

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0051557</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>Tower Hill Healthcare Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.																																																																																	
Address: <u>759 Kane Street</u> <u>South Elgin</u> <u>60177</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>Kane</u>																																																																																			
Telephone Number: <u>(847) 697-3310</u> Fax # <u>(847) 697-3354</u>																																																																																			
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>7/1/11</u></td><td colspan="2">(Telephone) <u>(847) 517-7070</u> Fax # (847)<u>517-7067</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Amanda Springborn</u></td><td colspan="2">Telephone Number: <u>(314) 925-3838</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	Date of Initial License for Current Owners: <u>7/1/11</u>		(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>		Type of Ownership:		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		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____			In the event there are further questions about this report, please contact:				Name: <u>Amanda Springborn</u>		Telephone Number: <u>(314) 925-3838</u>		Email Address: _____			
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Facility Name & ID Number Tower Hill Healthcare Center# 0051557 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 bedsN/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	74	108	4,446	4,628	8
9	SNF/PED					9
10	ICF	42,888	5,086	1,410	49,384	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,962	5,194	5,856	54,012	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.64%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve 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?

YesG. 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 7/1/11NO ☐

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 4,446

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: 12/31/2020Fiscal Year: 12/31/2020

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

Facility Name & ID Number Tower Hill Healthcare Center # 0051557 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	626,590	112,142	10,609	749,341		749,341		749,341			1
2	Food Purchase		500,172		500,172		500,172		500,172			2
3	Housekeeping	396,218	176,950	-	573,168		573,168		573,168			3
4	Laundry	71,651	25,577	-	97,228		97,228		97,228			4
5	Heat and Other Utilities			242,479	242,479		242,479		242,479			5
6	Maintenance	146,141	71,569	33,605	251,315		251,315		251,315			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	1,240,600	886,410	286,693	2,413,703		2,413,703		2,413,703			8
	B. Health Care and Programs											
9	Medical Director	-	-	24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,127,309	520,060	210,303	4,857,672		4,857,672	68,142	4,925,814			10
10a	Therapy	-	-	-								10a
11	Activities	183,895	11,307	3,827	199,029		199,029		199,029			11
12	Social Services	166,754	-	-	166,754		166,754		166,754			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	4,477,958	531,367	238,130	5,247,455		5,247,455	68,142	5,315,597			16
	C. General Administration											
17	Administrative	240,285	-	740,330	980,615		980,615	(331,892)	648,723			17
18	Directors Fees			-								18
19	Professional Services			169,382	169,382		169,382	(19,470)	149,912			19
20	Dues, Fees, Subscriptions & Promotions			70,181	70,181		70,181	(13,144)	57,037			20
21	Clerical & General Office Expenses	387,769	-	232,246	620,015		620,015	(77,298)	542,717			21
22	Employee Benefits & Payroll Taxes			860,761	860,761		860,761		860,761			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			4,767	4,767		4,767		4,767			24
25	Other Admin. Staff Transportation		-	14,617	14,617		14,617	(13,052)	1,565			25
26	Insurance-Prop.Liab.Malpractice			436,073	436,073		436,073	81,081	517,154			26
27	Other (specify):*			-								27
28	TOTAL General Administration	628,054		2,528,357	3,156,411		3,156,411	(373,775)	2,782,636			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,346,612	1,417,777	3,053,180	10,817,569		10,817,569	(305,633)	10,511,936			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			43,951	43,951		43,951	717,465	761,416			30
31	Amortization of Pre-Op. & Org.			140,107	140,107		140,107	11,255	151,362			31
32	Interest			168,200	168,200		168,200	465,109	633,309			32
33	Real Estate Taxes			-				90,580	90,580			33
34	Rent-Facility & Grounds			1,377,400	1,377,400		1,377,400	(1,377,400)				34
35	Rent-Equipment & Vehicles			90,307	90,307		90,307		90,307			35
36	Other (specify):* MIP Insurance			-				73,963	73,963			36
37	TOTAL Ownership			1,819,965	1,819,965		1,819,965	(19,028)	1,800,937			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				13,052	13,052			38
39	Ancillary Service Centers	-	266,972	646,617	913,589		913,589		913,589			39
40	Barber and Beauty Shops	-	-	52	52		52		52			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			447,685	447,685		447,685		447,685			42
43	Other (specify):* Non-Allowable Cos	-	-	299,535	299,535		299,535	(299,535)				43
44	TOTAL Special Cost Centers		266,972	1,393,889	1,660,861		1,660,861	(286,483)	1,374,378			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,346,612	1,684,749	6,267,034	14,298,395		14,298,395	(611,144)	13,687,251			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				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	415,089	30		9
10	Interest and Other Investment Income	(3,141)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(585)	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	(550)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,985)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(166,531)	43		24
25	Fund Raising, Advertising and Promotional	(12,066)	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 PG5A	(482,685)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (278,454)		\$	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)	(332,690)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (332,690)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (611,144)		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	\$ (1,214)	43	1
2	X-Ray Expense Med A	(4,335)	43	2
3	Managed Care Costs	(114,254)	43	3
4	State Replacement Tax	(8,690)	43	4
5	Lobbying Expense	(17,189)	20	5
6	Chamber of Commerce Dues	(455)	20	6
7	Disallow Management fees	(331,892)	17	7
8	Offset misc income	(4,656)	21	8
9				9
10				10
11				11
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40				40
41				41
42				42
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44				44
45				45
46				46
47				47
48				48
49	Total	(482,685)		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	100%	\$ 8,515	\$ 8,515	1
2	V	43	State Replacement Tax		Tower Hill Property LLC	100%	8,690	8,690	2
3	V	21	Bank Service Charge	975	Tower Hill Property LLC	100%		(975)	3
4	V	26	Insurance		Tower Hill Property LLC	100%	81,081	81,081	4
5	V	30	Depreciation		Tower Hill Property LLC	100%	302,376	302,376	5
6	V	36	MIP Insurance		Tower Hill Property LLC	100%	73,963	73,963	6
7	V	32	Interest		Tower Hill Property LLC	100%	469,225	469,225	7
8	V	33	Real Estate Tax		Tower Hill Property LLC	100%	90,580	90,580	8
9	V	34	Rent	1,377,400	Tower Hill Property LLC	100%		(1,377,400)	9
10	V	31	Amortization		Tower Hill Property LLC	100%	11,255	11,255	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,378,375			\$ 1,045,685	\$ * (332,690)	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:

1/1/2020

Ending:

12/31/2020

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 Supportive Living	Shabbona	Facility	1
2	Stuart Milstein	16%	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC			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					Program LLC			15
16								16
17					Cahokia Building LLC	Cahokia	Real Estate	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20					Property LLC			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

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 Prope	St. Joseph, MO	Real Estate	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

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%	N/A	50	85.00	GurPmt & Sal	\$ 185,000	L17 C(1,3&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	\$ 185,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Tower Hill Healthcare Center# 0051557 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3		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	\$ 11,169,558	9/1/2037	0.0405	\$ 460,916	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	700,000	2/15/2020	0.055	56,847	6	
7	Shareholder's Loan	X		Working Capital	Varies	6/30/12	1,250,000	643,000	Demand	Varies	2,315	7	
8	See Schedule 9A						4,086,148	3,651,782			117,347	8	
9	TOTAL Facility Related				\$76,623.68		\$ 20,436,148	\$ 16,164,340			\$ 637,425	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income offset				(4,116)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,116)	14	
15	TOTALS (line 9+line14)						\$ 20,436,148	\$ 16,164,340			\$ 633,309	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 73,963 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: 12/31/2020

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					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Kane Street Associates	X		Working Capital	\$23,863.33	8/29/13	2,101,608	1,667,242	9/1/37	0.0650	109,038		6
7	Tower Hill Property	X		Related Party Transactions	None	Ongoing			Demand	0.0109	8,309		7
8	Wisconsin Physician Services		X	MCR Advance Payments	\$23,769.79	4/30/20	570,475	570,475	4/30/22	0.0000	-		8
9	SBA-PPP Loan		X	Payroll & Oper Exp	None	4/20/20	1,414,065	1,414,065	4/20/22	0.01	-		
10	TOTAL Facility Related				\$47,633.12		\$ 4,086,148	\$ 3,651,782			\$ 117,347		9
	B. Non-Facility Related*												
11													10
12													11
13													12
14													13
15	TOTAL Non-Facility Related				\$0.00		\$ -	\$ -			\$ -		14

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	116,400	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.)		2019	\$	101,980	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(14,420)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	105,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	90,580	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	117,856	8	
		2016	118,403	9	
		2017	114,813	10	
		2018	113,013	11	
		2019	101,980	12	
Accrual : \$101,979.82 x 1.01% = \$102,999.62 Use \$105,000					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		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.

2019 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 2019 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 2019.

(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. 06-34-228-012	Long Term Care Property	\$ 101,979.82	\$ 101,979.82
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 101,979.82	\$ 101,979.82

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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

☒ (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?
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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	206		2012		\$ 7,828,000	\$	40	\$ 195,700	\$ 195,700	\$ 1,467,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Chiller Valve Replcement			2011	5,221	190	20	261	71	2,414	9
10											10
11	Remodel			2012	187,645	6,823	20	9,382	2,559	79,747	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	8,677	18
19	Ceiling Tiles throughout the facility			2012	6,196	225	20	310	85	2,633	19
20	Replace Defective 4" Cast Iron Pipe & Fittings - Kitchen			2012	5,660	206	20	283	77	2,406	20
21	Flower Islands - Parking Lot			2012	9,314	323	15	621	298	5,278	21
22	Sidewalk Work			2013	2,560	97	40	64	(33)	480	22
23	Paving & Sealing			2013	7,593	304	40	190	(114)	1,425	23
24	Kitchen Door			2013	2,504	91	40	63	(28)	472	24
25	Install Oversized Heavy Duty Door in Basement (Center Stairwell)			2013	3,256	118	40	81	(37)	608	25
26	and install trim around business manager office										26
27	Replace Fire Alarm Panel			2013	2,572	94	40	64	(30)	480	27
28											28
29	All Resident Bathrooms Remodeled - Light fixtures,Mirrors,			2014	295,853		40	7,396	7,396	48,076	29
30	Grab Bars, Crown Molding, Wallpaper, Tile, etc.										30
31											31
32	Thermostatic Mixing Value			2014	3,100	113	40	78	(36)	504	32
33											33
34	Parking Lot - Removed & replaced asphalt. Filled holes.			2015	126,168	5,993	20	6,308	315	34,696	34
35	Electric Box and Circuits - Mechanical Room			2015	8,100	295	20	405	110	2,228	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:

1/1/2020

Ending:

12/31/2020

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	\$ 1,523	37
38 Bathtub, Plumbing, Walls, Flooring								38
39								39
40 Thermostatic Mixing Valve - Kitchen	2016	2,925	102	20	146	44	659	40
41								41
42 Coil and Pan Replacement - Kitchen & Hallway Air Handlers	2017	32,769	1,638	20	1,638		5,731	42
43 Cooling Tower Fan Motor	2017	6,848	342	20	342		1,197	43
44 Replace Seal & Bearing Assembly on Condenser	2017	7,907	395	20	395		1,384	44
45 Pump -Chiller Room								45
46 Replace relief valves on boiler	2017	2,679	134	20	134		469	46
47								47
48 Water Heater - Mechanical Room	2018	16,200	589	27.5	589		1,473	48
49 Hot water holding tank for water heater - Mechanical Room	2018	24,700	898	27.5	898		2,245	49
50 Make island in parking lots	2018	7,314	488	15	488		1,219	50
51								51
52 Pump replacement in cooling tower	2019	12,248	306	20	612	306	919	52
53 6 piece cooling tower pack, water tubes-cooling tower	2019	14,762	369	20	738	369	1,107	53
54 Back exit door	2019	4,890	61	40	122	61	183	54
55								55
56 Back exit door	2020	5,280	66	40	66		66	56
57 Kitchen flooring	2020	52,000	1,300	20	1,300		1,300	57
58 Cooling tower - Mechanical Room	2020	39,913	998	20	998		998	58
59 Annunciator panel/fire alarm - for entire facility	2020	8,146	204	20	204		204	59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69 To adjust for book depreciation			-5,595			5,595		69
70 TOTAL (lines 4 thru 69)		\$ 8,763,806	\$ 17,909		\$ 231,175	\$ 213,266	\$ 1,678,552	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	\$5,231,262	\$23,404	\$527,603	\$504,199	5-10	\$4,174,482	71
72	Current Year Purchases	26,377	2,638	2,638		5	2,638	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$5,257,639	\$26,042	\$530,241	\$504,199		\$4,177,120	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)	\$14,433,445	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$43,951	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$761,416	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$717,465	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,855,672	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?

☒ YES

☐ NO
- If NO, see instructions.

		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: \$62,904 Description: See Schedule 14A

(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	\$8,333	17
18	Facility	2018 Ford Expedition	1,157	19,070	18
19					19
20					20
21	TOTAL		\$2,516	\$27,403	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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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: Tower Hill Healthcare Center
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	42,650
Copy machine	20,254
Total - Line 16	62,904

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.

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	

(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.

HFS 3745 (N-4-99)

IL478-2471

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	\$	3,947	\$ 284,196	\$	3,947	\$ 284,196	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,264	60,664		1,264	60,664	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,715	301,757		4,715	301,757	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 prescripts				247,401		247,401	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					19,571		19,571	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	9,926	\$ 646,617	\$ 266,972	9,926	\$ 913,589	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	\$ 1,547,265	\$ 1,581,473	1
2	Cash-Patient Deposits	113,695	113,695	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,172)	5,768,316	5,768,316	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	67,671	131,159	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Schedule 17A	750,059	1,188,475	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,247,006	\$ 8,783,118	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	669,997	935,806	15
16	Equipment, at Historical Cost	313,639	5,257,639	16
17	Accumulated Depreciation (book methods)	(543,016)	(5,855,672)	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	980,752	2,293,453	22
23	Other(specify): HUD option expenses	-	29,652	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,421,372	\$ 10,900,878	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,668,378	\$ 19,683,996	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,046,603	\$ 1,046,603	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	130,103	130,103	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	177,723	177,723	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,814	16,814	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	105,000	32
33	Accrued Interest Payable	537,304	575,004	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,445,535	1,445,535	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,354,082	\$ 3,496,782	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,994,782	16,164,340	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)	\$ 4,994,782	\$ 16,164,340	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,348,864	\$ 19,661,122	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,319,514	\$ 22,874	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,668,378	\$ 19,683,996	48

*(See instructions.)

Facility Name: Tower Hill Rehabilitation, LLC
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2020

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	After	
	Operating	Consolidation
Due From State - Interest	263,241	263,241
Escrow - Replacement Reserve	-	739,811
Escrow - Insurance	-	123,577
Escrow - Re Taxes	-	45,105
Escrow - Mip	-	23,466
Due To/From Tower Hill Pr	486,818	(6,725)
Total - Line 9	750,059	1,188,475

XV. Balance Sheet

Line 22 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
Intangible Asset - Goodwill	2,101,608	3,296,000
Accum. Amort. - Goodwill	(1,120,856)	(1,120,856)
Mortgage Costs	-	152,555
Accum Amort - Mtge Costs	-	(34,246)
Total - Line 22	980,752	2,293,453

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Due To/From State	65,779	65,779
Due To State Per Audit	855,435	855,435
Reimbursement Due / Bad Debt	273,894	273,894
Short Term Loan Exchange	(44,635)	(44,635)
Insurance Premiums Payable	59,195	59,195
Accrued Expenses	137,068	137,068
Due To/From Kane St Property	28,799	28,799
Accrued Mgmt Fees	70,000	70,000
Total - Line 36	1,445,535	1,445,535

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 873,220	1
2	Restatements (describe):		2
3			3
4	Adjustment in opening balance	3,522	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 876,742	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	442,772	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 442,772	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,319,514	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Tower Hill Healthcare Center

0051557

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 12,519,619	1
2	Discounts and Allowances for all Levels	(-)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,519,619	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	573,710	6
7	Oxygen	9,949	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 583,659	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,583,492	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)	\$ 1,583,492	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	3,141	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,141	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustments	46,600	28
28a	Miscellaneous Income	4,656	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 51,256	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,741,167	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,413,703	31
32	Health Care	5,247,455	32
33	General Administration	3,156,411	33
	B. Capital Expense		
34	Ownership	1,819,965	34
	C. Ancillary Expense		
35	Special Cost Centers	1,213,176	35
36	Provider Participation Fee	447,685	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,298,395	40
41	Income before Income Taxes (line 30 minus line 40)**	442,772	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 442,772	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,277,201	44
45	Private Pay - Net Inpatient Revenue	99,507	45
46	Medicare - Net Inpatient Revenue	2,906,058	46
47	Other-(specify) Hospice	292,066	47
48	Other-(specify) Insurance	(55,213)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,519,619	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.

^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	776	832	\$ 42,504	\$ 51.09	1
2	Assistant Director of Nursing	3,586	3,829	199,443	52.09	2
3	Registered Nurses	25,338	28,012	1,068,532	38.15	3
4	Licensed Practical Nurses	19,936	22,236	801,343	36.04	4
5	CNAs & Orderlies	98,559	104,606	2,015,487	19.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	268	276	6,213	22.51	9
10	Activity Assistants	12,684	13,740	177,682	12.93	10
11	Social Service Workers	6,182	6,275	166,754	26.57	11
12	Dietician					12
13	Food Service Supervisor	3,546	3,850	94,711	24.60	13
14	Head Cook	8,997	9,621	133,695	13.90	14
15	Cook Helpers/Assistants	31,644	33,275	398,184	11.97	15
16	Dishwashers					16
17	Maintenance Workers	6,370	6,898	146,141	21.19	17
18	Housekeepers	27,303	29,961	396,218	13.22	18
19	Laundry	4,199	4,598	71,651	15.58	19
20	Administrator	4,170	4,618	240,285	52.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,757	16,202	387,769	23.93	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)	269,315	288,829	\$ 6,346,612 *	\$ 21.97	34

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

** See instructions.

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	\$ 10,609	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant	Monthly	7,081	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	3,827	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Utilization Review Fees	Monthly	22,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 67,517		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,059	\$ 77,262	10(3)	50
51	Licensed Practical Nurses	555	40,530	10(3)	51
52	Certified Nurse Assistants/Aides	1,787	63,430	10(3)	52
53	TOTAL (lines 50 - 52)	3,401	\$ 181,222		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Victoria Hill		Adminstrator	0	\$ 203,393	Workers' Compensation Insurance		\$ 68,366	IDPH License Fee		\$ 1,990		
Jeremy Amster		Adminstrator	49	36,892	Unemployment Compensation Insurance		38,578	Advertising: Employee Recruitment				
					FICA Taxes		474,872	Health Care Worker Background Check				
					Employee Health Insurance		202,038	(Indicate # of checks performed 284)		3,412		
					Employee Meals			Patient Background Checks 127		1,270		
					Illinois Municipal Retirement Fund (IMRF)*			Health Care Council Of Illinois		34,378		
					Holiday Expense		20,698	Miscellaneous Dues & Permits		26,232		
					Uniforms		15,991	Miscellaneous Licenses & Inspections		7,399		
					Retirement Plan		25,253	Chamber of commerce due		(455)		
					Miscellaneous		14,965	Disallow Lobbying		(17,189)		
								Less: Public Relations Expense (				
								Non-allowable advertising (				
								Yellow page advertising (				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 240,285	TOTAL (agree to Schedule V, line 22, col.8)				\$ 860,761	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 57,037
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
Description			Amount	Description		Line #	Amount	Description		Amount		
Management Fees - Jeremy Amster			\$ 480,000	N/A			\$	Out-of-State Travel		\$		
Central Bookkeeping Office			260,330									

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Tower Hill Healthcare Center
IDPH License ID Number: 0051557
Fiscal Year End: 12/31/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Swanson, Martin & Bell, LLP	Legal	9,762
Cassiday Schade	Legal	30,013
Mathis, Marifian, & Richter, Ltd.	Legal	7,941
Stone, Mcguire & Siegel	Legal	7,286
Law Offices Of Daniel G. Parsons	Legal	5,002
Polsinelli	Legal	33,793
Hepler Broom Llc	Legal	11,261
Law Elder Law	Legal	5,000
Jackson Lewis	Legal	3,204
Lewis Brisbois Bisgaard & Smith	Legal	8,073
Post Legal Fees For Line	Legal	5,000
RSM US LLP	Accounting	16,135
Personnel Planners Inc.	Unemployment Consultant	1,325
MTS Consulting, LLC	Administrative Consultant	25,587
Total (agree to Schedule V, line 19, column 3)		169,382
Allocated from Management Company Legal Fees		8,515
Less: Non-Allowable Legal Fees		(27,985)
Total (agree to Schedule V, line 19, column 8)		149,912

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. Health Care Council of Illinois - \$ 34,378

(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 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,866 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. \$ 447,685
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. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) 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.