

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0005405

**Facility Name:** HILLTOP CONVALESCENT CENTER

**Address:** 910 WEST POLK STREET CHARLESTON 61920  
 Number City Zip Code

**County:** COLES

**Telephone Number:** 217-345-7066 **Fax #** 217-345-6017

**HFS ID Number:** 370776670001

**Date of Initial License for Current Owners:** 7/1/1958

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** JERRY W. JENNINGS **Telephone Number:** 217-787-8530

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 8/1/05 to 7/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

**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 HILLTOP CONVALESCENT CENTER

# 0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

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 \_\_\_\_\_

	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	36	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	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	955	28	4,662	5,645	8
9	SNF/PED					9
10	ICF	13,544	7,202		20,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,499	7,230	4,662	26,391	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.95%

D. How many bed-hold days during this year were paid by the Department? 0 (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

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 7/1/58

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 25 and days of care provided 4,662

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 7/31/06 Fiscal Year: 7/31/06

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	103,311	10,030	6,693	120,034		120,034		120,034		1
2	Food Purchase		113,640		113,640		113,640	(1,818)	111,822		2
3	Housekeeping	38,004	10,461		48,465		48,465		48,465		3
4	Laundry	25,215	10,504		35,719		35,719		35,719		4
5	Heat and Other Utilities			65,399	65,399		65,399		65,399		5
6	Maintenance	35,810	35,175	44,929	115,914		115,914	1,678	117,592		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>202,340</b>	<b>179,810</b>	<b>117,021</b>	<b>499,171</b>		<b>499,171</b>	<b>(140)</b>	<b>499,031</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,400	14,400		14,400	736	15,136		9
10	Nursing and Medical Records	961,123	239,450	79,217	1,279,790	(166,881)	1,112,909	7,416	1,120,325		10
10a	Therapy	40,028	4,318	235,813	280,159	(235,813)	44,346		44,346		10a
11	Activities	47,151	1,741		48,892		48,892		48,892		11
12	Social Services	38,745		6,554	45,299		45,299		45,299		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Utility Workers</b>	1,866			1,866		1,866		1,866		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,088,913</b>	<b>245,509</b>	<b>335,984</b>	<b>1,670,406</b>	<b>(402,694)</b>	<b>1,267,712</b>	<b>8,152</b>	<b>1,275,864</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	61,512		14,988	76,500	1,158	77,658	39,529	117,187		17
18	Directors Fees										18
19	Professional Services			157,249	157,249		157,249	(151,185)	6,064		19
20	Dues, Fees, Subscriptions & Promotions			20,418	20,418		20,418	(12,619)	7,799		20
21	Clerical & General Office Expenses	53,377	11,384	7,150	71,911		71,911	31,370	103,281		21
22	Employee Benefits & Payroll Taxes			246,320	246,320		246,320	20,147	266,467		22
23	Inservice Training & Education			2,067	2,067		2,067	1,882	3,949		23
24	Travel and Seminar			9,298	9,298	(5,329)	3,969	756	4,725		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			85,988	85,988		85,988	36	86,024		26
27	Other (specify):*			41,373	41,373		41,373	(41,373)			27
28	<b>TOTAL General Administration</b>	<b>114,889</b>	<b>11,384</b>	<b>584,851</b>	<b>711,124</b>	<b>(4,171)</b>	<b>706,953</b>	<b>(111,457)</b>	<b>595,496</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,406,142</b>	<b>436,703</b>	<b>1,037,856</b>	<b>2,880,701</b>	<b>(406,865)</b>	<b>2,473,836</b>	<b>(103,445)</b>	<b>2,370,391</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			26,725	26,725		26,725	1,094	27,819		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			37,633	37,633		37,633		37,633		33
34	Rent-Facility & Grounds							5,309	5,309		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			64,358	64,358		64,358	6,403	70,761		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					406,865	406,865		406,865		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,130	59,130		59,130		59,130		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			59,130	59,130	406,865	465,995		465,995		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,406,142	436,703	1,161,344	3,004,189		3,004,189	(97,042)	2,907,147		45

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning: 8/1/05

Ending: 7/31/06

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(680)	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	(1,016)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(385)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,770)	27		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,364)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,989)	27		24
25	Fund Raising, Advertising and Promotional	(12,877)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,614)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>VENDING</u>	(1,138)	2		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (60,833)		\$	30

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	2	
		Amount	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)	(36,209)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (36,209)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (97,042)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	<u>THERAPY</u>	X		235,813	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		26,716	10	42
43	Prescription Drugs	X		113,147	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Supp, Amb</u>	X		2,725	10	45
46	Other-Attach Schedule <u>Oxygen</u>	X		28,464	10	46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 406,865		47

BHF USE ONLY						
48		49		50		52

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 8/1/05

Ending: 7/31/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending:

7/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(680)	0	0	0	0	0	0	0	0	0	0	(680)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(680)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(680)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	339	0	0	0	0	0	0	0	0	0	339	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,364)	(147,984)	0	0	0	0	0	0	0	0	0	(151,348)	19
20	Fees, Subscriptions & Promotions	(12,877)	0	0	0	0	0	0	0	0	0	0	(12,877)	20
21	Clerical & General Office Expenses	(385)	0	0	0	0	0	0	0	0	0	0	(385)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(339)	0	0	0	0	0	0	0	0	0	(339)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(41,373)	0	0	0	0	0	0	0	0	0	0	(41,373)	27
28	<b>TOTAL General Administration</b>	<b>(57,999)</b>	<b>(147,984)</b>	<b>0</b>	<b>(205,983)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(58,679)</b>	<b>(147,984)</b>	<b>0</b>	<b>(206,663)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,016)	0	0	0	0	0	0	0	0	0	0	(1,016)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,016)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,016)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(59,695)</b>	<b>(147,984)</b>	<b>0</b>	<b>(207,679)</b>	<b>45</b>								

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending:

7/31/06

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	78.18	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	Nursing Home Mngr	SPRINGFIELD	MANAGEMENT
DANA KLEIN KAVY	4.24	MEADOW MANOR	TAYLORVILLE			
PHILIP KLEIN	4.24	MENARD CONVALESCENT CENTER	PETERSBURG			
LISA KLEIN GILDAR	4.24	SUNRISE MANOR OF VIRDEN	VIRDEN			
DAVID & RAQUEL KLEIN	4.55					
JERRY & PAULA JENNINGS	4.55					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 MANAGEMENT FEE	\$ 156,492	NURSING HOME MANAGERS	39.39%	\$	\$ (156,492)	1
2	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS	39.39%	111,775	111,775	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,508	8,508	3
4	V	24 TRAVEL	339	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(339)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		339	339	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 156,831			\$ 120,622	\$ * (36,209)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

## 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	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					\$ 17,498	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	78.18					2,351	17-7	2
3											3
4											4
5	H. RAYMOND KLEIN AND JERRY JENNINGS WERE PAID BY NURSING HOME										5
6	MANAGERS, INC, A RELATED ORGANIZATION. TOTAL COMPENSATION										6
7	OF \$10,010 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE FIVE										7
8	RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK. TOTAL										8
9	COMPENSATION OF \$78,175 FOR JERRY JENNINGS WAS ALLOCATED AMONG										9
10	THE FIVE RELATED NURSING HOMES BASED UPON 35 HOURS PER WEEK.										10
11											11
12											12
13								TOTAL	\$ 19,849		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 HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending: 7/31/06

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 NURSING HOME MANAGERS, INC  
 Street Address 2653 W. LAWRENCE, SUITE B  
 City / State / Zip Code SPRINGFIELD, IL 62704  
 Phone Number ( 217 ) 787-8530  
 Fax Number ( 217 ) 787-9840

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	SEE ATTACHED SCHEDULES				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Sam Klein Primary Trust	X		WORKING CAPITAL		3/31/06	60,000	50,000	DEMAND		6									
7										7										
8										8										
9	<b>TOTAL Facility Related</b>						\$ 60,000	\$ 50,000		\$	9									
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 60,000	\$ 50,000		\$	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **HILLTOP CONVALESCENT CENTER**

# **0005405** Report Period Beginning: **8/1/05**

Ending: **7/31/06**

**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 2005 report.		\$	<b>34,614</b>	<b>1</b>																				
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.)		\$	<b>33,745</b>	<b>2</b>																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(869)</b>	<b>3</b>																				
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>38,502</b>	<b>4</b>																				
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>																				
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>37,633</b>	<b>7</b>																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2001	<u>29,241</u>	<u>8</u>																						
2002	<u>31,126</u>	<u>9</u>																						
2003	<u>31,594</u>	<u>10</u>																						
2004	<u>31,951</u>	<u>11</u>																						
2005	<u>35,539</u>	<u>12</u>																						
<b>LINE 2 2ND INSTALLMENT 2004</b>	<b>\$15975</b>	<b>LINE 4 2ND INSTALLMENT 2005</b>	<b>\$17770</b>																					
<b>1ST INSTALLMENT 2005</b>	<b>17770</b>	<b>7/12 OF 35539</b>	<b>20732</b>																					
	<b>33745</b>		<b>38502</b>																					
<table border="1"> <tr> <td colspan="3"><b>FOR BHF USE ONLY</b></td> <td></td> </tr> <tr> <td><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td><b>13</b></td> </tr> <tr> <td><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td><b>14</b></td> </tr> <tr> <td><b>15</b></td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td><b>15</b></td> </tr> <tr> <td><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td><b>16</b></td> </tr> </table>					<b>FOR BHF USE ONLY</b>				<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>FOR BHF USE ONLY</b>																								
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>																					
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																					
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																					
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																					

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HILLTOP CONVALESCENT CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0005405

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-1-00706-000</u>	<u>HILLTOP NURSING HOME</u>	\$ <u>35,539.54</u>	\$ <u>35,539.54</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>35,539.54</u>	\$ <u>35,539.54</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405 Report Period Beginning:

8/1/05 Ending:

7/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

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).

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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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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	<u>NURSING HOME</u>		<u>1966</u>	\$ <u>5,295</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>5,295</b>	3

Facility Name &amp; ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending:

7/31/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	72		1966		\$ 253,434	\$		\$	\$	\$ 253,434	4
5	36			1972	240,043					240,043	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		LANDSCAPING		1975	2,877		10			2,877	9
10		LANDSCAPING		1980	1,417		5			1,417	10
11		IMPROVEMENT		1979	17,131		15			17,131	11
12		IMPROVEMENT		1981	4,330		VARIOUS			4,330	12
13		IMPROVEMENT		1982	3,570		15			3,570	13
14		IMPROVEMENT		1983	3,583		15			3,583	14
15		IMPROVEMENT		1984	2,461		15			2,461	15
16		IMPROVEMENT		1985	14,201		15			14,201	16
17		AIR CONDITIONER		1986	1,620		10			1,620	17
18		CONDENSER		1986	3,068		15			3,068	18
19		ROOF		1986	19,843		15			19,843	19
20		CUBICLE TRACKS		1987	997	32	20	48	16	997	20
21		AIR CONDITIONER		1987	1,149	36	10		(36)	1,149	21
22		AIR CONDITIONER		1988	3,145	100	10		(100)	3,145	22
23		WATER HEATER		1988	982	31	15		(31)	982	23
24		WATER HEATER		1989	2,194	70	15	1	(69)	2,194	24
25		AIR CONDITIONER		1991	1,959	62	10		(62)	1,959	25
26		SIDEWALK		1991	3,120	99	20	156	57	2,444	26
27		WIRING		1992	1,384	44	20	70	26	1,026	27
28		AIR CONDITIONER		1992	1,474	47	10		(47)	1,474	28
29		DOOR ALARM, FURNACE, IMPROVEMENT		1993	6,664	212	15	444	232	5,995	29
30		LANDSCAPING		1993	2,824	188	10		(188)	2,824	30
31		BLACKTOP - PER 1991 AUDIT		1990	2,186		15	146	146	1,898	31
32		AIR CONDITIONER		1994	1,613	41	10		(41)	1,613	32
33		LIGHTING		1995	2,729	70	10		(70)	2,729	33
34		AIR CONDITIONER		1996	1,112	29	8		(29)	1,112	34
35		EXHAUST FAN, FLOORING, WATER HEATERS		1996	5,048	129	15	336	207	3,535	35
36		REMODELING - WALLS		1996	1,080	28	30	36	8	360	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 &amp; ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending:

7/31/06

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	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	WATER HEATER	1996	\$ 1,611	\$ 41	15	\$ 108	\$ 67	\$ 1,038	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	3,303	38
39	AIR CONDITIONER	1999	3,185	82	10	319	237	2,417	39
40	ROOF	1999	68,332	1,752	20	3,416	1,664	24,485	40
41	FURNACE	2000	1,273	33	15	85	52	580	41
42	AIR CONDITIONER	2001	1,404	36	10	140	104	842	42
43	GAZEBO	2001	1,374	35	15	91	56	534	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	513	44
45	FIRE DAMPERS	2002	1,451	37	15	96	59	435	45
46	FURNACE	2002	2,200	56	15	147	91	660	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	2,443	47
48	FIRE/RADIATION DAMPERS	2002	1,770	45	15	118	73	502	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	1,253	49
50	WATER HEATER	2004	4,320	111	15	288	177	864	50
51	FURNACE	2004	1,525	39	15	101	62	254	51
52	SIDEWALKS	2004	3,375	87	15	225	138	506	52
53	FIRE DOOR, WHEELCHAIR RAMP	2005	6,450	165	20	322	157	349	53
54	AIR CONDITIONER	2005	1,300	33	8	163	130	217	54
55	LIGHT POLES	2005	3,365	86	15	224	138	299	55
56	LANDSCAPING	2006	2,320	77	10	58	(19)	58	56
57	FURNACE	2006	1,330	33	15	89	56	89	57
58	SIDING	2006	1,200	17	15	47	30	47	58
59	SIDEWALKS	2006	4,130	49	15	138	89	138	59
60	FIRE WALLS	2006	15,706	151	20	327	176	327	60
61	ROOF	2006	2,400	18	20	40	22	40	61
62	DOORS	2006	8,757	65	15	195	130	195	62
63	CIRCULATING PUMP	2006	899	5	15	15	10	15	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 770,775	\$ 4,883		\$ 9,329	\$ 4,446	\$ 645,417	70

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/05 Ending: 7/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 170,008	\$ 17,583	\$ 13,970	\$ (3,613)	VAR	\$ 90,735	71
72	Current Year Purchases	8,672	1,299	1,183	(116)	VAR	1,183	72
73	Fully Depreciated Assets	197,130					197,130	73
74	ASSETS NO LONGER IN SERVICE	(58,078)					(58,078)	74
75	TOTALS	\$ 317,732	\$ 18,882	\$ 15,153	\$ (3,729)		\$ 230,970	75

D. Vehicle Depreciation (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	RESIDENT TRANSPORT	2000 DODGE CARAVAN	2006	\$ 24,550	\$ 2,960	\$ 1,227	\$ (1,733)	5	\$ 1,227	76
77										77
78										78
79										79
80	TOTALS			\$ 24,550	\$ 2,960	\$ 1,227	\$ (1,733)		\$ 1,227	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 1,118,352	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 26,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 25,709	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (1,016)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 877,614	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_/2007 \$ \_\_\_\_\_

13. \_\_\_\_\_/2008 \$ \_\_\_\_\_

14. \_\_\_\_\_/2009 \$ \_\_\_\_\_

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	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		hrs	\$	1,644	\$ 110,230	\$	1,644	\$ 110,230	1
2	Licensed Speech and Language Development Therapist		hrs		82	6,415		82	6,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,165	119,168		2,165	119,168	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				113,147		113,147	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Oxygen, Labs, Xray, Supplies, Amb</b>						57,905		57,905	13
14	<b>TOTAL</b>			\$	3,891	\$ 235,813	\$ 171,052	3,891	\$ 406,865	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.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning: 8/1/05

Ending:

7/31/06

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of 7/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 7,128	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	818,410		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,658		6
7	Other Prepaid Expenses	30,629		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 869,825	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,295		13
14	Buildings, at Historical Cost	768,589		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	398,571		16
17	Accumulated Depreciation (book methods)	(945,780)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 226,675	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,096,500	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 247,033	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,056		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,571		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,501		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,614		35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 382,775	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 382,775	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 713,725	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,096,500	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>673,086</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>673,086</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>234,514</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(193,875)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>40,639</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>713,725</b>	<b>24</b> *

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning: 8/1/05

Ending: 7/31/06

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,129,843	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,129,843	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,337	6
7	Oxygen	21,080	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 100,417	8
<b>C. Other Operating Revenue</b>			
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	680	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	816	21
22	Laundry	360	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,856	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,221	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,221	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending 1138 Bad Debt Recovery 2843	3,981	28
28a	Admit Fees 200 Old checks 171 W/A 14	385	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,366	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,238,703	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	499,171	31
32	Health Care	1,670,406	32
33	General Administration	711,124	33
<b>B. Capital Expense</b>			
34	Ownership	64,358	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	59,130	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,004,189	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	234,514	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 234,514	43

\* 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.

Facility Name & ID Number **HILLTOP CONVALESCENT CENTER**

# **0005405**

Report Period Beginning:

8/1/05

Ending:

7/31/06

**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	2,000	2,080	\$ 56,213	\$ 27.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,107	7,530	149,866	19.90	3
4	Licensed Practical Nurses	14,790	15,309	246,727	16.12	4
5	CNAs & Orderlies	52,308	53,322	508,317	9.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,476	3,599	40,028	11.12	8
9	Activity Director	2,040	2,193	21,063	9.60	9
10	Activity Assistants	3,060	3,214	26,088	8.12	10
11	Social Service Workers	3,935	4,141	38,745	9.36	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,121	26,517	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,712	9,963	76,794	7.71	15
16	Dishwashers					16
17	Maintenance Workers	4,083	4,193	35,810	8.54	17
18	Housekeepers	5,121	5,248	38,004	7.24	18
19	Laundry	3,063	3,175	25,215	7.94	19
20	Administrator	2,000	2,080	61,512	29.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,684	4,953	53,377	10.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	262	265	1,866	7.04	33
34	TOTAL (lines 1 - 33)	119,562	123,386	\$ 1,406,142 *	\$ 11.40	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	192	\$ 6,693	1-3	35
36	Medical Director	120	14,400	9-3	36
37	Medical Records Consultant	38	2,415	10-3	37
38	Nurse Consultant	635	31,802	10-3	38
39	Pharmacist Consultant	96	2,875	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	108	6,554	12-3	45
46	Other(specify)	18	900	10-3	46
47	<u>ADMINISTRATIVE CONSULTANT</u>	452	14,988	17-3	47
48	<u>MEDICARE CONSULTANT</u>	192	11,937	10-3	48
49	TOTAL (lines 35 - 48)	1,851	\$ 92,564		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	102	\$ 4,190	10-3	50
51	Licensed Practical Nurses	555	20,853	10-3	51
52	Certified Nurse Assistants/Aides	165	4,245	10-3	52
53	TOTAL (lines 50 - 52)	822	\$ 29,288		53

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning: 8/1/05

Ending: 7/31/06

**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		
ARACELI HENSON	ADMINISTRATOR	0	\$ 61,512	Workers' Compensation Insurance	\$ 58,585	IDPH License Fee	\$ 35		
				Unemployment Compensation Insurance	17,781	Advertising: Employee Recruitment	4,460		
				FICA Taxes	104,560	Health Care Worker Background Check	2,560		
				Employee Health Insurance		(Indicate # of checks performed <u>81</u> )			
				Employee Meals		Patient Background Checks	79		
				Illinois Municipal Retirement Fund (IMRF)*		PUBLIC RELATIONS	12,877		
				EMPLOYEE LABS AND VACCINES	2,036	DUES AND SUBSCRIPTIONS	180		
				HOLIDAY PARTY	640	FRANCHISE FEE	163		
				GIFT CERTIFICATES	1,125	AUTOMOBILE LICENSE	143		
				EMPLOYEE CAFETERIA PLAN	58,075	NHM ALLOCATION	258		
				EMPLOYEE LIFE INSURANCE	3,518	Less: Public Relations Expense	(12,877)		
				NHM ALLOCATION	20,147	Non-allowable advertising	( )		
						Yellow page advertising	( )		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 266,467	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,799		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
\$ 61,512									
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	
ADMINISTRATIVE CONSULTANT	\$ 14,988			EMPLOYEE LABS/VACCINES	22	\$ 2,036	Out-of-State Travel	\$	
				HOLIDAY PARTY	22	640			
				GIFT CERTIFICATES	22	1,125			
							In-State Travel		
							SEE ATTACHED SCHEDULE	3,969	
							NHM ALLOCATION	1,095	
							TSF 31% TO ADMINISTRATIVE	(339)	
							Seminar Expense		
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							TOTAL		\$ 4,725
\$ 14,988									
C. Professional Services									
Vendor/Payee	Type	Amount							
NURSING HOME MNGRS	MANAGEMENT	\$ 156,492							
FELDMAN, WASSER, ET AL	LEGAL	448							
CSC	CORP. REPRESENTATION	309							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			\$ 3,801		
\$ 157,249									

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/05

Ending:

7/31/06

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 8 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,033 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,130  
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? YES 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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? YES Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NO  
d. Have vehicle usage logs been maintained? YES  
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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**PAGE 3 & 4 - SCHEDULE V**

PAGE 3 - SCHEDULE V - LINE 23

LINE 27 - OTHER GENERAL ADMINISTRATION

BAD DEBT	\$ 32,989
SALES TAX	4,770
ILLINOIS RT TAX	3,614
TOTAL LINE 27 - COLUMN 3	<u>\$ 41,373</u>

DETAIL - INSERVICE TRAINING & EDUCATION

ADMINISTRATIVE TRAINING	\$ 310
MEDICARE TRAINING	25
MEDICAID TRAINING	435
NURSING SEMINARS	190
HOME OFFICE INSERVICES	1,107
NURSING HOME MANAGERS ALLOCATION	1,882
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 3,949</u>

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:		LINE #
OXYGEN	\$ (28,464)	10
MEDICARE AMBULANCE	(35)	10
MEDICARE DRUGS	(113,147)	10
MEDICARE LAB FEES	(10,222)	10
MEDICARE SUPPLIES	(2,690)	10
MEDICARE X-RAYS	(16,494)	10
PHYSICAL THERAPY	(119,168)	10A
SPEECH THERAPY	(6,415)	10A
OCCUPATIONAL THERAPY	<u>(110,230)</u>	10A
RECLASS TO: ANCILLARY SERVICES	<u>\$ 406,865</u>	39
RECLASS TO:		
NURSE CONSULTANT MILEAGE	\$ 4,171	10
ADMINISTRATIVE CONSULTANT MILEAGE	<u>1,158</u>	17
RECLASS FROM: TRAVEL	<u>\$ (5,329)</u>	24

PAGE 21 - SECTION G

DETAIL - IN STATE TRAVEL

MEETINGS/SEMINARS MILEAGE REIMBURSEMENT	\$ 1,615
RELATED FACILITIES MILEAGE REIMBURSEMENT	607
ADMINISTRATIVE MILEAGE REIMBURSEMENT	473
PATIENT SCREENING MILEAGE REIMBURSEMENT	405
ACTIVITY/SOCIAL SERVICE MILEAGE REIMBURSEMENT	731
MISCELLANEOUS MILEAGE REIMBURSEMENT	138
SECTION G - TOTAL BEFORE HOME OFFICE ADJUSTMENT	<u>\$ 3,969</u>

**Cell:** F8

**Comment:** Jerry Jennings:

HILLTOP CONVALESCENT CENTER

# 0005405

8/1/05 TO 7/31/06

PAGE 25

**PAGE 13 - SCHEDULE XI - SECTION E**

RECONCILIATION OF DEPRECIATION	\$ 25,709
NURSING HOME MANAGERS ALLOCATION	<u>2,110</u>
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 27,819</u>

**PAGE 23 - SCHEDULE XX - QUESTION 12**

SALARY COSTS ALLOCATED TO DEPARTMENTS  
WORKED BASED UPON TIME CARDS.

**PAGE 19 - SCHEDULE XVII**

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	\$ 234,514
* MANAGEMENT FEE 7/31/03	(15,920)
* MANAGEMENT FEE 7/31/04	18,647
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	<u>(2,221)</u>
TAXABLE INCOME	<u>\$ 235,020</u>

\* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED  
FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY  
WITH PRIOR COST REPORTS AND TO CONFORM TO  
ACCRUAL ACCOUNTING METHODS.

CENTRAL OFFICE COST ALLOCATION  
 HILLTOP  
 2005

	AUG 05	SEPT	OCT	NOV	DEC	JAN 06	FEB	MARCH	APRIL	MAY	JUNE	JULY	TOTAL	LINE
SALARIES-ADMIN	\$3,037	\$3,145	\$3,235	\$3,180	\$3,212	\$3,020	\$2,988	\$3,085	\$3,109	\$2,983	\$2,904	\$2,940	\$36,839	17
SALARIES-CLERIC	2,384	2,469	2,539	2,496	2,521	2,383	2,357	2,434	2,453	2,353	2,291	2,319	28,999	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	830	859	884	869	878	445	440	454	458	439	427	433	7,416	10
ACCOUNTING	17	17	18	18	18	11	11	11	11	11	10	11	163	19
WORK COMP INS	56	58	60	59	60	22	22	22	22	22	21	21	445	22
SUPPLIES	66	68	70	69	69	101	100	104	104	100	98	99	1,048	21
TELEPHONE	135	139	143	141	142	145	143	148	149	143	139	141	1,708	21
EMPL BENEFITS	1,198	1,240	1,276	1,254	1,267	1,157	1,145	1,182	1,192	1,143	1,113	1,127	14,294	22
PAYROLL TAXES	417	432	444	437	441	465	460	475	479	459	447	452	5,408	22
TRAVEL	116	120	124	122	123	70	70	72	73	70	68	69	1,095	24
IN SERVICE	106	109	113	111	112	191	189	195	197	189	184	186	1,882	23
MEDICAL CONSULT	0	0	0	0	0	106	105	108	109	104	102	103	736	9
MACHINE RENTAL	37	38	39	39	39	22	22	22	22	21	21	21	344	6
OWNERS COMP	192	199	205	201	203	194	192	198	200	191	186	189	2,351	17
INS-PROP,LIAB,WC	(35)	(36)	(37)	(37)	(37)	31	31	32	32	31	30	31	36	26
DEPRECIATION	170	177	182	178	180	176	174	179	181	173	169	171	2,110	30
RENT	422	437	449	441	446	447	443	457	461	442	430	436	5,309	34
MAINTENANCE	121	126	129	127	129	101	100	103	104	99	97	98	1,334	6
FEES & PUBLICAT	33	34	35	34	34	13	13	13	13	13	12	12	258	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
<b>TOTAL</b>	<b>\$9,300</b>	<b>\$9,632</b>	<b>\$9,908</b>	<b>\$9,740</b>	<b>\$9,838</b>	<b>\$9,099</b>	<b>\$9,001</b>	<b>\$9,295</b>	<b>\$9,368</b>	<b>\$8,986</b>	<b>\$8,748</b>	<b>\$8,858</b>	<b>\$111,775</b>	
<b>FIXED ASSETS</b>													<b>111,775</b>	
EQUIP - PRIOR	9,416	9,752	10,032	9,861	9,961	15,141	14,979	15,468	15,589	14,953	14,558	14,741	12,871	
EQUIP - CURR	5,214	5,400	5,555	5,461	5,516	0	0	144	145	139	227	230	2,336	
EQUIP - FULLY DEP	4,334	4,488	4,617	4,539	4,584	4,485	4,437	4,582	4,618	4,429	4,312	4,366	4,483	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	1,527	1,581	1,626	1,599	1,615	1,580	1,563	1,614	1,627	1,560	1,519	1,538	1,579	



OCCUPIED DAYS 2005	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST		2,091	2,047	1,833		1,280	1,960	9,211
SEPTEMBER		2,059	1,881	1,778		1,163	1,877	8,758
OCTOBER		2,210	1,902	1,854		1,173	1,999	9,138
NOVEMBER		2,175	1,844	1,936		1,216	1,978	9,149
DECEMBER		2,329	2,001	2,007		1,332	2,030	9,699
TOTAL	0	25,531	25,359	21,119	0	16,793	23,573	112,375 112,375

OCCUPIED DAYS 2006	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST							
SEPTEMBER							
OCTOBER							
NOVEMBER							
DECEMBER							
TOTAL	15,521	14,369	14,242	0	9,661	12,599	66,392 66,392

ALLOCATION PERCENTAGE 2005	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%
AUGUST	0.00%	22.70%	22.22%	19.90%	13.90%	21.28%	100.00%
SEPTEMBER	0.00%	23.51%	21.48%	20.30%	13.28%	21.43%	100.00%
OCTOBER	0.00%	24.18%	20.81%	20.29%	12.84%	21.88%	100.00%
NOVEMBER	0.00%	23.77%	20.16%	21.16%	13.29%	21.62%	100.00%
DECEMBER	0.00%	24.01%	20.63%	20.69%	13.73%	20.93%	100.00%

ALLOCATION PERCENTAGE 2006	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%