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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 01/01/2015 to 12/31/2015 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) RSM US 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: 01/01/2015 Ending: 12/31/2015

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	284	489	6,183	6,956	8
9	SNF/PED					9
10	ICF	41,709	12,252	6,850	60,811	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,993	12,741	13,033	67,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.13%

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 6,183

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	634,406	78,781	12,415	725,602		725,602	402	726,004			1
2	Food Purchase		557,455		557,455		557,455		557,455			2
3	Housekeeping	389,899	77,554		467,453		467,453		467,453			3
4	Laundry	132,102	25,405		157,507		157,507		157,507			4
5	Heat and Other Utilities			153,425	153,425		153,425		153,425			5
6	Maintenance	145,065	69,945	32,938	247,948		247,948		247,948			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,301,472	809,140	198,778	2,309,390		2,309,390	402	2,309,792			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,840,688	257,797	56,091	4,154,576		4,154,576		4,154,576			10
10a	Therapy											10a
11	Activities	172,534	71,319	6,600	250,453		250,453		250,453			11
12	Social Services	144,821			144,821		144,821		144,821			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,158,043	329,116	74,691	4,561,850		4,561,850		4,561,850			16
	C. General Administration											
17	Administrative	156,777		647,249	804,026		804,026	(261,400)	542,626			17
18	Directors Fees											18
19	Professional Services			83,424	83,424		83,424	2,155	85,579			19
20	Dues, Fees, Subscriptions & Promotions			39,874	39,874		39,874	(15,631)	24,243			20
21	Clerical & General Office Expenses	435,630		168,809	604,439		604,439	12,089	616,528			21
22	Employee Benefits & Payroll Taxes			801,259	801,259		801,259		801,259			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,781	5,781		5,781		5,781			24
25	Other Admin. Staff Transportation			26,914	26,914		26,914	(17,440)	9,474			25
26	Insurance-Prop.Liab.Malpractice			61,423	61,423		61,423	105,267	166,690			26
27	Other (specify):*											27
28	**TOTAL General Administration**	592,407		1,834,733	2,427,140		2,427,140	(174,960)	2,252,180			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,051,922	1,138,256	2,108,202	9,298,380		9,298,380	(174,558)	9,123,822			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: 01/01/2015 Ending: 12/31/2015

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			91,547	91,547		91,547	639,958	731,505			30
31	Amortization of Pre-Op. & Org.			140,107	140,107		140,107	88,120	228,227			31
32	Interest			193,297	193,297		193,297	504,355	697,652			32
33	Real Estate Taxes							128,550	128,550			33
34	Rent-Facility & Grounds			1,442,000	1,442,000		1,442,000	(1,442,000)				34
35	Rent-Equipment & Vehicles			121,861	121,861		121,861	(9,389)	112,472			35
36	Other (specify):* MIP Insurance							80,097	80,097			36
37	TOTAL Ownership			1,988,812	1,988,812		1,988,812	(10,308)	1,978,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,343	872,020	1,168,363		1,168,363	17,440	1,185,803			39
40	Barber and Beauty Shops			400	400		400		400			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			485,885	485,885		485,885		485,885			42
43	Other (specify):* Non-Allowable Cos			235,208	235,208		235,208	(235,208)				43
44	TOTAL Special Cost Centers		296,343	1,593,513	1,889,856		1,889,856	(217,768)	1,672,088			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,051,922	1,434,599	5,690,527	13,177,048		13,177,048	(402,635)	12,774,413			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: 01/01/2015 Ending: 12/31/2015

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	(648,542)	30		9
10	Interest and Other Investment Income	(39,829)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(911)	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	(1,324)	43		18
19	Entertainment				19
20	Contributions	(5,565)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,285)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,782)	43		24
25	Fund Raising, Advertising and Promotional	(10,479)	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 Page 5A	(428,399)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,206,116)		$	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)	803,481		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 803,481		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (402,635)		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: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (18,161)	43	1
2	Travel	(2,706)	43	2
3	Managed Care Costs	(130,280)	43	3
4	Offset Miscellaneous Income	29	21	4
5	Lobbying Dues	(15,486)	20	5
6	Chamber of Commerce Dues	(395)	20	6
7	Disallow Mangement Fees	(261,400)	17	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**	(428,399)		49

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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	19	Accounting	$	Tower Hill Property LLC	100.00%	$ 7,440	$ 7,440	1
2	V	20	Licenses		Tower Hill Property LLC	100.00%	250	250	2
3	V	21	Bank Service Charge		Tower Hill Property LLC	100.00%	3,074	3,074	3
4	V	26	Insurance		Tower Hill Property LLC	100.00%	185,364	185,364	4
5	V	30	Depreciation		Tower Hill Property LLC	100.00%	1,288,500	1,288,500	5
6	V	30	Amortization		Tower Hill Property LLC	100.00%	88,120	88,120	6
7	V	32	Interest	664	Tower Hill Property LLC	100.00%	544,847	544,183	7
8	V	33	Real Estate Tax		Tower Hill Property LLC	100.00%	128,550	128,550	8
9	V	34	Rent	1,442,000	Tower Hill Property LLC	100.00%		(1,442,000)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,442,664			$ 2,246,145	$ * 803,481	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jeremy Amster	49%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Supp	Shabbona	Supportive Living	1
2	Stuart Milstein	16%	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Ari Milstein	16%			SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	16%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	Services Co.		Management Comp	4
5	David Zuckerman	2%	Oregon Living & Rehabilitation, LLC	Oregon	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Albert Milstein	1%	Prairie Crossing Living & Rehab Center	Shabbona				6
7					Groves Community	Independence, MO	Hospice	7
8					Hospice			8
9			Beauvais Manor Healthcare and Rehab	St. Louis, MO	Forest View Senior	Independence, MO	Independent	9
10			Hillside Manor Healthcare and Rehab	St. Louis, MO	Residences		Living	10
11			Rancho Manor Healthcare and Rehab	Florissant, MO	White Oak Living	Independence, MO	Residential	11
12			Rosewood Health & Rehab	Independence, MO	Center		Care	12
13			Seasons Care Center	Kansas City, MO				13
14			Carriage Square Living & Rehab	St. Joseph, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Linn Living & Rehabilitation Center	Linn, MO	Program LLC			15
16								16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LL	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20								20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23					Oregon Property	Oregon	Real Estate	23
24					LLC			24
25					Shabbona Building	Shabbona	Real Estate	25
26					Associates LLC			26
27								27
28								28
29								29
30								30

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19					Linn Property LLC	Linn, MO	Real Estate	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Administrative	49.00	N/A	50	85.00	Guar Pymts	$ 228,600	L17 C(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	$ 228,600		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: 01/01/2015 Ending: 2/31/2015

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 [X]

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		N/A								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: 01/01/2015 Ending: 12/31/2015

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lancaster Pollard Mortgage Co		X	Mortgage	$76,623.68	8/29/13	$ 14,100,000	$ 13,280,639	9/1/37	0.0405	$ 544,847	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Varies	8/1/11	1,000,000	2,305,000	7/5/16	Varies	73,866	6
7	Shareholder's Loan	X		Working Capital	Varies	6/30/12	1,250,000	68,000	Demand	Varies	899	7
8	Kane Street Assoc.	X		Working Capital	$30,046.78	8/29/13	2,101,608	1,768,870	9/1/23	0	118,532	8
9	TOTAL Facility Related				$106,670.46		$ 18,451,608	$ 17,422,509			$ 738,144	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(39,829)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (40,492)	14
15	TOTALS (line 9+line14)						$ 18,451,608	$ 17,422,509			$ 697,652	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 80,097 Line # 36

* 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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 93,200	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.)	2014	$ 109,250	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,050	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 112,500	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 Managment Co.		
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.		$ 128,550	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	100,853	8
	2011	97,514	9
	2012	99,327	10
	2013	90,489	11
	2014	109,250	12

Accrual : 109,250 X 1.03% = $112,527.50. Use $112,500.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tower Hill Rehabilitation, LLC 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 2014 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 2014.

	(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	$ 109,249.96	$ 109,249.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,249.96	$ 109,249.96

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? _____ YES X _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,040 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	41,040	2012	$ 412,000	1
2					2
3	TOTALS	41,040		$ 412,000	3

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 195,700	$ 195,700	$ 489,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	190	20	261	71	1,109	9
10											10
11	Remodel			2012	187,645	6,823	20	9,382	2,559	32,837	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	742	20	1,021	279	3,573	18
19	Ceiling Tiles throughout the facility			2012	6,196	225	20	310	85	1,084	19
20	Replace Defective 4" Cast Iron Pipe & Fittings - Kitchen			2012	5,660	206	20	283	77	991	20
21	Flower Islands - Parking Lot			2012	9,314	358	15	621	263	2,173	21
22	Sidewalk Work			2013	2,560	108	40	64	(44)	160	22
23	Paving & Sealing			2013	7,593	337	40	190	(147)	475	23
24	Kitchen Door			2013	2,504	91	40	63	(28)	157	24
25	Install Oversized Heavy Duty Door in Basement (Center Stairwell)			2013	3,256	118	40	81	(37)	203	25
26	and install trim around business manager office										26
27	Replace Fire Alarm Panel			2013	2,572	94	40	64	(30)	160	27
28											28
29	All Resident Bathrooms Remodeled - Light fixtures,Mirrors,			2014	295,853	592	40	7,396	6,804	11,094	29
30	Grab Bars, Crown Molding, Wallpaper, Tile, etc.										30
31											31
32	Thermostatic Mixing Value			2014	3,100	113	40	78	(36)	117	32
33											33
34	Parking Lot - Removed & replaced asphalt. Filled holes.			2015	126,168	66,238	20	3,154	(63,084)	3,154	34
35	Electric Box and Circuits - Mechanical Room			2015	8,100	258	20	203	(56)	203	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: 01/01/2015 Ending: 12/31/2015

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	Bathroom Project: Remodel 2 Patient Room Bathrooms -	2015	$ 11,065	$ 17	40	$ 138	$ 121	$ 138	37
38	Bathtub, Plumbing, Walls, Flooring								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)		$ 8,525,225	$ 76,510		$ 219,009	$ 142,499	$ 546,878	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: 01/01/2015 Ending: 12/31/2015

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	$ 5,184,689	$ 15,037	$ 512,496	$ 497,459	10	$ 1,541,855	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,184,689	$ 15,037	$ 512,496	$ 497,459		$ 1,541,855	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	N/A			$	$	$	$		$	76
77										77
78										78
79										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)	$ 14,121,914	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,547	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 731,505	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 639,958	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,088,733	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: 01/01/2015 Ending: 12/31/2015

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. [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:		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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 98,361 Description: Medical Equipment
    (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	$ 1176.00	$ 14,111	17
18					18
19					19
20					20
21	TOTAL		$ 1,176.00	$ 14,111	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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$	4,984	$ 358,836	$	4,984	$ 358,836	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,299	110,357		2,299	110,357	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,294	402,827		6,294	402,827	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				235,236		235,236	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					61,107		61,107	12
13	Other (specify): Ambulance	39(3)			242	17,440		242	17,440	13
14	TOTAL			$	13,819	$ 889,460	$ 296,343	13,819	$ 1,185,803	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: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 104,602	$ 294,257	1
2	Cash-Patient Deposits	50,274	50,274	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	5,712,285	5,712,285	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,736	133,785	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,549,139	1,084,995	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,473,036	$ 7,275,596	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	431,416	697,225	15
16	Equipment, at Historical Cost	240,688	5,184,689	16
17	Accumulated Depreciation (book methods)	(297,336)	(2,088,733)	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 (spe See Schedule 17A	1,681,287	2,820,666	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,056,055	$ 14,853,847	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,529,091	$ 22,129,443	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,254,599	$ 1,254,599	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,614	58,614	28
29	Short-Term Notes Payable	2,305,000	2,305,000	29
30	Accrued Salaries Payable	311,172	311,172	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,631	28,631	31
32	Accrued Real Estate Taxes(Sch.IX-B)		112,500	32
33	Accrued Interest Payable	36,551	81,373	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,111,418	1,111,418	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,105,985	$ 5,263,307	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,836,870	15,117,509	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,836,870	$ 15,117,509	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,942,855	$ 20,380,816	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,586,236	$ 1,748,627	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,529,091	$ 22,129,443	48

*(See instructions.)

Facility Name: **Tower Hill Healthcare Center**
IDPH License ID Number: **0051557**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
NH Due From State - Interest	213,252	213,252
NH Escrow - Replacement Reserve	-	677,782
NH Escrow - Repairs	-	10,566
NH Escrow - Insurance	-	92,103
NH Escrow - RE Taxes	-	55,175
NH Escrow - MIP	-	25,071
NH Escrow - Unapplied	-	639
NH Employee Loans	3,033	3,033
NH Employee Payroll Advance	7,375	7,375
NH Due To/From Tower Hill	1,325,479	-
Total - Line 9	**1,549,139**	**1,084,995**

XV. Balance Sheet
Line 22 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
NH Intangible Asset - Goodwill	2,101,608	3,296,000
NH Accum Amort - Goodwill	(420,321)	(658,835)
NH Mortgage Costs	-	203,684
NH Accum Amort - Mtg Costs	-	(20,183)
Total - Line 23	**1,681,287**	**2,820,666**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
NH Due/From State	(7,228)	(7,228)
NH Due to State Per Audit	(136,078)	(136,078)
NH Reimbursement Due/ Bad Debt	(5,634)	(5,634)
NH Insurance Premiums	(39,404)	(39,404)
NH Accrued Expenses	(875,074)	(875,074)
NH Due to/From Kane St Property	(48,000)	(48,000)
Total - Line 36	**(1,111,418)**	**(1,111,418)**

Facility Name & ID Number Tower Hill Healthcare Center **#** 0051557 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,026,560	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,026,560	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	559,675	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) **Rounding**	1	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 559,676	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)**	$ 2,586,236	24	*

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 12,919,121	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,919,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	693,880	6
7	Oxygen	15,869	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 709,749	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***	39,829	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,829	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Medicaid Income Adjustments**	68,053	28
28a	**Miscellaneous Income**	(29)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 68,024	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,736,723	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,309,390	31
32	Health Care	4,561,850	32
33	General Administration	2,427,140	33
	B. Capital Expense		
34	Ownership	1,988,812	34
	C. Ancillary Expense		
35	Special Cost Centers	1,403,971	35
36	Provider Participation Fee	485,885	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,177,048	40
41	**Income before Income Taxes (line 30 minus line 40)****	559,675	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 559,675	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,356,446	44
45	Private Pay - Net Inpatient Revenue	2,187,634	45
46	Medicare - Net Inpatient Revenue	3,182,547	46
47	Other-(specify) **Hospice**	192,494	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,919,121	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: 01/01/2015 Ending: 12/31/2015

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			$ 2,986	$	1
2	Assistant Director of Nursing	1,383	1,384	51,506	37.22	2
3	Registered Nurses	42,358	44,788	1,441,827	32.19	3
4	Licensed Practical Nurses	20,501	21,668	582,188	26.87	4
5	CNAs & Orderlies	127,084	138,693	1,762,181	12.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,149	15,354	172,534	11.24	10
11	Social Service Workers	6,720	6,800	144,821	21.30	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,208	56,665	25.66	13
14	Head Cook	8,434	9,575	111,667	11.66	14
15	Cook Helpers/Assistants	38,623	42,148	466,074	11.06	15
16	Dishwashers					16
17	Maintenance Workers	8,278	8,934	145,065	16.24	17
18	Housekeepers	33,078	36,465	389,899	10.69	18
19	Laundry	10,801	12,086	132,102	10.93	19
20	Administrator	3,680	4,200	156,777	37.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,255	19,387	435,630	22.47	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	335,392	363,690	$ 6,051,922 *	$ 16.64	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	$ 12,415	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	Monthly	8,320	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	21,771	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	6,600	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Utilization Review Fees	Monthly	26,000	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 87,106		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				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: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Victoria Hill	Adminstrator	0	$ 156,777
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,777

B. Administrative - Other

Description	Amount
See Schedule 21B	$ 647,249
TOTAL (agree to Schedule V, line 17, col. 3)	$ 647,249
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	See Schedule 21C	$ 83,424
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 83,424

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,754
Unemployment Compensation Insurance	56,002
FICA Taxes	460,486
Employee Health Insurance	172,255
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	11,242
Uniforms	6,359
Life Insurance	(364)
Miscellaneous Employee Benefits	11,525
TOTAL (agree to Schedule V, line 22, col.8)	$ 801,259

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 66)	790
Patient Background Checks 60	596
Illinois Council on Long Term Care	26,624
Miscellaneous Dues & Permits	3,416
Miscellaneous Licenses & Inspections	4,468
Allocated from RE Entity	250
Less: Chamber of Commerce	(395)
Less: Public Relations Expense	( )
Non-allowable advertising	(15,486)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,243

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,781
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,781

**See instructions.

Facility Name: **Tower Hill Healthcare Center**
IDPH License ID Number: **0051557**
Fiscal Year End: **12/31/2015**

Schedule 21B

XIX. SUPPORT SCHEDULES
B. Administrative - Other

Description	Amount
Central Bookkeeping Office	157,249
Management Fees - Jeremy Amster (Eliminated on Sch. V., (	490,000
Total (agree to Schedule V, line 17, column 3)	647,249
Less: Non-Allowable Management Fees	(261,400)
Total (agree to Schedule V, line 17, column 8)	385,849

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Daniel Parsons	Legal	3,172
Field and Goldberg, LLC	Legal	1,159
Hepler Brrom, LLC	Legal	27,747
Lancaster Pollard	Legal	129
Northwest Orthopaedics	Legal	700
Polsinelli Shughart	Legal	8,140
Stone, McGuire and Siegel	Legal	4,190
Personal Planners	Unemployment Consultants	1,237
RSM US LLP	Accounting	26,135

E-Health Data	Administrative Consultants	10,815
	Total (agree to Schedule V, line 19, column 3)	83,424
Allocated from Management Company Legal Fees		
Allocated from Management Company Professional Services		7,440
Less: Non-Allowable Legal Fees		(5,285)
	Total (agree to Schedule V, line 19, column 8)	85,579

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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 - $ 26,624**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **81, 880** 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. $ **485,885**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.