



Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405 Report Period Beginning: 8/1/08 Ending: 7/31/09

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	4,339	278	3,522	8,139	8
9	SNF/PED					9
10	ICF	5,682	8,542		14,224	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,021	8,820	3,522	22,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.73%

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 36 and days of care provided 3,522

Medicare 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: 7/31/09 Fiscal Year: 7/31/09

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 8/1/08 Ending: 7/31/09

**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
	<b>A. General Services</b>										
1	Dietary	116,462	13,502	11,393	141,357		141,357		141,357		1
2	Food Purchase		138,969		138,969		138,969	(3,224)	135,745		2
3	Housekeeping	68,800	15,250		84,050		84,050		84,050		3
4	Laundry	18,507	12,376		30,883		30,883		30,883		4
5	Heat and Other Utilities			103,174	103,174		103,174		103,174		5
6	Maintenance	38,016	39,812	74,044	151,872		151,872	12,588	164,460		6
7	Other (specify):* <b>Utility Workers</b>	4,384			4,384		4,384		4,384		7
8	<b>TOTAL General Services</b>	246,169	219,909	188,611	654,689		654,689	9,364	664,053		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,800	16,800		16,800	2,343	19,143		9
10	Nursing and Medical Records	1,147,555	352,650	35,774	1,535,979	(197,280)	1,338,699	5,630	1,344,329		10
10a	Therapy	25,475	4,329	307,011	336,815	(307,011)	29,804		29,804		10a
11	Activities	61,086	3,750		64,836		64,836		64,836		11
12	Social Services	50,138		6,067	56,205		56,205		56,205		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,284,254	360,729	365,652	2,010,635	(504,291)	1,506,344	7,973	1,514,317		16
	<b>C. General Administration</b>										
17	Administrative	44,623		25,272	69,895	5,179	75,074	41,074	116,148		17
18	Directors Fees										18
19	Professional Services			173,074	173,074		173,074	(158,348)	14,726		19
20	Dues, Fees, Subscriptions & Promotions			61,749	61,749		61,749	(26,672)	35,077		20
21	Clerical & General Office Expenses	140,505	16,886	10,294	167,685		167,685	42,161	209,846		21
22	Employee Benefits & Payroll Taxes			265,512	265,512		265,512	(309)	265,203		22
23	Inservice Training & Education			5,480	5,480		5,480	536	6,016		23
24	Travel and Seminar			17,033	17,033	(10,319)	6,714	1,014	7,728		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,313	50,313		50,313	372	50,685		26
27	Other (specify):*			12,321	12,321		12,321	6,754	19,075		27
28	<b>TOTAL General Administration</b>	185,128	16,886	621,048	823,062	(5,140)	817,922	(93,418)	724,504		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,715,551	597,524	1,175,311	3,488,386	(509,431)	2,978,955	(76,081)	2,902,874		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			49,849	49,849		49,849	(5,271)	44,578			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			32,374	32,374		32,374		32,374			33
34	Rent-Facility & Grounds							5,432	5,432			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			82,223	82,223		82,223	161	82,384			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					509,431	509,431		509,431			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	509,431	568,561		568,561			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,715,551	597,524	1,316,664	3,629,739		3,629,739	(75,920)	3,553,819			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,819)	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	(6,755)	30		9
10	Interest and Other Investment Income	(240)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,098)	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	(133)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,223)	27		24
25	Fund Raising, Advertising and Promotional	(24,590)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,150)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(405)	2		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (49,413)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(26,507)	VARIOUS	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (26,507)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (75,920)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39	<u>THERAPY</u>	X		307,011	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		21,495	10	42
43	Prescription Drugs	X		154,392	10	43
44	<u>OXYGEN</u>	X		19,586	10	44
45	Other-Attach Schedule <u>SUPPLIES</u>	X		6,947	10	45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 509,431		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 8/1/08

Ending: 7/31/09

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:

8/1/08

Ending:

7/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,819)	0	0	0	0	0	0	0	0	0	0	(2,819)	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>(2,819)</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>(2,819)</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	456	0	0	0	0	0	0	0	0	0	456	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(133)	(158,196)	0	0	0	0	0	0	0	0	0	(158,329)	19
20	Fees, Subscriptions & Promotions	(26,740)	0	0	0	0	0	0	0	0	0	0	(26,740)	20
21	Clerical & General Office Expenses	(240)	0	0	0	0	0	0	0	0	0	0	(240)	21
22	Employee Benefits & Payroll Taxes	0	(19,075)	0	0	0	0	0	0	0	0	0	(19,075)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(456)	0	0	0	0	0	0	0	0	0	(456)	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):*	(12,321)	19,075	0	0	0	0	0	0	0	0	0	6,754	27
28	<b>TOTAL General Administration</b>	<b>(39,434)</b>	<b>(158,196)</b>	<b>0</b>	<b>(197,630)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(42,253)</b>	<b>(158,196)</b>	<b>0</b>	<b>(200,449)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLTOP CONVALESCENT CENTER# 0005405

Report Period Beginning:

8/1/08

Ending:

7/31/09

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	(6,755)	0	0	0	0	0	0	0	0	0	0	(6,755)	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>(6,755)</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>(6,755)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(49,008)	(158,196)	0	0	0	0	0	0	0	0	0	(207,204)	45

**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
<u>SAM KLEIN</u>	<u>90.9</u>	<u>JACKSONVILLE CONVALESCENT CENTER</u>	<u>JACKSONVILLE</u>	<u>Nursing Home Mngrs</u>	<u>SPRINGFIELD</u>	<u>MANAGEMENT</u>
<u>DAVID &amp; RAQUEL KLEIN</u>	<u>4.55</u>	<u>MEADOW MANOR</u>	<u>TAYLORVILLE</u>			
<u>JERRY &amp; PAULA JENNINGS</u>	<u>4.55</u>	<u>MENARD CONVALESCENT CENTER</u>	<u>PETERSBURG</u>			
		<u>SUNRISE MANOR OF VIRDEN</u>	<u>VIRDEN</u>			

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 MANAGEMENT FEE	\$ 166,700	NURSING HOME MANAGERS	39.39%	\$	\$ (166,700)	1
2	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS	39.39%	131,689	131,689	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,504	8,504	3
4	V	24 TRAVEL	456	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(456)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		456	456	5
6	V	22 Employee Benefits & Payroll Taxes	19,075	TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS			(19,075)	6
7	V	27 OTHER ADMINISTRATIVE		AND PAYROLL TAXES TO OTHER PER DESK REVIEW		19,075	19,075	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 186,231			\$ 159,724	\$ * (26,507)	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: 8/1/08 Ending: 7/31/09

## 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					\$ 20,030	17-7	1	
2											2	
3											3	
4											4	
5											5	
6		JERRY JENNINGS WAS PAID BY NURSING HOME										6
7		MANAGERS, INC., A RELATED ORGANIZATION TOTAL										7
8		COMPENSATION OF \$107,674 WAS ALLOCATED AMONG										8
9		THE FIVE RELATED NURSING HOMES BASED UPON 35 HOURS PER WEEK.										9
10											10	
11											11	
12											12	
13								TOTAL	\$ 20,030		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:

8/1/08

Ending: 7/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/08

Ending:

7/31/09

**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										
										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	<b>STOCKHOLDERS</b>	<b>X</b>	<b>WORKING CAPITAL</b>		<b>1/1/09</b>	<b>10,000</b>	<b>10,000</b>	<b>DEMAND</b>		6									
7										7									
8										8									
9	<b>TOTAL Facility Related</b>					<b>\$ 10,000</b>	<b>\$ 10,000</b>			9									
<b>B. Non-Facility Related*</b>																			
10										10									
11										11									
12										12									
13										13									
14	<b>TOTAL Non-Facility Related</b>					<b>\$</b>	<b>\$</b>			14									
15	<b>TOTALS (line 9+line14)</b>					<b>\$ 10,000</b>	<b>\$ 10,000</b>			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:

8/1/08

Ending:

7/31/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1966</u>	<u>\$ 5,295</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 5,295</b>	<b>3</b>

Facility Name & ID Number **HILLTOP CONVALESCENT CENTER**# **0005405**

Report Period Beginning:

**8/1/08**

Ending:

**7/31/09****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
	<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	49	20		(49)	997	20
21		AIR CONDITIONER		1987	1,149	56	10		(56)	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	140	15		(140)	2,194	24
25		AIR CONDITIONER		1991	1,959	124	10		(124)	1,959	25
26		SIDEWALK		1991	3,120	198	20	156	(42)	2,912	26
27		WIRING		1992	1,384	44	20	69	25	1,233	27
28		AIR CONDITIONER		1992	1,474	47	10		(47)	1,474	28
29		DOOR ALARM, FURNACE, IMPROVEMENT		1993	6,664	130	15		(130)	6,664	29
30		LANDSCAPING		1993	2,824		10			2,824	30
31		BLACKTOP - PER 1991 AUDIT		1990	2,186		15			2,186	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	337	208	4,544	35
36		REMODELING - WALLS		1996	1,080	28	30	36	8	468	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:

8/1/08

Ending:

7/31/09

## 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	\$ 1,360	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	4,374	38
39	AIR CONDITIONER	1999	3,185	82	10	132	50	3,185	39
40	ROOF	1999	68,332	1,752	20	3,416	1,664	34,735	40
41	FURNACE	2000	1,273	33	15	85	52	835	41
42	AIR CONDITIONER	2001	1,404	36	10	140	104	1,264	42
43	GAZEBO	2001	1,374	35	15	92	57	809	43
44	SMOKE DETECTORS	2001	1,648	42	15	109	67	842	44
45	FIRE DAMPERS	2002	1,451	37	15	97	60	726	45
46	FURNACE	2002	2,200	56	15	147	91	1,100	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	4,103	47
48	FIRE / RADIATION DAMPERS	2002	1,770	45	15	118	73	856	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	2,213	49
50	WATER HEATER	2004	4,320	111	15	288	177	1,728	50
51	FURNACE	2004	1,525	39	15	102	63	560	51
52	SIDEWALKS	2004	3,375	87	15	225	138	1,181	52
53	FIRE DOOR, WHEELCHAIR RAMP	2005	6,450	165	20	323	158	1,317	53
54	AIR CONDITIONER	2005	1,300	33	8	163	130	704	54
55	LIGHT POLES	2005	3,365	86	15	224	138	971	55
56	LANDSCAPING	2006	2,320	179	10	232	53	754	56
57	FURNACE	2006	1,330	34	15	89	55	355	57
58	SIDING	2006	1,200	31	15	80	49	287	58
59	SIDEWALKS	2006	4,130	106	15	275	169	963	59
60	FIRE WALLS	2006	15,706	403	20	785	382	2,683	60
61	ROOF	2006	2,400	62	20	120	58	400	61
62	DOORS	2006	8,757	225	15	584	359	1,946	62
63	CIRCULATNG PUMP	2006	899	23	15	60	37	195	63
64	ELECTRICAL, ETC REPAIRS PER IDPH	2007	44,282	1,135	20	2,214	1,079	4,797	64
65	GARDEN / PATIO CONCRETE	2008	3,675	94	20	184	90	352	65
66	HVAC SYSTEM	2008	36,021	924	15	2,401	1,477	4,002	66
67	FURNACE	2008	3,979	102	15	265	163	442	67
68	ELECTRICAL WORK - REPLACE MAIN PANEL	2008	6,918	177	20	346	169	404	68
69	REMODEL NURSES STATION	2008	1,917	49	15	127	78	138	69
70	TOTAL (lines 4 thru 69)		\$ 867,567	\$ 8,010		\$ 15,359	\$ 7,349	\$ 686,344	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:

8/1/08

Ending:

7/31/09

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 867,567	\$ 8,010		\$ 15,359	\$ 7,349	\$ 686,344	1
2	2009	252,329	1,890	20	3,154	1,264	3,154	2
3	2009	6,100	7	8	64	57	64	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		\$ 1,125,996	\$ 9,907		\$ 18,577	\$ 8,670	\$ 689,562	34

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

**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	\$ 184,979	\$ 19,719	\$ 18,762	\$ (957)	VAR	\$ 97,477	71
72	Current Year Purchases	31,736	18,348	845	(17,503)	VAR	845	72
73	Fully Depreciated Assets	241,708					241,708	73
74	<b>ASSETS NO LONGER IN SERVICE</b>	<b>(58,078)</b>					<b>(58,078)</b>	74
75	<b>TOTALS</b>	\$ 400,345	\$ 38,067	\$ 19,607	\$ (18,460)		\$ 281,952	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	\$ 1,875	\$ 4,910	\$ 3,035	5	\$ 15,957	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 24,550	\$ 1,875	\$ 4,910	\$ 3,035		\$ 15,957	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)	\$ 1,556,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,094	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,755)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 987,471	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	<b>TOTALS</b>	\$	\$	\$	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: \_\_\_\_\_

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

<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	39-8	hrs	\$	1,744	\$ 118,453	\$	1,744	\$ 118,453	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		118	8,746		118	8,746	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		3,188	179,812		3,188	179,812	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				154,392		154,392	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>LABS &amp; XRAY</b>	39-8					21,495		21,495	12
13	Other (specify): <b>SUPPLIES &amp; OXYGE</b>	39-8					26,533		26,533	13
14	<b>TOTAL</b>			\$	5,050	\$ 307,011	\$ 202,420	5,050	\$ 509,431	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.

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

As of **7/31/09** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 88,384	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	411,352		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,686		6
7	Other Prepaid Expenses	67,897		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>	\$ 573,319	\$	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	1,123,811		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	481,185		16
17	Accumulated Depreciation (book methods)	(1,052,103)		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>	\$ 558,188	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,131,507	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 701,506	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,000		29
30	Accrued Salaries Payable	60,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,018		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,835		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 812,066	\$	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>	\$ 812,066	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 319,441	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,131,507	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>504,733</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>504,733</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(185,292)	<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>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>	\$ (185,292)	<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>319,441</b>	<b>24</b> *

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER# 0005405Report Period Beginning: 8/1/08Ending: 7/31/09

**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	\$ 3,727,986	1
2	Discounts and Allowances for all Levels	(393,993)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,333,993	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,712	6
7	Oxygen	13,936	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 98,648	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	2,819	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	3,271	21
22	Laundry	1,130	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,220	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,469	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,469	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING 405 ADMIT FEES 240</b>	645	28
28a	<b>BAD DEBT RECOVERY</b>	472	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,117	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,444,447	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	654,689	31
32	Health Care	2,010,635	32
33	General Administration	823,062	33
<b>B. Capital Expense</b>			
34	Ownership	82,223	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>	\$ 3,629,739	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(185,292)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (185,292)	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:

**8/1/08**

Ending:

**7/31/09**

**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	1,390	1,430	\$ 38,168	\$ 26.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,279	3,582	83,801	23.40	3
4	Licensed Practical Nurses	23,135	23,858	512,385	21.48	4
5	CNAs & Orderlies	48,406	49,143	513,201	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,204	2,364	25,475	10.78	8
9	Activity Director	2,139	2,305	25,348	11.00	9
10	Activity Assistants	4,004	4,119	35,738	8.68	10
11	Social Service Workers	3,679	3,943	50,138	12.72	11
12	Dietician					12
13	Food Service Supervisor	1,168	1,354	15,636	11.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,117	11,307	100,826	8.92	15
16	Dishwashers					16
17	Maintenance Workers	3,804	3,994	38,016	9.52	17
18	Housekeepers	7,841	8,072	68,800	8.52	18
19	Laundry	1,925	2,047	18,507	9.04	19
20	Administrator	1,654	1,694	44,623	26.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,121	10,600	140,505	13.26	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>	484	484	4,384	9.06	33
34	TOTAL (lines 1 - 33)	126,350	130,296	\$ 1,715,551 *	\$ 13.17	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	290	\$ 11,393	1-3	35
36	Medical Director	120	16,800	9-3	36
37	Medical Records Consultant	29	2,108	10-3	37
38	Nurse Consultant	383	14,197	10-3	38
39	Pharmacist Consultant	80	1,975	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	96	6,067	12-3	45
46	Other(specify)				46
47	<u>ADMINISTRATIVE CONSULTANT</u>	1,016	25,272	17-3	47
48					48
49	TOTAL (lines 35 - 48)	2,014	\$ 77,812		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	456	17,494	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	456	\$ 17,494		53





Facility Name &amp; ID Number HILLTOP CONVALESCENT CENTER

# 0005405

Report Period Beginning:

8/1/08

Ending: 7/31/09

**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? 12 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,597 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. \$ 2,819
- (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: \_\_\_\_\_
- (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

BAD DEBT	\$	6,223
SALES TAX		6,098
TOTAL LINE 27 - COLUMN 3	\$	<u>12,321</u>

DETAIL - INSERVICE TRAINING & EDUCATION

REHAB & RESTORATIVE WORKSHOP	\$	600
PSYCHOSOCIAL SEMINAR		295
ONLINE EMPLOYEE TRAINING		1,932
MEDICARE TRAINING		455
CPR TRAINING		970
HOME OFFICE INSERVICES		204
HOTEL FOR MEETING		56
INHAA CONFERENCE		250
DON MEETING		41
DIETARY CLASS		532
LTC SURVEYOR WORKSHOP		145
NURSING HOME MANAGERS ALLOCATION		536
SCHEDULE V - LINE 23 - COLUMN 8	\$	<u>6,016</u>

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:		LINE #
OXYGEN PRIVATE & MEDICAI	\$ (13,936)	10
MEDICARE DRUGS	(138,856)	10
MEDICARE IV'S	(15,536)	10
MEDICARE LAB FEES	(10,115)	10
MEDICARE SUPPLIES	(6,947)	10
MEDICARE X-RAYS	(11,380)	10
MEDICARE OXYGEN	(5,650)	10
PHYSICAL THERAPY	(179,812)	10A
SPEECH THERAPY	(8,746)	10A
OCCUPATIONAL THERAPY	<u>(118,453)</u>	10A
RECLASS TO: ANCILLARY SERVICES	\$ <u>509,431</u>	39
RECLASS TO:		
NURSE CONSULTANT MILEAG	\$ 5,140	10
ADMINISTRATIVE CONSULTANT MILEAG	<u>5,179</u>	17
RECLASS FROM: TRAVEL	\$ <u>(10,319)</u>	24

**PAGE 2 - SCHEDULE III - QUESTION K**

NUMBER OF BEDS CERTIFIED FOR MEDICARE

8/1/08 - 3/29/09	25 BEDS
3/30/09 - 7/31/09	36 BEDS

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

SALARY COSTS ALLOCATED TO DEPARTMENTS  
WORKED BASED UPON TIME CARDS.

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

RECONCILIATION OF DEPRECIATION	\$ 43,094
NURSING HOME MANAGERS ALLOCATION	<u>1,484</u>
SCHEDULE V - LINE 30 - COLUMN 8	\$ <u><u>44,578</u></u>

**PAGE 19 - SCHEDULE XVII**

## RECONCILIATION OF INCOME

NET INCOME - LINE 43	\$ (185,292)
* MANAGEMENT FEE 7/31/08	(89,018)
* MANAGEMENT FEE 7/31/09	46,718
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	<u>(3,469)</u>
TAXABLE INCOME	\$ <u><u>(231,061)</u></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.

## PAGE 21 - SECTION F

## DETAIL - DUES, FEES, SUBSCRIPTIONS

PUBLIC RELATIONS	\$ 24590
YELLOW PAGES	2150
LICENSE PLATES	78
DUES & SUBSCRIPTIONS	475
FOOD PERMIT	270
FRANCHISE FEES	<u>233</u>
SECTION F - TOTAL	\$ <u><u>27,796</u></u>

## PAGE 21 - SECTION G

## DETAIL - TRAVEL

DON TRAVEL	\$ 335
RNC TRAVEL	570
COMMUNITY RELATIONS TRAVEL	3008
HOTELS	541
RESIDENT SCREENING	405
OFFICE / ADMINISTRATIVE TRAVEL	629
MEETINGS	940
MISC TRAVEL	<u>286</u>
SECTION G - TOTAL	\$ <u><u>6,714</u></u>

CENTRAL OFFICE COST ALLOCATION  
HILLTOP  
2008

	AUG 08	SEPT	OCT	NOV	DEC	JAN 09	FEB	MARCH	APRIL	MAY	JUNE	JULY	TOTAL	2008
SALARIES-ADMIN	861	812	788	739	772	\$2,343	\$2,508	\$2,375	\$2,284	\$2,394	\$2,361	\$2,350	\$20,588	17
SALARIES-CLERIC	3,367	3,175	3,081	2,890	3,020	3,215	3,441	3,259	3,134	3,284	3,239	3,225	38,330	21
SALARIES-CONTR	2,609	2,461	2,388	2,240	2,341	1,127	1,206	1,142	1,099	1,151	1,135	1,130	20,030	17
SALARIES-NURSE	846	798	774	726	759	243	261	247	237	249	245	244	5,630	10
ACCOUNTING	(129)	(122)	(118)	(111)	(116)	81	87	82	79	83	82	82	(19)	19
WORK COMP INS	(18)	(17)	(17)	(16)	(17)	(32)	(34)	(32)	(31)	(32)	(32)	(32)	(309)	22
SUPPLIES	232	219	213	199	208	81	86	82	79	83	81	81	1,645	21
TELEPHONE	180	170	165	155	162	225	241	228	219	230	226	225	2,426	21
EMPL BENEFITS	1,492	1,407	1,365	1,281	1,338	846	905	857	824	864	852	848	12,879	22
PAYROLL TAXES	633	597	579	544	568	462	494	468	450	472	465	463	6,196	22
TRAVEL	148	139	135	127	133	111	119	113	108	114	112	112	1,470	24
IN SERVICE	60	57	55	52	54	36	39	37	35	37	37	36	536	23
MEDICAL CONSULT	(297)	(280)	(271)	(255)	(266)	192	206	195	188	197	194	193	(4)	9
MACHINE RENTAL	991	934	907	851	889	793	849	804	773	810	799	795	10,194	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	81	76	74	69	72	0	0	0	0	0	0	0	372	26
DEPRECIATION	25	23	23	21	22	193	207	196	188	197	195	194	1,484	30
RENT	384	362	352	330	345	516	552	523	503	527	520	518	5,432	34
MAINTENANCE	(9)	(8)	(8)	(7)	(8)	343	367	348	335	351	346	344	2,394	6
FEES & PUBLICAT	11	10	10	9	10	3	3	3	3	3	3	3	68	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL DIRECTOF	509	480	465	437	456	0	0	0	0	0	0	0	2,347	9
<b>TOTAL</b>	<b>11,975</b>	<b>11,294</b>	<b>10,958</b>	<b>10,281</b>	<b>10,743</b>	<b>\$10,778</b>	<b>\$11,537</b>	<b>\$10,927</b>	<b>\$10,509</b>	<b>\$11,012</b>	<b>\$10,860</b>	<b>\$10,812</b>	<b>\$131,689</b>	
FIXED ASSETS	0	0	0	0	0								131,689	
EQUIP - PRIOR	13,775	12,992	12,606	11,826	12,358	12,512	13,393	12,685	12,200	12,784	12,608	12,552	12,691	
EQUIP - CURR	4,380	4,131	4,008	3,760	3,929	258	276	262	252	264	260	3,991	2,148	
EQUIP - FULLY DEP	5,318	5,016	4,866	4,566	4,771	4,830	5,170	4,897	4,710	4,935	4,867	4,846	4,899	
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	1,357	1,280	1,242	1,165	1,218	1,233	1,320	1,250	1,202	1,260	1,242	1,237	1,250	

NURSING HOME MANAGERS  
COST ALLOCATION  
AUGUST 2008

ALLOCATION PERCENT	DADR	HLTP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
0.00%	20.18%	22.13%	23.13%	15.30%	18.23%	100.00%	
SALARIES-ADMIN	\$0	\$861	\$945	\$987	\$653	\$820	\$4,266
SALARIES-CLERIC	\$0	3,367	3,684	3,861	2,552	3,207	16,611
SALARIES-CONTR	\$0	2,809	2,863	2,933	1,978	2,486	12,969
SALARIES-NURSE	\$0	486	529	570	641	808	4,133
ACCOUNTING	\$0	1,229	1,342	1,480	988	1,230	6,269
WORK COMP INS	\$0	189	208	221	174	178	1,071
SUPPLIES	\$0	1,602	1,637	1,711	1,131	1,421	7,381
TELEPHONE	\$0	180	198	207	137	172	893
EMPL BENEFITS	\$0	1,462	1,537	1,611	1,021	1,281	6,113
PAYROLL TAXES	\$0	633	685	726	480	603	3,137
TRAVEL	\$0	146	162	169	112	141	732
IN SERVICE	\$0	60	66	69	46	57	299
MEDICAL CONSULT	\$0	597	628	649	420	528	2,722
MACHINE RENTAL	\$0	991	1,087	1,136	751	944	4,909
OWNERS COMP	\$0	0	0	0	0	0	0
INS-PROPLIABWC	\$0	81	88	92	61	77	399
DEPRECIATION	\$0	22	24	25	16	20	103
RENT	\$0	384	422	441	291	368	1,904
MAINTENANCE	\$0	89	100	105	68	86	448
FEES & PUBLIC	\$0	11	12	12	8	10	53
ADVERTISING	\$0	0	0	0	0	0	0
MEDICAL DIRECTOR	\$0	509	558	583	386	485	2,500
<b>TOTAL</b>	<b>\$0</b>	<b>\$10,175</b>	<b>\$13,140</b>	<b>\$13,734</b>	<b>\$9,078</b>	<b>\$11,401</b>	<b>\$59,796</b>

FIXED ASSETS	\$0	13,775	15,116	15,799	10,442	13,124	68,256
EQUIP - PRIOR	\$0	4,380	4,806	5,033	3,320	4,173	21,702
EQUIP - CURR	\$0	2,129	2,342	2,480	1,608	2,030	10,560
EQUIP - FULLY DEP	\$0	0	0	0	0	0	0
BLDG - PRIOR	\$0	0	0	0	0	0	0
BLDG - CURR	\$0	0	0	0	0	0	0
BLDG - FULLY DEP	\$0	1,357	1,489	1,557	1,029	1,293	6,725

NURSING HOME MANAGERS  
COST ALLOCATION  
SEPTEMBER 2008

ALLOCATION PERCENT	DADR	HLTP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
0.00%	19.03%	21.67%	22.13%	14.57%	18.59%	100.00%	
SALARIES-ADMIN	\$0	\$812	\$1,004	\$970	\$665	\$814	\$4,266
SALARIES-CLERIC	\$0	3,175	3,528	3,795	2,599	3,385	16,611
SALARIES-CONTR	\$0	2,841	2,941	3,041	2,024	2,529	12,969
SALARIES-NURSE	\$0	798	867	924	653	801	4,133
ACCOUNTING	\$0	1,229	1,342	1,480	988	1,230	6,269
WORK COMP INS	\$0	177	202	216	174	177	1,071
SUPPLIES	\$0	1,602	1,637	1,711	1,131	1,421	7,381
TELEPHONE	\$0	170	210	223	139	171	893
EMPL BENEFITS	\$0	1,462	1,548	1,621	1,021	1,281	6,113
PAYROLL TAXES	\$0	597	739	774	489	599	3,137
TRAVEL	\$0	139	172	187	114	140	732
IN SERVICE	\$0	57	70	74	47	57	299
MEDICAL CONSULT	\$0	598	648	672	420	528	2,722
MACHINE RENTAL	\$0	994	1,106	1,155	766	977	4,909
OWNERS COMP	\$0	0	0	0	0	0	0
INS-PROPLIABWC	\$0	76	84	88	62	78	399
DEPRECIATION	\$0	21	23	24	15	19	103
RENT	\$0	362	448	473	297	384	1,904
MAINTENANCE	\$0	89	100	105	68	86	448
FEES & PUBLIC	\$0	10	12	12	8	10	53
ADVERTISING	\$0	0	0	0	0	0	0
MEDICAL DIRECTOR	\$0	480	593	613	393	481	2,500
<b>TOTAL</b>	<b>\$0</b>	<b>\$10,124</b>	<b>\$13,370</b>	<b>\$13,499</b>	<b>\$9,243</b>	<b>\$11,321</b>	<b>\$59,796</b>

FIXED ASSETS	\$0	12,992	16,071	15,528	10,633	13,032	68,256
EQUIP - PRIOR	\$0	4,131	5,110	4,937	3,381	4,143	21,702
EQUIP - CURR	\$0	2,129	2,342	2,480	1,608	2,030	10,560
EQUIP - FULLY DEP	\$0	0	0	0	0	0	0
BLDG - PRIOR	\$0	0	0	0	0	0	0
BLDG - CURR	\$0	0	0	0	0	0	0
BLDG - FULLY DEP	\$0	1,280	1,583	1,530	1,048	1,284	6,725

NURSING HOME MANAGERS  
COST ALLOCATION  
OCTOBER 2008

ALLOCATION PERCENT	DADR	HLTP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
0.00%	19.47%	21.67%	22.13%	14.57%	18.59%	100.00%	
SALARIES-ADMIN	\$0	\$788	\$1,019	\$1,031	\$630	\$789	\$4,266
SALARIES-CLERIC	\$0	3,081	3,385	3,633	2,497	3,265	16,611
SALARIES-CONTR	\$0	2,841	2,941	3,041	2,024	2,529	12,969
SALARIES-NURSE	\$0	774	1,032	1,014	658	776	4,133
ACCOUNTING	\$0	1,229	1,342	1,480	988	1,230	6,269
WORK COMP INS	\$0	177	202	216	174	177	1,071
SUPPLIES	\$0	1,602	1,637	1,711	1,131	1,421	7,381
TELEPHONE	\$0	165	213	216	134	165	893
EMPL BENEFITS	\$0	1,462	1,588	1,687	1,021	1,281	6,113
PAYROLL TAXES	\$0	579	749	798	470	580	3,137
TRAVEL	\$0	139	172	187	114	140	732
IN SERVICE	\$0	55	71	72	45	55	299
MEDICAL CONSULT	\$0	597	651	669	420	528	2,722
MACHINE RENTAL	\$0	907	1,173	1,187	736	908	4,909
OWNERS COMP	\$0	0	0	0	0	0	0
INS-PROPLIABWC	\$0	74	85	86	60	74	399
DEPRECIATION	\$0	21	23	24	15	19	103
RENT	\$0	352	455	460	285	352	1,904
MAINTENANCE	\$0	89	100	105	68	86	448
FEES & PUBLIC	\$0	10	13	13	8	10	53
ADVERTISING	\$0	0	0	0	0	0	0
MEDICAL DIRECTOR	\$0	465	602	609	377	466	2,500
<b>TOTAL</b>	<b>\$0</b>	<b>\$10,058</b>	<b>\$14,174</b>	<b>\$14,345</b>	<b>\$8,883</b>	<b>\$10,975</b>	<b>\$59,796</b>

FIXED ASSETS	\$0	12,606	16,305	15,502	10,218	12,625	68,256
EQUIP - PRIOR	\$0	4,008	5,184	5,247	3,249	4,014	21,702
EQUIP - CURR	\$0	2,129	2,342	2,480	1,608	2,030	10,560
EQUIP - FULLY DEP	\$0	0	0	0	0	0	0
BLDG - PRIOR	\$0	0	0	0	0	0	0
BLDG - CURR	\$0	0	0	0	0	0	0
BLDG - FULLY DEP	\$0	1,242	1,606	1,626	1,007	1,244	6,725

NURSING HOME MANAGERS  
COST ALLOCATION  
NOVEMBER 2008

ALLOCATION PERCENT	DADR	HLTP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
0.00%	17.33%	21.67%	22.13%	15.34%	18.59%	100.00%	
SALARIES-ADMIN	\$0	\$739	\$1,010	\$1,032	\$652	\$833	\$4,266
SALARIES-CLERIC	\$0	2,890	3,249	3,407	2,549	3,256	16,611
SALARIES-CONTR	\$0	2,841	2,941	3,041	2,024	2,529	12,969
SALARIES-NURSE	\$0	726	993	1,015	641	818	4,133
ACCOUNTING	\$0	1,229	1,342	1,480	988	1,230	6,269
WORK COMP INS	\$0	177	202	216	174	177	1,071
SUPPLIES	\$0	1,602	1,637	1,711	1,131	1,421	7,381
TELEPHONE	\$0	155	213	216	134	165	893
EMPL BENEFITS	\$0	1,462	1,588	1,687	1,021	1,281	6,113
PAYROLL TAXES	\$0	544	743	799	479	612	3,137
TRAVEL	\$0	137	173	187	112	143	732
IN SERVICE	\$0	52	71	72	45	55	299
MEDICAL CONSULT	\$0	597	651	669	420	528	2,722
MACHINE RENTAL	\$0	907	1,173	1,187	736	908	4,909
OWNERS COMP	\$0	0	0	0	0	0	0
INS-PROPLIABWC	\$0	69	84	87	61	76	399
DEPRECIATION	\$0	21	23	24	15	19	103
RENT	\$0	330	451	461	291	372	1,904
MAINTENANCE	\$0	89	100	105	68	86	448
FEES & PUBLIC	\$0	9	12	13	8	10	53
ADVERTISING	\$0	0	0	0	0	0	0
MEDICAL DIRECTOR	\$0	437	597	610	385	492	2,500
<b>TOTAL</b>	<b>\$0</b>	<b>\$10,281</b>	<b>\$14,047</b>	<b>\$14,359</b>	<b>\$8,906</b>	<b>\$11,862</b>	<b>\$59,796</b>

FIXED ASSETS	\$0	11,826	16,159	15,518	10,429	13,244	68,256
EQUIP - PRIOR	\$0	3,780	5,138	5,252	3,316	4,238	21,702
EQUIP - CURR	\$0	2,129	2,342	2,480	1,608	2,030	10,560
EQUIP - FULLY DEP	\$0	0	0	0	0	0	0
BLDG - PRIOR	\$0	0	0	0	0	0	0
BLDG - CURR	\$0	0	0	0	0	0	0
BLDG - FULLY DEP	\$0	1,165	1,592	1,627	1,028	1,313	6,725

NURSING HOME MANAGERS  
COST ALLOCATION  
DECEMBER 2008

ALLOCATION PERCENT	DADR	HLTP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
0.00%	18.13%	21.67%	22.13%	15.34%	18.59%	100.00%	
SALARIES-ADMIN	\$0	\$772	\$1,029	\$993	\$654	\$816	\$4,266
SALARIES-CLERIC	\$0	3,020	3,408	3,614	2,559	3,322	16,611
SALARIES-CONTR	\$0	2,841	2,941	3,041	2,024	2,529	12,969
SALARIES-NURSE	\$0	759	1,012	976	643	802	4,133
ACCOUNTING	\$0	1,229	1,342	1,480	988	1,230	6,269
WORK COMP INS	\$0	177	202	216	174	177	1,071
SUPPLIES	\$0	1,602	1,637	1,711	1,131	1,421	7,381
TELEPHONE	\$0	152	216	228	137	171	893
EMPL BENEFITS	\$0	1,462	1,588	1,687	1,021	1,281	6,113
PAYROLL TAXES	\$0	588	757	790	461	600	3,137
TRAVEL	\$0	137	173	187	112	143	732
IN SERVICE	\$0	54	72	70	46	57	299

OCCUPIED DAYS 2008	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,239	2,512	2,573		1,460	1,936	10,720
FEBRUARY	2,140	2,453	2,399		1,407	1,909	10,308
MARCH	2,260	2,436	2,476		1,475	1,985	10,632
APRIL	2,248	2,186	2,456		1,483	1,867	10,240
MAY	2,356	2,118	2,479		1,731	2,002	10,686
JUNE	2,283	2,143	2,410		1,661	1,881	10,378
JULY	2,369	2,288	2,429		1,632	1,992	10,710
AUGUST	2,137	2,345	2,451		1,620	2,036	10,589
SEPTEMBER	1,988	2,459	2,376		1,627	1,994	10,444
OCTOBER	1,980	2,561	2,592		1,605	1,983	10,721
NOVEMBER	1,777	2,428	2,482		1,567	2,002	10,256
DECEMBER	1,901	2,534	2,445		1,611	2,009	10,500
<b>TOTAL</b>	<b>25,678</b>	<b>28,463</b>	<b>29,568</b>	<b>0</b>	<b>18,879</b>	<b>23,596</b>	<b>126,184</b> 126,184

OCCUPIED DAYS 2009	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,861	2,413	2,389		1,630	1,859	10,152
FEBRUARY	1,752	2,160	2,088		1,341	1,588	8,929
MARCH	1,882	2,368	2,469		1,567	1,841	10,127
APRIL	1,701	2,113	2,469		1,466	1,768	9,517
MAY	1,816	2,090	2,434		1,499	1,857	9,696
JUNE	1,718	2,003	2,476		1,350	1,754	9,301
JULY	1,838	2,163	2,658		1,510	1,826	9,995
AUGUST	1,833	2,214	2,647		1,481	1,952	10,127
SEPTEMBER	0	0	0		0	0	0
OCTOBER	0	0	0		0	0	0
NOVEMBER	0	0	0		0	0	0
DECEMBER							0
<b>TOTAL</b>	<b>14,401</b>	<b>17,524</b>	<b>19,630</b>	<b>0</b>	<b>11,844</b>	<b>14,445</b>	<b>77,844</b> 77,844

ALLOCATION PERCENTAGE 2008	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	20.89%	23.43%	24.00%	13.62%	18.06%	100.00%
FEBRUARY	20.76%	23.80%	23.27%	13.65%	18.52%	100.00%
MARCH	21.26%	22.91%	23.29%	13.87%	18.67%	100.00%
APRIL	21.95%	21.35%	23.98%	14.48%	18.23%	100.00%
MAY	22.05%	19.82%	23.20%	16.20%	18.73%	100.00%
JUNE	22.00%	20.65%	23.22%	16.01%	18.12%	100.00%
JULY	22.12%	21.36%	22.68%	15.24%	18.60%	100.00%
AUGUST	20.18%	22.15%	23.15%	15.30%	19.23%	100.00%
SEPTEMBER	19.03%	23.54%	22.75%	15.58%	19.09%	100.00%
OCTOBER	18.47%	23.89%	24.18%	14.97%	18.50%	100.00%
NOVEMBER	17.33%	23.67%	24.20%	15.28%	19.52%	100.00%
DECEMBER	18.10%	24.13%	23.29%	15.34%	19.13%	100.00%

ALLOCATION PERCENTAGE 2009	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.33%	23.77%	23.53%	16.06%	18.31%	100.00%
FEBRUARY	19.62%	24.19%	23.38%	15.02%	17.78%	100.00%
MARCH	18.58%	23.38%	24.38%	15.47%	18.18%	100.00%
APRIL	17.87%	22.20%	25.94%	15.40%	18.58%	100.00%
MAY	18.73%	21.56%	25.10%	15.46%	19.15%	100.00%
JUNE	18.47%	21.54%	26.62%	14.51%	18.86%	100.00%
JULY	18.39%	21.64%	26.59%	15.11%	18.27%	100.00%