

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 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
IRS Exemption Code _____	<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 8/1/06 to 7/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) <u>JERRY W. JENNINGS</u> (Date) _____
Paid Preparer	(Title) <u>CONTROLLER</u>
	(Signed) _____ (Date) _____
Paid Preparer	(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: 8/1/06 Ending: 7/31/07

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	<u>36</u>	Skilled (SNF)	<u>36</u>	<u>13,140</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>72</u>	Intermediate (ICF)	<u>72</u>	<u>26,280</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>108</u>	TOTALS	<u>108</u>	<u>39,420</u>	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	<u>594</u>		<u>4,140</u>	<u>4,734</u>	8
9	SNF/PED					9
10	ICF	<u>12,810</u>	<u>7,112</u>		<u>19,922</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,404</u>	<u>7,112</u>	<u>4,140</u>	<u>24,656</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.55%

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)

NONEF. 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 4,140Medicare Intermediary NATIONAL GOVERNMENT SERVICES OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 7/31/07 Fiscal Year: 7/31/07

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/06 Ending: 7/31/07

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	110,897	9,519	6,828	127,244		127,244		127,244		1
2	Food Purchase		110,250		110,250		110,250	(1,996)	108,254		2
3	Housekeeping	39,231	11,423		50,654		50,654		50,654		3
4	Laundry	25,918	5,100		31,018		31,018		31,018		4
5	Heat and Other Utilities			74,489	74,489		74,489		74,489		5
6	Maintenance	37,496	23,649	34,306	95,451		95,451	1,978	97,429		6
7	Other (specify):* Utility Workers	5,141			5,141		5,141		5,141		7
8	TOTAL General Services	218,683	159,941	115,623	494,247		494,247	(18)	494,229		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400	2,629	17,029		9
10	Nursing and Medical Records	1,072,343	265,123	73,013	1,410,479	(176,447)	1,234,032	6,260	1,240,292		10
10a	Therapy	40,745	4,817	279,022	324,584	(279,022)	45,562		45,562		10a
11	Activities	50,423	3,701		54,124		54,124	9,611	63,735		11
12	Social Services	49,388		6,551	55,939		55,939		55,939		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,212,899	273,641	372,986	1,859,526	(455,469)	1,404,057	18,500	1,422,557		16
	C. General Administration										
17	Administrative	61,236		16,380	77,616	1,843	79,459	29,223	108,682		17
18	Directors Fees										18
19	Professional Services			158,835	158,835		158,835	(147,178)	11,657		19
20	Dues, Fees, Subscriptions & Promotions			27,714	27,714		27,714	(14,097)	13,617		20
21	Clerical & General Office Expenses	66,743	13,913	8,492	89,148		89,148	26,321	115,469		21
22	Employee Benefits & Payroll Taxes			266,985	266,985		266,985	20,161	287,146		22
23	Inservice Training & Education			5,981	5,981		5,981	1,898	7,879		23
24	Travel and Seminar			7,637	7,637	(6,454)	1,183	591	1,774		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,906	79,906		79,906	(73)	79,833		26
27	Other (specify):*			34,235	34,235		34,235	(34,235)			27
28	TOTAL General Administration	127,979	13,913	606,165	748,057	(4,611)	743,446	(117,389)	626,057		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,559,561	447,495	1,094,774	3,101,830	(460,080)	2,641,750	(98,907)	2,542,843		29

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

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 8/1/06 Ending: 7/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			24,385	24,385		24,385	8,110	32,495		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			31,253	31,253		31,253		31,253		33
34	Rent-Facility & Grounds							4,903	4,903		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			55,638	55,638		55,638	13,013	68,651		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					460,080	460,080		460,080		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	TOTAL Special Cost Centers			59,130	59,130	460,080	519,210		519,210		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,559,561	447,495	1,209,542	3,216,598		3,216,598	(85,894)	3,130,704		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: 8/1/06

Ending: 7/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,106)	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	6,168	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(6,000)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,383)	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	(1,426)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(522)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,023)	27		24
25	Fund Raising, Advertising and Promotional	(14,287)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,403)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>VENDING</u>	(890)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,872)		\$	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)	(35,022)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,022)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (85,894)		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		279,022	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		19,622	10	42
43	Prescription Drugs	X		128,734	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>OXYGEN</u>	X		28,800	10	45
46	Other-Attach Schedule <u>SUPPLIES</u>	X		3,902	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 460,080		47

BHF USE ONLY					
48		49		50	51
					52

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 8/1/06

Ending: 7/31/07

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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

8/1/06

Ending:

7/31/07

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,106)	0	0	0	0	0	0	0	0	0	0	(1,106)	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	TOTAL General Services	(1,106)	0	0	0	0	0	0	0	0	0	0	(1,106)	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	265	0	0	0	0	0	0	0	0	0	265	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(522)	(147,616)	0	0	0	0	0	0	0	0	0	(148,138)	19
20	Fees, Subscriptions & Promotions	(14,287)	0	0	0	0	0	0	0	0	0	0	(14,287)	20
21	Clerical & General Office Expenses	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	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	(265)	0	0	0	0	0	0	0	0	0	(265)	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):*	(34,235)	0	0	0	0	0	0	0	0	0	0	(34,235)	27
28	TOTAL General Administration	(55,044)	(147,616)	0	(202,660)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,150)	(147,616)	0	(203,766)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

8/1/06

Ending:

7/31/07

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	6,168	0	0	0	0	0	0	0	0	0	0	6,168	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	TOTAL Ownership	6,168	0	0	0	0	0	0	0	0	0	0	6,168	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(49,982)	(147,616)	0	(197,598)	45								

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

8/1/06

Ending:

7/31/07

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
SAM KLEIN	90.9	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
DAVID & RAQUEL KLEIN	4.55	MEADOW MANOR	TAYLORVILLE			
JERRY & PAULA JENNINGS	4.55	MENARD CONVALESCENT CENTER	PETERSBURG			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

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	\$ 156,494	NURSING HOME MANAGERS	39.39%	\$	\$ (156,494)	1
2	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS	39.39%	112,594	112,594	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,878	8,878	3
4	V	24 TRAVEL	265	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(265)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		265	265	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		\$ 156,759			\$ 121,737	\$ * (35,022)	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: 8/1/06 Ending: 7/31/07

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					\$ 16,920	17-7	1
2	H. RAYMOND KLEIN			0.00					413	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 \$1925 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE FIVE										7
8	RELATED NURSING HOMES BASED UPON 10 HORS PER WEEK. TOTAL										8
9	COMPENSATION OF \$78232 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	\$ 17,333		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:

8/1/06

Ending: 7/31/07

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 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	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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/06 Ending: 7/31/07

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>32,832.12</u>	\$ <u>32,832.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>32,832.12</u>	\$ <u>32,832.12</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

8/1/06 Ending:

7/31/07

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).

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	TOTALS			\$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

8/1/06

Ending:

7/31/07

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	72		1966		\$ 253,434	\$		\$	\$	\$ 253,434	4
5	36			1972	240,043					240,043	5
6											6
7											7
8											8
	Improvement Type**										
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		(32)	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		(70)	2,194	24
25		AIR CONDITIONER		1991	1,959	62	10		(62)	1,959	25
26		SIDEWALK		1991	3,120	99	20	156	57	2,600	26
27		WIRING		1992	1,384	44	20	69	25	1,095	27
28		AIR CONDITIONER		1992	1,474	47	10		(47)	1,474	28
29		DOOR ALARM, FURNACE, IMPROVEMENT		1993	6,664	212	15	445	233	6,440	29
30		LANDSCAPING		1993	2,824	99	10		(99)	2,824	30
31		BLACKTOP - PER 1991 AUDIT		1990	2,186		15	146	146	2,044	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	3,871	35
36		REMODELING - WALLS		1996	1,080	28	30	36	8	396	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 HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

8/1/06

Ending:

7/31/07

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	\$ 107	\$ 66	\$ 1,145	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	3,660	38
39	AIR CONDITIONER	1999	3,185	82	10	318	236	2,735	39
40	ROOF	1999	68,332	1,752	20	3,417	1,665	27,902	40
41	FURNACE	2000	1,273	33	15	85	52	665	41
42	AIR CONDITIONER	2001	1,404	36	10	141	105	983	42
43	GAZEBO	2001	1,374	35	15	92	57	626	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	623	44
45	FIRE DAMPERS	2002	1,451	37	15	97	60	532	45
46	FURNACE	2002	2,200	56	15	147	91	807	46
47	EXHAUST REMOVATIONS	2002	8,298	213	15	554	341	2,997	47
48	FIRE/RADIATION DAMPERS	2002	1,770	45	15	118	73	620	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	1,573	49
50	WATER HEATER	2004	4,320	111	15	288	177	1,152	50
51	FURNACE	2004	1,525	39	15	102	63	356	51
52	SIDEWALKS	2004	3,375	87	15	225	138	731	52
53	FIRE DOOR, WHEELCHAIR RAMP	2005	6,450	165	20	323	158	672	53
54	AIR CONDITIONER	2005	1,300	33	8	162	129	379	54
55	LIGHT POLES	2005	3,365	86	15	224	138	523	55
56	LANDSCAPING	2006	2,320	155	10	232	77	290	56
57	FURNACE	2006	1,330	34	15	88	54	177	57
58	SIDING	2006	1,200	31	15	80	49	127	58
59	SIDEWALKS	2006	4,130	106	15	275	169	413	59
60	FIRE WALLS	2006	15,706	403	20	785	382	1,112	60
61	ROOF	2006	2,400	62	20	120	58	160	61
62	DOORS	2006	8,757	224	15	583	359	778	62
63	CIRCULATING PUMP	2006	899	23	15	60	37	75	63
64	ELECTRICAL, ETC REPAIRS PER IDPH	2007	44,282	237	20	369	132	369	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 815,057	\$ 5,654		\$ 10,967	\$ 5,313	\$ 656,384	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: 8/1/06 Ending: 7/31/07

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	\$ 152,719	\$ 12,452	\$ 13,599	\$ 1,147	VAR	\$ 79,556	71
72	Current Year Purchases	6,041	1,479	1,077	(402)	VAR	1,077	72
73	Fully Depreciated Assets	223,091					223,091	73
74	ASSETS NO LONGER IN SERVICE	(58,078)					(58,078)	74
75	TOTALS	\$ 323,773	\$ 13,931	\$ 14,676	\$ 745		\$ 245,646	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	\$ 4,800	\$ 4,910	\$ 110	5	\$ 6,137	76
77										77
78										78
79										79
80	TOTALS			\$ 24,550	\$ 4,800	\$ 4,910	\$ 110		\$ 6,137	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)	\$ 1,168,675	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,385	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,553	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,168	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 908,167	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	TOTAL				\$			7

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.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/06 Ending: 7/31/07

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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-8	hrs	\$	1,804	\$ 112,447	\$	1,804	\$ 112,447	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		195	13,521		195	13,521	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		3,049	153,054		3,049	153,054	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				128,063		128,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Labs,Xray,O2,Supp,Iv	39-8					52,995		52,995	13
14	TOTAL			\$	5,048	\$ 279,022	\$ 181,058	5,048	\$ 460,080	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: 8/1/06

Ending:

7/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 56,238	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	539,078		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,432		6
7	Other Prepaid Expenses	84,338		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 693,086	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,295		13
14	Buildings, at Historical Cost	812,872		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	404,612		16
17	Accumulated Depreciation (book methods)	(970,165)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 252,614	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 945,700	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 120,926	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,187		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,984		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,403		35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 240,596	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 240,596	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 705,104	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 945,700	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 713,725	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 713,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,129	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	(57,750)	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)	\$ (8,621)	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)	\$ 705,104	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER# 0005405Report Period Beginning: 8/1/06Ending: 7/31/07**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,294,961	1
2	Discounts and Allowances for all Levels	(165,079)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,129,882	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,025	6
7	Oxygen	24,872	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 117,897	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,106	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	1,304	21
22	Laundry	390	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,800	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,761	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,761	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 890 , BAD DEBT RECOVERY 5497	6,387	28
28a	ADMIT FEE 200, W/A 12, OLD CHECKS 5788	6,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,387	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,265,727	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	494,247	31
32	Health Care	1,859,526	32
33	General Administration	748,057	33
B. Capital Expense			
34	Ownership	55,638	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	59,130	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,216,598	40
41	Income before Income Taxes (line 30 minus line 40)**	49,129	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 49,129	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:

8/1/06

Ending:

7/31/07

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	2,040	2,160	\$ 52,195	\$ 24.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,824	6,195	125,457	20.25	3
4	Licensed Practical Nurses	21,047	21,597	383,552	17.76	4
5	CNAs & Orderlies	51,189	52,262	511,139	9.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,738	3,861	40,745	10.55	8
9	Activity Director	2,082	2,206	21,654	9.82	9
10	Activity Assistants	3,241	3,342	28,769	8.61	10
11	Social Service Workers	4,331	4,820	49,388	10.25	11
12	Dietician					12
13	Food Service Supervisor	2,464	2,600	30,143	11.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,287	9,683	80,754	8.34	15
16	Dishwashers					16
17	Maintenance Workers	3,945	4,326	37,496	8.67	17
18	Housekeepers	5,066	5,160	39,231	7.60	18
19	Laundry	2,835	3,108	25,918	8.34	19
20	Administrator	2,000	2,080	61,236	29.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,435	5,823	66,743	11.46	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>	571	573	5,141	8.97	33
34	TOTAL (lines 1 - 33)	125,095	129,796	\$ 1,559,561 *	\$ 12.02	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	\$ 6,828	1-3	35
36	Medical Director	120	14,400	9-3	36
37	Medical Records Consultant	34	2,210	10-3	37
38	Nurse Consultant	535	29,897	10-3	38
39	Pharmacist Consultant	96	3,160	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	106	6,551	12-3	45
46	Other(specify)				46
47	<u>ADMINISTRATIVE CONSULTANT</u>	616	16,380	17-3	47
48	<u>MEDICARE CONSULTANT</u>	14	2,051	10-3	48
49	TOTAL (lines 35 - 48)	1,713	\$ 81,477		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	108	\$ 5,131	10-3	50
51	Licensed Practical Nurses	280	9,780	10-3	51
52	Certified Nurse Assistants/Aides	977	20,784	10-3	52
53	TOTAL (lines 50 - 52)	1,365	\$ 35,695		53

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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,419 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. \$ 1,106
- (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? 0
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 \$5,000, 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

FINES & PENALTIES	\$ 1,426
BAD DEBT	23,023
SALES TAX	4,383
ILLINOIS RT TAX	5,403
TOTAL LINE 27 - COLUMN 3	<u>\$ 34,235</u>

DETAIL - INSERVICE TRAINING & EDUCATION

NURSE AIDE INSTRUCTOR TRAINING	\$ 175
ONLINE EMPLOYEE TRAINING	3,264
MEDICAID TRAINING	175
MDI TRAINING	649
HOME OFFICE INSERVICES	1,719
NURSING HOME MANAGERS ALLOCATION	1,898

SCHEDULE V - LINE 23 - COLUMN 8 \$ 7,880

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:		LINE #
OXYGEN	\$ (28,800)	10
MEDICARE OTHER	(351)	10
MEDICARE DRUGS	(128,063)	10
MEDICARE IV'S	(671)	10
MEDICARE LAB FEES	(8,199)	10
MEDICARE SUPPLIES	(3,551)	10
MEDICARE X-RAYS	(11,423)	10
PHYSICAL THERAPY	(153,054)	10A
SPEECH THERAPY	(13,521)	10A
OCCUPATIONAL THERAPY	<u>(112,447)</u>	10A
RECLASS TO: ANCILLARY SERVICES	<u>\$ 460,080</u>	39
RECLASS TO:		
NURSE CONSULTANT MILEAG	\$ 4,611	10
ADMINISTRATIVE CONSULTANT MILEAG	<u>1,843</u>	17
RECLASS FROM: TRAVEL	<u>\$ (6,454)</u>	24

PAGE 21 - SECTION F

DETAIL - DUES, FEES, SUBSCRIPTIONS

DUES & SUBSCRIPTIONS	\$ 320
FOOD PERMIT	10
AUTO LICENSE	78
FRANCHISE FEES	187

SECTION F - TOTAL BEFORE HOME OFFICE ADJUSTMENT \$ 595

Cell: F8

Comment: Jerry Jennings:

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	\$ 30,553
NURSING HOME MANAGERS ALLOCATION	<u>1,942</u>
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 32,495</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	\$ 49,129
* MANAGEMENT FEE 7/31/06	(18,647)
* MANAGEMENT FEE 7/31/07	0
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	<u>(2,761)</u>
TAXABLE INCOME	<u>\$ 27,721</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
 2006

	AUG 06	SEPT	OCT	NOV	DEC	JAN 07	FEB	MARCH	APRIL	MAY	JUNE	JULY	2006 TOTAL	LINE
SALARIES-ADMIN	3,370	3,341	2,963	2,866	3,032	\$1,881	\$1,828	\$1,821	\$1,862	\$1,860	\$1,854	\$1,868	\$28,545	17
SALARIES-CLERIC	2,737	2,713	2,406	2,327	2,463	2,518	2,446	2,437	2,492	2,490	2,482	2,500	30,012	21
SALARIES-CONTR	0	0	0	0	0	1,394	1,354	1,349	1,379	1,378	1,374	1,384	9,611	17
SALARIES-NURSE	444	440	390	377	399	610	593	591	604	604	602	606	6,260	10
ACCOUNTING	54	53	47	46	48	103	100	100	102	102	102	103	960	19
WORK COMP INS	46	45	40	39	41	64	62	62	63	63	63	63	650	22
SUPPLIES	65	65	57	55	59	82	79	79	81	81	80	81	863	21
TELEPHONE	125	124	110	107	113	126	122	122	124	124	124	125	1,446	21
EMPL BENEFITS	1,381	1,369	1,214	1,174	1,242	1,169	1,136	1,132	1,157	1,156	1,152	1,161	14,442	22
PAYROLL TAXES	440	436	386	374	395	441	428	426	436	436	434	437	5,069	22
TRAVEL	98	97	86	83	88	59	57	57	58	58	58	58	856	24
IN SERVICE	280	278	246	238	252	88	85	85	87	87	86	87	1,898	23
MEDICAL CONSULT	228	226	200	194	205	229	222	221	226	226	225	227	2,629	9
MACHINE RENTAL	26	26	23	22	23	20	19	19	20	20	20	20	257	6
OWNERS COMP	89	89	79	76	80	0	0	0	0	0	0	0	413	17
INS-PROP,LIAB,WC	114	113	100	97	102	(87)	(84)	(84)	(86)	(86)	(85)	(86)	(73)	26
DEPRECIATION	174	172	153	148	156	165	161	160	164	163	163	164	1,942	30
RENT	442	438	389	376	398	415	403	401	410	410	409	412	4,903	34
MAINTENANCE	191	190	168	163	172	121	118	117	120	120	120	120	1,721	6
FEES & PUBLICAT	22	22	20	19	20	13	12	12	13	13	12	13	190	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	
TOTAL	10,325	10,235	9,078	8,779	9,290	\$9,408	\$9,141	\$9,107	\$9,311	\$9,303	\$9,273	\$9,343	\$112,594	
FIXED ASSETS	0	0	0	0	0								112,594	
EQUIP - PRIOR	14,971	14,841	13,163	12,730	13,470	13,745	13,355	13,305	13,603	13,591	13,548	13,650	13,664	
EQUIP - CURR	234	232	205	199	483	0	0	228	233	233	232	862	262	
EQUIP - FULLY DEP	4,435	4,396	3,899	3,771	3,990	4,947	4,806	4,788	4,896	4,891	4,875	4,912	4,551	
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	1,562	1,549	1,374	1,328	1,406	1,464	1,423	1,417	1,449	1,448	1,443	1,454	1,443	

OCCUPIED DAYS	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2006							
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	2,154	2,036	2,111		1,269	1,703	9,273
SEPTEMBER	2,072	1,880	2,074		1,249	1,723	8,998
OCTOBER	1,974	2,055	2,267		1,418	1,951	9,665
NOVEMBER	1,830	1,947	2,126		1,414	1,948	9,265
DECEMBER	2,029	2,088	2,182		1,441	1,968	9,708
TOTAL	25,580	24,375	25,002	0	16,452	21,892	113,301 113,301

DAYS	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2007							
JANUARY	2,105	2,057	2,233		1,442	1,831	9,668
FEBRUARY	1,883	1,964	1,995		1,398	1,661	8,901
MARCH	2,115	2,213	2,327		1,564	1,816	10,035
APRIL	2,110	2,059	2,367		1,470	1,786	9,792
MAY	2,143	2,106	2,417		1,514	1,774	9,954
JUNE	2,064	2,099	2,224		1,533	1,698	9,618
JULY	2,163	2,215	2,305		1,590	1,731	10,004
AUGUST	2,265	2,186	2,329		1,594	1,714	10,088
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	16,848	16,899	18,197	0	12,105	14,011	78,060 78,060

ALLOCATION PERCENTAGE	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
2006						
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%
AUGUST	23.23%	21.96%	22.77%	13.68%	18.37%	100.00%
SEPTEMBER	23.03%	20.89%	23.05%	13.88%	19.15%	100.00%
OCTOBER	20.42%	21.26%	23.46%	14.67%	20.19%	100.00%
NOVEMBER	19.75%	21.01%	22.95%	15.26%	21.03%	100.00%
DECEMBER	20.90%	21.51%	22.48%	14.84%	20.27%	100.00%

ALLOCATION PERCENTAGE	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
2007						
JANUARY	21.77%	21.28%	23.10%	14.92%	18.94%	100.00%
FEBRUARY	21.15%	22.06%	22.41%	15.71%	18.66%	100.00%
MARCH	21.08%	22.05%	23.19%	15.59%	18.10%	100.00%
APRIL	21.55%	21.03%	24.17%	15.01%	18.24%	100.00%
MAY	21.53%	21.16%	24.28%	15.21%	17.82%	100.00%
JUNE	21.46%	21.82%	23.12%	15.94%	17.65%	100.00%
JULY	21.62%	22.14%	23.04%	15.89%	17.30%	100.00%
AUGUST	22.45%	21.67%	23.09%	15.80%	16.99%	100.00%