

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 South Elgin 60177
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	206	Skilled (SNF)	206	75,396	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,396	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	28	445	4,923	5,396	8
9	SNF/PED					9
10	ICF	39,974	11,167	7,843	58,984	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,002	11,612	12,766	64,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.39%

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 ☒ 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 ☒

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 ☒ Date 7/1/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 206 and days of care provided 4,922

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	703,434	99,492	11,821	814,747		814,747	1,425	816,172			1
2	Food Purchase		562,997		562,997		562,997	(58)	562,939			2
3	Housekeeping	413,026	68,985		482,011		482,011		482,011			3
4	Laundry	109,831	28,088		137,919		137,919		137,919			4
5	Heat and Other Utilities			163,311	163,311		163,311		163,311			5
6	Maintenance	154,916	103,088	28,943	286,947		286,947		286,947			6
7	Other (specify):*											7
8	TOTAL General Services	1,381,207	862,650	204,075	2,447,932		2,447,932	1,367	2,449,299			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	3,871,233	221,844	53,977	4,147,054		4,147,054		4,147,054			10
10a	Therapy											10a
11	Activities	187,427	40,505	7,113	235,045		235,045		235,045			11
12	Social Services	143,748			143,748		143,748		143,748			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,202,408	262,349	72,090	4,536,847		4,536,847		4,536,847			16
	C. General Administration											
17	Administrative	201,787		693,378	895,165		895,165	(389,800)	505,365			17
18	Directors Fees											18
19	Professional Services			95,947	95,947		95,947	3,270	99,217			19
20	Dues, Fees, Subscriptions & Promotions			31,564	31,564		31,564	(4,659)	26,905			20
21	Clerical & General Office Expenses	377,931		158,074	536,005		536,005	4,964	540,969			21
22	Employee Benefits & Payroll Taxes			791,409	791,409		791,409		791,409			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,395	10,395		10,395	(3,279)	7,116			24
25	Other Admin. Staff Transportation			27,550	27,550		27,550	(21,929)	5,621			25
26	Insurance-Prop.Liab.Malpractice			115,971	115,971		115,971	250,713	366,684			26
27	Other (specify):*											27
28	TOTAL General Administration	579,718		1,924,288	2,504,006		2,504,006	(160,720)	2,343,286			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,163,333	1,124,999	2,200,453	9,488,785		9,488,785	(159,353)	9,329,432			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,601	38,601		38,601	703,355	741,956			30
31	Amortization of Pre-Op. & Org.			140,107	140,107		140,107	88,120	228,227			31
32	Interest			191,938	191,938		191,938	491,648	683,586			32
33	Real Estate Taxes							126,856	126,856			33
34	Rent-Facility & Grounds			1,542,000	1,542,000		1,542,000	(1,542,000)				34
35	Rent-Equipment & Vehicles			121,543	121,543		121,543		121,543			35
36	Other (specify):* MIP Insurance							84,954	84,954			36
37	TOTAL Ownership			2,034,189	2,034,189		2,034,189	(47,067)	1,987,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		309,058	1,011,399	1,320,457		1,320,457	21,929	1,342,386			39
40	Barber and Beauty Shops			275	275		275		275			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			479,364	479,364		479,364		479,364			42
43	Other (specify):* Non-Allowable Cos			175,950	175,950		175,950	(175,950)				43
44	TOTAL Special Cost Centers		309,058	1,666,988	1,976,046		1,976,046	(154,021)	1,822,025			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,163,333	1,434,057	5,901,630	13,499,020		13,499,020	(360,441)	13,138,579			45

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

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	(58)	2		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	(390,061)	30		9
10	Interest and Other Investment Income	(49,334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(970)	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	(1,528)	43		18
19	Entertainment				19
20	Contributions	(1,582)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,340)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,303)	43		24
25	Fund Raising, Advertising and Promotional	(5,346)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(814)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(554,397)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,017,733)		\$	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)	657,292		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 657,292		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (360,441)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Expense Med A	\$ (19,054)	43	1
2	Travel	(23,398)	43	2
3	Managed Care Costs	(113,955)	43	3
4	Offset Miscellaneous Income	(1,677)	21	4
5	Lobbying Expense	(6,118)	20	5
6	Chamber of Commerce Dues	(395)	20	6
7	Disallow Mangement Fees	(389,800)	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	(554,397)		49

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. ☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting	\$	Tower Hill Property LLC	1	\$ 7,610	\$ 7,610	1
2	V	20	Licenses		Tower Hill Property LLC	1			2
3	V	21	Bank Service Charge		Tower Hill Property LLC	1	6,641	6,641	3
4	V	26	Insurance		Tower Hill Property LLC	1	335,667	335,667	4
5	V	30	Depreciation		Tower Hill Property LLC	1	1,093,416	1,093,416	5
6	V	30	Amortization		Tower Hill Property LLC	1	88,120	88,120	6
7	V	32	Interest	708	Tower Hill Property LLC	1	541,690	540,982	7
8	V	33	Real Estate Tax		Tower Hill Property LLC	1	126,856	126,856	8
9	V	34	Rent	1,542,000	Tower Hill Property LLC	1		(1,542,000)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,542,708			\$ 2,200,000	\$ * 657,292	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:

01/01/2016

Ending:

12/31/2016

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%						3
4	Elana Minkove	16%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove				4
5	David Zuckerman	2%	Oregon Living & Rehabilitation, LLC	Oregon				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 LI	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:

01/01/2016

Ending:

12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeremy Amster	Owner	Administrative	49.00	N/A	50	85.00	Guar Pymts	\$ 100,200	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	\$ 100,200		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: 01/01/2016 Ending: 2/31/2016

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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	\$ 12,891,857	9/1/37	0.0405	\$ 528,390	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	2,240,000	7/5/16	Varies	83,423	6	
7	Shareholder's Loan	X		Working Capital	Varies	6/30/12	1,250,000	343,000	Demand	Varies	1,650	7	
8	See Schedule 9A						2,101,608	1,696,672			120,165	8	
9	TOTAL Facility Related				\$76,623.68		\$ 18,451,608	\$ 17,171,529			\$ 733,628	9	
	B. Non-Facility Related*												
10												10	
11												11	
12								Interest Income			(50,042)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (50,042)	14	
15	TOTALS (line 9+line14)						\$ 18,451,608	\$ 17,171,529			\$ 683,586	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 84,954 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: Tower Hill Healthcare Center
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	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					
	Working Capital												
6	Kane Street Associates	X		Working Capital	\$23,863.33	8/29/13	2,101,608	1,696,672	9/1/37	0.0650	106,865	6	
7	Tower Hill	X		Related Party Transactions	None	Ongoing			Demand	0.0109	13,300	7	
8												8	
9	TOTAL Facility Related				\$23,863.33		\$ 2,101,608	\$ 1,696,672			\$ 120,165	9	

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-34-228-012</u>	<u>Long term care property</u>	\$ <u>117,855.84</u>	\$ <u>117,855.84</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>117,855.84</u></u>	\$ <u><u>117,855.84</u></u>

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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

☒ (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?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	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:

01/01/2016

Ending:

12/31/2016

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	\$ 684,950	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	190	20	261	71	1,370	9
10											10
11	Remodel			2012	187,645	6,823	20	9,382	2,559	42,219	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	4,594	18
19	Ceiling Tiles throughout the facility			2012	6,196	225	20	310	85	1,394	19
20	Replace Defective 4" Cast Iron Pipe & Fittings - Kitchen			2012	5,660	206	20	283	77	1,274	20
21	Flower Islands - Parking Lot			2012	9,314	323	15	621	298	2,794	21
22	Sidewalk Work			2013	2,560	97	40	64	(33)	224	22
23	Paving & Sealing			2013	7,593	304	40	190	(114)	665	23
24	Kitchen Door			2013	2,504	91	40	63	(28)	220	24
25	Install Oversized Heavy Duty Door in Basement (Center Stairwell)			2013	3,256	118	40	81	(37)	284	25
26	and install trim around business manager office										26
27	Replace Fire Alarm Panel			2013	2,572	94	40	64	(30)	224	27
28											28
29	All Resident Bathrooms Remodeled - Light fixtures,Mirrors,			2014	295,853		40	7,396	7,396	18,491	29
30	Grab Bars, Crown Molding, Wallpaper, Tile, etc.										30
31											31
32	Thermostatic Mixing Value			2014	3,100	113	40	78	(36)	194	32
33											33
34	Parking Lot - Removed & replaced asphalt. Filled holes.			2015	126,168	5,993	20	6,308	315	9,463	34
35	Electric Box and Circuits - Mechanical Room			2015	8,100	295	20	405	110	608	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:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Bathroom Project: Remodel 2 Patient Room Bathrooms -	2015	\$ 11,065	\$	40	\$ 277	\$ 277	\$ 415	37
38 Bathtub, Plumbing, Walls, Flooring								38
39								39
40 Thermostatic Mixing Valve - Kitchen	2016	2,925	102	20	73	(29)	73	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)		\$ 8,528,150	\$ 15,716		\$ 222,577	\$ 206,861	\$ 769,454	70

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

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	\$17,352	\$518,625	\$501,273	10	\$2,071,321	71
72	Current Year Purchases	9,220	5,533	754	(4,779)	5-10	754	72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	\$5,193,909	\$22,885	\$519,379	\$496,494		\$2,072,075	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	2	
	Reference	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)	\$14,134,059	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$38,601	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$741,956	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$703,355	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,841,529	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.

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: *

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: \$101,825Description: Medical Equipment \$101,825
(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	2015 Infiniti QX80	\$1,359	\$17,303	17
18	Facility	2016 Acura MDX	603.87	2,415	18
19					19
20					20
21	TOTAL		\$1,963	\$19,718	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ 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)	\$			

- (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.

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	

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	6,378	\$ 459,250	\$	6,378	\$ 459,250	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,815	87,118		1,815	87,118	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,266	465,031		7,266	465,031	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				262,312		262,312	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					46,746		46,746	12
13	Other (specify): <u>Ambulance</u>	39(3)			305	21,929		305	21,929	13
14	TOTAL			\$	15,764	\$ 1,033,328	\$ 309,058	15,764	\$ 1,342,386	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,200	\$ 3,200	1
2	Cash-Patient Deposits	71,536	71,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,000)	6,767,380	6,767,380	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,935	132,692	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	1,387,352	1,221,181	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,273,403	\$ 8,195,989	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	434,341	700,150	15
16	Equipment, at Historical Cost	249,909	5,193,909	16
17	Accumulated Depreciation (book methods)	(386,990)	(2,841,529)	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	1,541,180	2,592,439	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,838,440	\$ 13,884,969	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,111,843	\$ 22,080,958	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,458,912	\$ 1,436,788	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,383	75,383	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	363,411	363,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,221	35,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)		121,500	32
33	Accrued Interest Payable	97,948	140,458	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	938,981	938,981	36
37	Accrued Management Fees	163,333	163,333	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,133,189	\$ 3,275,075	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,279,672	17,171,529	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)	\$ 4,279,672	\$ 17,171,529	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,412,861	\$ 20,446,604	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,698,982	\$ 1,634,354	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,111,843	\$ 22,080,958	48

*(See instructions.)

Facility Name: Tower Hill Healthcare Center
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2016

Schedule 17A

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

		After	
	Description	Operating	Consolidation
2073 NH->	DUE FROM STATE - INTEREST	246,689	246,689
2900 NH->	Escrow - Replacement Reserve	-	783,479
2902 NH->	Escrow - Repairs	-	-
2903 NH->	Escrow - Insurance	-	115,048
2904 NH->	Escrow - RE Taxes	-	41,433
2905 NH->	Escrow - MIP	-	20,759
2906 NH->	Escrow - Unapplied	-	-
3010 NH->	EMPLOYEE LOANS	3,161	3,161
3015 NH->	EMPLOYEE PAYROLL ADVANC	7,848	7,848
8811 NH->	DUE TO/FROM TOWER HILL PR	1,126,890	-
7052 NH->	PRIOR OWNER BALANCE	2,764	2,764
Total - Line 9		1,387,352	1,221,181

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

		After	
	Description	Operating	Consolidation
6040 NH->	INTANGIBLE ASSET - GOODWIL	2,101,608	3,296,000
6041 NH->	ACCUM. AMORT. - GOODWILL	(560,428)	(878,568)
6045 NH->	Mortgage Costs	-	203,684
6046 NH->	Accum Amort - Mtge Costs	-	(28,677)
Total - Line 22		1,541,180	2,592,439

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

		After	
	Description	Operating	Consolidation
2070 NH->	DUE FROM STATE	7,228	7,228
2075 NH->	DUE TO STATE PER AUDIT	126,888	126,888
3029 NH->	REIMBURSEMENT DUE / BAD D	2,764	2,764
3030 NH->	SHORT TERM LOAN EXCHANGI	-	-
7055 NH->	INSURANCE PREMIUMS PAYAB	28,686	28,686
7310 NH->	ACCRUED EXPENSES	725,415	725,415
7830 NH->	DUE TO/FROM KANE ST PROPEI	48,000	48,000
Total - Line 36		938,981	938,981

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,586,236	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(51,051)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,535,185	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	163,797	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		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 163,797	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)	\$ 2,698,982	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Tower Hill Healthcare Center

0051557

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,590,073	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,590,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	991,371	6
7	Oxygen	11,692	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,003,063	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	58	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)	\$ 58	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,334	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,334	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Medicaid Income Adjustments</u>	18,612	28
28a	<u>Miscellaneous Income</u>	1,677	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,289	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,662,817	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,447,932	31
32	Health Care	4,536,847	32
33	General Administration	2,504,006	33
	B. Capital Expense		
34	Ownership	2,034,189	34
	C. Ancillary Expense		
35	Special Cost Centers	1,496,682	35
36	Provider Participation Fee	479,364	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,499,020	40
41	Income before Income Taxes (line 30 minus line 40)**	163,797	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 163,797	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,691,274	44
45	Private Pay - Net Inpatient Revenue	2,202,169	45
46	Medicare - Net Inpatient Revenue	2,646,070	46
47	Other-(specify) <u>Hospice</u>	50,560	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,590,073	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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	224	224	\$ 16,808	\$ 75.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,821	43,894	1,427,495	32.52	3
4	Licensed Practical Nurses	21,658	23,064	676,873	29.35	4
5	CNAs & Orderlies	118,745	129,663	1,750,057	13.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,985	16,125	187,427	11.62	10
11	Social Service Workers	6,240	6,440	143,748	22.32	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,112	55,814	26.43	13
14	Head Cook	6,704	7,568	91,871	12.14	14
15	Cook Helpers/Assistants	45,062	48,857	555,749	11.38	15
16	Dishwashers					16
17	Maintenance Workers	8,821	9,629	154,916	16.09	17
18	Housekeepers	34,262	37,996	413,026	10.87	18
19	Laundry	8,741	9,927	109,831	11.06	19
20	Administrator	4,160	4,400	201,787	45.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,115	17,839	377,931	21.19	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					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	329,607	357,735	\$ 6,163,333 *	\$ 17.23	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,246	L1, C3, C7	35
36	Medical Director	Monthly	11,000	L9, C3	36
37	Medical Records Consultant	Monthly	9,475	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	20,502	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	7,113	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Utilization Review Fees	Monthly	24,000	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 85,336		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number

Tower Hill Healthcare Center

STATE OF ILLINOIS

0051557

Report Period Beginning:

01/01/2016

Page 21

Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Victoria Hill	Adminstrator	0	\$ 158,787
Jeremy Amster	Adminstrator	49	43,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 201,787

B. Administrative - Other

Description	Amount
See Schedule 21B	\$ 693,378
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 693,378

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	See Schedule 21C	\$ 95,947
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 95,947

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 91,053
Unemployment Compensation Insurance	84,203
FICA Taxes	456,377
Employee Health Insurance	113,679
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	14,975
Uniforms	21,136
Life Insurance	(350)
Miscellaneous Employee Benefits	(1,933)
Retirement	12,269
TOTAL (agree to Schedule V, line 22, col.8)	\$ 791,409

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

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 158)	1,900
Patient Background Checks 117	1,170
Illinois Council on Long Term Care	18,540
Miscellaneous Dues & Permits	676
Miscellaneous Licenses & Inspections	11,132
Less: Chamber of Commerce	(395)
Less: Public Relations Expense	()
Non-allowable advertising	(6,118)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,905

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	7,116
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,116

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Tower Hill Healthcare Center
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2016

Schedule 21B

XIX. SUPPORT SCHEDULES
B. Administrative - Other

Description	Amount
Central Bookkeeping Office	203,378
Management Fees - Jeremy Amster (Eliminated on Sch. V., (	490,000
Total (agree to Schedule V, line 17, column 3)	693,378
Less: Non-Allowable Management Fees	(389,800)
Total (agree to Schedule V, line 17, column 8)	303,578

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Dan Parsons	Legal	4,000
Hepler Broom	Legal	44,619
Lowenbaum Law	Legal	335
Polsinelli PC	Legal	8,135
Stone, Mcguire & Siegel	Legal	4,743
Personal Planners	Unemployment Consultant	1,396
RSM US LLP	Accounting	23,980
E-Health Data	Administrative Consultant	8,739
Total (agree to Schedule V, line 19, column 3)		95,947
Allocated from Management Company Professional Services		7,610
Less: Non-Allowable Legal Fees		(4,340)
Total (agree to Schedule V, line 19, column 8)		99,217

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 - \$ 18,540
- (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? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,639 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. \$ 479,364
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ 58
- (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