participation Fee	478,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,424,019	40
41	**Income before Income Taxes (line 30 minus line 40)****	666,242	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 666,242	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,701,847	44
45	Private Pay - Net Inpatient Revenue	1,927,793	45
46	Medicare - Net Inpatient Revenue	3,227,340	46
47	Other-(specify) Hospice	151,356	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,008,336	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: 01/01/13 Ending: 12/31/13

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	2,120	$ 88,562	$ 41.77	1
2	Assistant Director of Nursing	2,080	2,120	80,263	37.86	2
3	Registered Nurses	37,304	39,756	1,223,848	30.78	3
4	Licensed Practical Nurses	23,162	24,432	675,780	27.66	4
5	CNAs & Orderlies	122,573	131,845	1,659,873	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	13,034	14,086	155,028	11.01	9
10	Activity Assistants					10
11	Social Service Workers	10,226	10,306	219,831	21.33	11
12	Dietician	2,080	2,080	54,241	26.08	12
13	Food Service Supervisor	11,822	13,339	163,301	12.24	13
14	Head Cook	32,793	36,079	369,549	10.24	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,865	8,934	137,329	15.37	17
18	Housekeepers	31,935	35,489	354,174	9.98	18
19	Laundry	11,104	12,686	130,702	10.30	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	21,926	23,008	461,095	20.04	23
24	Clerical					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)	329,984	356,280	$ 5,773,576 *	$ 16.21	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	$ 17,672	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	Monthly	13,346	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	26,180	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 69,198		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: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster *	Administrator/Owner	49	$ 215,400
* Administrator's wages reported on Sch V, L17 C7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 215,400

B. Administrative - Other

Description	Amount
Management Fees-Special-Rosemary Betz	$ 12,000
Central Bookkeeping Office (Eliminated on Sch. V, Col. 7)	127,778
Administrative Consultant	560
Jeremy Amster (Eliminated on Sch. V, Col. 7)	490,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 630,338
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Krueger & Co., PC	Accounting	$ 2,000
McGladrey LLP	Accounting	3,920
ACC Consulting	Accounting	15,085
Personnel Planners	U/E Consultant	1,463
See Sch 21C	Legal	51,792
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 74,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,649
Unemployment Compensation Insurance	66,286
FICA Taxes	441,678
Employee Health Insurance	81,654
Employee Meals	12,305
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	20,348
Uniforms	14,392
Life Insurance	(652)
Miscellaneous Employee Benefits	13,025
TOTAL (agree to Schedule V, line 22, col.8)	$ 772,685

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 164)	1,973
Patient Background Checks	
Illinois Council on Long Term Care	40,901
Miscellaneous Dues & Permits	1,983
Miscellaneous Licenses	6,398
Inspection Fees - Protective Fire & Safety	1,000
Less: Public Relations Expense	( )
Non-allowable advertising	(5,837)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,418

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,306
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,306

**See instructions.

Tower Hill Rehabilitation, LLC
0051557
12/31/13

Schedule 21C

XIX. SUPPORT SCHEDULE

C. Professional Services

Polsinelli Shughart	35,841
Daniel Parsons	500
Stephen N. Sher	11,863
CT Lien Solutions	1,337
Canning Law	3,430
New Chicago Curr Ex	317
MPRO	560
Steven T. Mann Trust	4,250
Field and Goldberg LLC	2,016
Legal Accrual	(8,557)
Post Funds to cover Field/Goldberg	235
Total Legal, Line 19, Column 3	51,792
Unemployment Consultant	1,463
Accounting	21,005
Total (agree to Schedule V, line 19, column 3)	74,260
Disallowed Legal fees	(11,863)
Total (agree to Schedule V, line 19, column 8)	62,398

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council Long Term Care - $ 40,901**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **83,846** 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. $ **478,175**
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. $ **12,305** 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 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.