

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405 Report Period Beginning: 08/01/09 Ending: 07/31/10

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	6,334		1,684	8,018	8
9	SNF/PED					9
10	ICF	4,128	7,613		11,741	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,462	7,613	1,684	19,759	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.12%

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 7/1/1958

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 1,684

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: 07/31/10 Fiscal Year: 07/31/10

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

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/09 Ending: 07/31/10

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	121,126	11,872	11,784	144,782		144,782		144,782		1
2	Food Purchase		140,997		140,997		140,997	(4,837)	136,160		2
3	Housekeeping	48,896	14,450		63,346		63,346		63,346		3
4	Laundry	23,769	15,294		39,063		39,063		39,063		4
5	Heat and Other Utilities			77,634	77,634		77,634		77,634		5
6	Maintenance	48,710	28,201	65,367	142,278		142,278	11,253	153,531		6
7	Other (specify):* UTILITY WORKERS	19,593			19,593		19,593		19,593		7
8	TOTAL General Services	262,094	210,814	154,785	627,693		627,693	6,416	634,109		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800	2,195	18,995		9
10	Nursing and Medical Records	1,072,201	283,066	22,732	1,377,999	(103,211)	1,274,788	11,175	1,285,963		10
10a	Therapy	39,114	4,369	252,968	296,451	(252,968)	43,483		43,483		10a
11	Activities	59,372	2,343		61,715		61,715		61,715		11
12	Social Services	50,394		5,684	56,078		56,078		56,078		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,221,081	289,778	298,184	1,809,043	(356,179)	1,452,864	13,370	1,466,234		16
	C. General Administration										
17	Administrative	56,405		25,105	81,510	3,842	85,352	27,353	112,705		17
18	Directors Fees										18
19	Professional Services			137,918	137,918		137,918	(126,491)	11,427		19
20	Dues, Fees, Subscriptions & Promotions			49,969	49,969		49,969	(26,325)	23,644		20
21	Clerical & General Office Expenses	129,769	19,503	7,893	157,165		157,165	44,586	201,751		21
22	Employee Benefits & Payroll Taxes			310,469	310,469		310,469	1,144	311,613		22
23	Inservice Training & Education			7,125	7,125		7,125	1,499	8,624		23
24	Travel and Seminar			16,618	16,618	(9,442)	7,176	671	7,847		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,552	38,552		38,552	879	39,431		26
27	Other (specify):*			71,499	71,499		71,499	(50,147)	21,352		27
28	TOTAL General Administration	186,174	19,503	665,148	870,825	(5,600)	865,225	(126,831)	738,394		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,669,349	520,095	1,118,117	3,307,561	(361,779)	2,945,782	(107,045)	2,838,737		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			36,070	36,070		36,070	20,653	56,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			32,278	32,278		32,278		32,278			33
34	Rent-Facility & Grounds							8,158	8,158			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			68,348	68,348		68,348	28,811	97,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					361,779	361,779		361,779			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	361,779	420,909		420,909			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,669,349	520,095	1,245,595	3,435,039		3,435,039	(78,234)	3,356,805			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	
	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	(4,707)	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	18,924	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(538)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,748)	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	(2,202)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,751)	27		24
25	Fund Raising, Advertising and Promotional	(22,724)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,824)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(130)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (86,700)		\$	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)	8,466	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,466		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (78,234)		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		252,968	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		13,653	10	42
43	Prescription Drugs	X		73,010	10	43
44	Oxygen	X		16,468	10	44
45	<u>Other-Attach Schedule Supplies</u>	X		5,680	10	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 361,779		47

BHF USE ONLY

48		49		50		51		52	
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HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 08/01/09

Ending: 07/31/10

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:

08/01/09

Ending:

07/31/10

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	(4,707)	0	0	0	0	0	0	0	0	0	0	(4,707)	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	(4,707)	0	0	0	0	0	0	0	0	0	0	(4,707)	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	302	0	0	0	0	0	0	0	0	0	302	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,202)	(124,209)	0	0	0	0	0	0	0	0	0	(126,411)	19
20	Fees, Subscriptions & Promotions	(26,548)	0	0	0	0	0	0	0	0	0	0	(26,548)	20
21	Clerical & General Office Expenses	(538)	0	0	0	0	0	0	0	0	0	0	(538)	21
22	Employee Benefits & Payroll Taxes	0	(21,352)	0	0	0	0	0	0	0	0	0	(21,352)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(302)	0	0	0	0	0	0	0	0	0	(302)	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):*	(71,499)	21,352	0	0	0	0	0	0	0	0	0	(50,147)	27
28	TOTAL General Administration	(100,787)	(124,209)	0	0	0	0	0	0	0	0	0	(224,996)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,494)	(124,209)	0	0	0	0	0	0	0	0	0	(229,703)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

08/01/09

Ending:

07/31/10

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)	
	D. Ownership													
30	Depreciation	18,924	0	0	0	0	0	0	0	0	0	0	18,924	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	18,924	0	0	0	0	0	0	0	0	0	0	18,924	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(86,570)	(124,209)	0	0	0	0	0	0	0	0	0	(210,779)	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 & RAQUEL KLEIN</u>	<u>4.55</u>	<u>MEADOW MANOR</u>	<u>TAYLORVILLE</u>			
<u>JERRY & 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	\$ 130,995	NURSING HOME MANAGERS, INC.	39.39%	\$	(130,995)	1
2	V	VAR	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	39.39%	132,675	132,675	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION		6,786	6,786	3
4	V	24	TRAVEL	302	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(302)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE - PER DESK REVIEW		302	302	5
6	V	22	EMPL. BENEFITS & PR TAXES	21,352	TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS			(21,352)	6
7	V	27	OTHER ADMINISTRATIVE		AND PAYROLL TAXES TO OTHER - PER DESK REVIEW		21,352	21,352	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 152,649				\$ 161,115	\$ * 8,466	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: 08/01/09 Ending: 07/31/10

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					\$ 5,905	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 \$33,387 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	\$ 5,905		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:

08/01/09

Ending: 07/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	SEE ATTACHED SCHEDULES				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

08/01/09

Ending:

07/31/10

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

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	50,912	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	48,271	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,641)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	34,919	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	32,278	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	35,539	8	
	2006	32,832	9	
	2007	31,780	10	
	2008	32,155	11	
	2009	32,233	12	
LINE 2: BOTH INSTALLMENTS 2008	\$32,155	LINE 4: 2009 TAX BILL 2ND INSTALLMENT	\$16,116	
1ST INSTALLMENT 2009	\$16,116	7/12 OF \$32,233	\$18,803	
	\$48,271		\$34,919	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

08/01/09

Ending:

07/31/10

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:

	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	TOTALS			\$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER

0005405

Report Period Beginning:

08/01/09

Ending:

07/31/10

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	3,068	26
27	WIRING		1992	1,384	44	20	69	25	1,302	27
28	AIR CONDITIONER		1992	1,474	47	10		(47)	1,474	28
29	DOOR ALARM, FURNACE, IMPROVEMENT		1993	6,664	171	15		(171)	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	4,881	35
36	REMODELING - WALLS		1996	1,080	28	30	36	8	504	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:

08/01/09

Ending:

07/31/10**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	\$ 1,467	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	4,731	38
39	AIR CONDITIONER	1999	3,185	82	10		(82)	3,185	39
40	ROOF	1999	68,332	1,752	20	3,417	1,665	38,152	40
41	FURNACE	2000	1,273	33	15	84	51	919	41
42	AIR CONDITIONER	2001	1,404	36	10	140	104	1,404	42
43	GAZEBO	2001	1,374	35	15	91	56	900	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	952	44
45	FIRE DAMPERS	2002	1,451	37	15	96	59	822	45
46	FURNACE	2002	2,200	56	15	147	91	1,247	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	4,656	47
48	FIRE / RADIATION DAMPERS	2002	1,770	45	15	118	73	974	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	2,533	49
50	WATER HEATER	2004	4,320	111	15	288	177	2,016	50
51	FURNACE	2004	1,525	39	15	101	62	661	51
52	SIDEWALKS	2004	3,375	87	15	225	138	1,406	52
53	FIRE DOOR, WHEELCHAIR RAMP	2005	6,450	165	20	322	157	1,639	53
54	AIR CONDITIONER	2005	1,300	33	8	163	130	867	54
55	LIGHT POLES	2005	3,365	86	15	225	139	1,196	55
56	LANDSCAPING	2006	2,320	161	10	232	71	986	56
57	FURNACE	2006	1,330	34	15	89	55	444	57
58	SIDING	2006	1,200	31	15	80	49	367	58
59	SIDEWALKS	2006	4,130	106	15	276	170	1,239	59
60	FIRE WALLS	2006	15,706	403	20	786	383	3,469	60
61	ROOF	2006	2,400	62	20	120	58	520	61
62	DOORS	2006	8,757	225	15	584	359	2,530	62
63	CIRCULATING PUMP	2006	899	23	15	60	37	255	63
64	ELECTRICAL, ETC , REPAIRS PER IDPH	2007	44,282	1,135	20	2,214	1,079	7,011	64
65	GARDEN / PATIO CONCRETE	2008	3,675	94	20	184	90	536	65
66	HVAC SYSTEM	2008	36,021	924	15	2,402	1,478	6,404	66
67	FURNACE	2008	3,979	102	15	265	163	707	67
68	ELECTRICAL WORK - REPLACE MAIN PANEL	2008	6,918	177	20	345	168	749	68
69	REMODEL NURSES STATION	2008	1,917	49	15	128	79	266	69
70	TOTAL (lines 4 thru 69)		\$ 867,567	\$ 7,765		\$ 15,227	\$ 7,462	\$ 701,571	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:

08/01/09

Ending:

07/31/10

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	
1	Totals from Page 12A, Carried Forward		\$ 867,567	\$ 7,765		\$ 15,227	\$ 7,462	\$ 701,571	1
2	HVAC SYSTEM, SPRINKLER SYSTEM - PER FEDERAL REG	2009	252,329	6,470	20	12,617	6,147	15,771	2
3	AIR CONDITIONING	2009	6,100	156	8	762	606	826	3
4	SIDEWALKS	2010	4,519	44	15	100	56	100	4
5	WATER HEATER	2010	4,536	83	15	227	144	227	5
6	AIR CONDITIONING	2010	15,836	288	15	704	416	704	6
7	EXHAUST & DAMPERS	2010	13,708	55	15	164	109	164	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,164,595	\$ 14,861		\$ 29,801	\$ 14,940	\$ 719,363	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	\$ 215,260	\$ 17,430	\$ 19,979	\$ 2,549	Various	\$ 116,846	71
72	Current Year Purchases	3,251	1,904	304	(1,600)	Various	304	72
73	Fully Depreciated Assets	243,163					243,163	73
74	ASSETS NO LONGER IN SERVICE	(58,078)					(58,078)	74
75	TOTALS	\$ 403,596	\$ 19,334	\$ 20,283	\$ 949		\$ 302,235	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	\$ 20,867	76
77										77
78										78
79										79
80	TOTALS			\$ 24,550	\$ 1,875	\$ 4,910	\$ 3,035		\$ 20,867	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)	\$ 1,598,036	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,994	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,924	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,042,465	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: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ _____ 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

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>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	\$	1,230	\$ 87,757	\$	1,230	\$ 87,757	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		116	10,370		116	10,370	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		2,842	154,841		2,842	154,841	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				73,010		73,010	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABS & X-RAYS	39-8					13,653		13,653	12
13	Other (specify): SUPPLIES&OXYGEN	39-8					22,148		22,148	13
14	TOTAL			\$	4,188	\$ 252,968	\$ 108,811	4,188	\$ 361,779	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 **07/31/10**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 13,944	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	575,824		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,025		6
7	Other Prepaid Expenses	14,087		7
8	Accounts Receivable (owners or related parties)	5,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 622,880	\$	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	1,162,410		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	484,436		16
17	Accumulated Depreciation (book methods)	(1,088,173)		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)	\$ 563,968	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,186,848	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,456,873	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,060		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,070		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,919		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,558,922	\$	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)	\$ 1,558,922	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (372,074)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,186,848	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 319,441	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 319,441	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(691,515)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (691,515)	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)	\$ (372,074)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER# 0005405Report Period Beginning: 08/01/09Ending: 07/31/10

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	\$ 2,798,604	1
2	Discounts and Allowances for all Levels	(178,712)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,619,892	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,174	6
7	Oxygen	14,068	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 113,242	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	4,707	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	1,356	21
22	Laundry	1,274	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,337	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	822	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 822	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING-\$130 ADMIT FEE-\$120 JURY DUTY-\$77	327	28
28a	LEGAL-\$1051 BD RECOVERY-\$512 OLD CKS-\$341	1,904	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,231	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,743,524	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	627,693	31
32	Health Care	1,809,043	32
33	General Administration	870,825	33
B. Capital Expense			
34	Ownership	68,348	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)*	\$ 3,435,039	40
41	Income before Income Taxes (line 30 minus line 40)**	(691,515)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (691,515)	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:

08/01/09

Ending:

07/31/10

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	2,006	2,166	\$ 57,115	\$ 26.37	1
2	Assistant Director of Nursing	457	501	10,892	21.74	2
3	Registered Nurses	3,767	3,850	89,241	23.18	3
4	Licensed Practical Nurses	20,256	21,221	461,528	21.75	4
5	CNAs & Orderlies	41,873	43,046	453,425	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,324	3,482	39,114	11.23	8
9	Activity Director	1,842	2,124	22,564	10.62	9
10	Activity Assistants	3,902	4,096	36,808	8.99	10
11	Social Service Workers	3,665	3,964	50,394	12.71	11
12	Dietician					12
13	Food Service Supervisor	2,379	2,531	30,257	11.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,963	10,163	90,869	8.94	15
16	Dishwashers					16
17	Maintenance Workers	4,465	4,678	48,710	10.41	17
18	Housekeepers	5,671	5,843	48,896	8.37	18
19	Laundry	2,455	2,617	23,769	9.08	19
20	Administrator	2,006	2,086	56,405	27.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,162	9,802	129,769	13.24	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) UTILITY WORK	2,270	2,280	19,593	8.59	33
34	TOTAL (lines 1 - 33)	119,463	124,450	\$ 1,669,349 *	\$ 13.41	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	293	\$ 11,784	1-3	35
36	Medical Director	120	16,800	9-3	36
37	Medical Records Consultant	42	2,930	10-3	37
38	Nurse Consultant	464	15,476	10-3	38
39	Pharmacist Consultant	96	3,480	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	81	5,684	12-3	45
46	Other(specify)				46
47	Administrative Consultant	904	25,105	17-3	47
48					48
49	TOTAL (lines 35 - 48)	2,000	\$ 81,259		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	16	638	10-3	51
52	Certified Nurse Assistants/Aides	8	209	10-3	52
53	TOTAL (lines 50 - 52)	24	\$ 847		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DONNA COAD	ADMINISTRATOR	0	\$ 56,405	Workers' Compensation Insurance	\$ 34,378	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	39,525	Advertising: Employee Recruitment	17,969	
				FICA Taxes	124,381	Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed 74)	1,259	
				Employee Meals		Patient Background Checks 53	848	
				Illinois Municipal Retirement Fund (IMRF)*		SEE ATTACHED SCHEDULE	27,903	
				EMPLOYEE CAFETERIA PLAN	104,394			
				EMPLOYEE LIFE INSURANCE	3,677	NHM ALLOCATION	223	
				LABS & VACCINES	2,390			
				GIFT CERTIFICATES	1,200	Less: Public Relations Expense	(22,724)	
				HOLIDAY PARTY	524	Non-allowable advertising (
				NHM ALLOCATION	22,496	Yellow page advertising	(3,824)	
				TSF TO OTHER ADMIN - PER DESK REVIEW	(21,352)			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 56,405	TOTAL (agree to Schedule V, line 22, col.8)	\$ 311,613	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,644	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ADMINISTRATIVE CONSULTANT			\$ 25,105	LABS & VACCINES	22	\$ 2,390	Out-of-State Travel	\$
				GIFT CERTIFICATES	22	1,200		
				HOLIDAY PARTY	22	524	In-State Travel	
							SEE ATTACHED SCHEDULE	7,176
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 25,105	TOTAL		\$ 4,114	NHM ALLOCATION	973
(Attach a copy of any management service agreement)							TSF 31% TO ADMINISTRATIVE	(302)
C. Professional Services								
Vendor/Payee	Type		Amount					
NURSING HOME MANAGERS	MANAGEMENT FEE		\$ 130,995				Seminar Expense	
FELDMAN, ETAL	LEGAL		2,202					
ACCUCARE	ACCOUNTING		4,365				Entertainment Expense	(
C S C	CORP. REPRESENTATION		356				(agree to Sch. V,	
							line 24, col. 8)	\$ 7,847
TOTAL (agree to Schedule V, line 19, column 3)			\$ 137,918					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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? 15 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,336 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. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 4,707
- (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. \$ _____
- (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

LINE 27 - OTHER GENERAL ADMINISTRATION

BAD DEBT	\$	66,751
SALES TAX		4,748
TOTAL LINE 27 - COLUMN 3	\$	<u>71,499</u>

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION		
REHAB & RESTORATIVE WORKSHOP	\$	600
SOCIAL SERVICE SEMINAR		590
ACCUCARE TRAINING		1,290
CPR TRAINING		602
HOME OFFICE INSERVICES		2,534
ADMINISTRATIVE WORKSHOPS		589
INHAA CONFERENCE		690
DIETARY CLASS		230
NURSING HOME MANAGERS ALLOCATION		1,499
SCHEDULE V - LINE 23 - COLUMN 8	\$	<u>8,624</u>

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:		LINE #
OXYGEN PRIVATE & MEDICAID	\$ (14,068)	10
MEDICARE DRUGS	(64,159)	10
MEDICARE IV'S	(8,851)	10
MEDICARE LAB FEES	(10,078)	10
MEDICARE SUPPLIES	(5,680)	10
MEDICARE X-RAYS	(3,575)	10
MEDICARE OXYGEN	(2,400)	10
PHYSICAL THERAPY	(154,841)	10A
SPEECH THERAPY	(10,370)	10A
OCCUPATIONAL THERAPY	<u>(87,757)</u>	10A
RECLASS TO: ANCILLARY SERVICES	\$ <u>361,779</u>	39
RECLASS TO:		
NURSE CONSULTANT MILEAGE	\$ 5,600	10
ADMINISTRATIVE CONSULTANT MILEAGE	<u>3,842</u>	17
RECLASS FROM: TRAVEL	\$ <u>(9,442)</u>	24

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	\$ 54,994
NURSING HOME MANAGERS ALLOCATION	<u>1,729</u>
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 56,723</u>

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	\$ (691,515)
* MANAGEMENT FEE 7/31/09	(46,718)
* MANAGEMENT FEE 7/31/10	17,712
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	<u>(822)</u>
TAXABLE INCOME	<u>\$ (721,343)</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	\$ 22724
YELLOW PAGES	3824
ADMINISTRATOR LICENSE	103
DUES & SUBSCRIPTIONS	735
FOOD PERMIT	265
FRANCHISE FEES	102
CLIA LAB WAIVER	150

SECTION F - TOTAL

\$ 27,903

PAGE 21 - SECTION G

DETAIL - TRAVEL

DIETARY TRAVEL	\$ 545
MAINTENANCE TRAVEL	577
COMMUNITY RELATIONS TRAVEL	3132
ACTIVITY TRAVEL	104
RESIDENT SCREENING	372
OFFICE / ADMINISTRATIVE TRAVEL	1051
MEETINGS	1034
MISC TRAVEL	361

SECTION G - TOTAL

\$ 7,176

CENTRAL OFFICE COST ALLOCATION
HILLTOP
2009

	AUG 09	SEPT	OCT	NOV	DEC	JAN 10	FEB	MARCH	APRIL	MAY	JUNE	JULY	2009 TOTAL	LINE #
SALARIES-ADMIN	2,234	2,114	2,145	2,101	2,032	\$1,398	\$1,450	\$1,538	\$1,592	\$1,518	\$1,538	\$1,486	\$21,146	17
SALARIES-CLERIC	3,520	3,331	3,380	3,310	3,202	3,092	3,206	3,401	3,520	3,357	3,400	3,285	40,005	21
SALARIES-CONTR	(413)	(391)	(397)	(389)	(376)	1,046	1,085	1,151	1,191	1,136	1,151	1,112	5,905	17
SALARIES-NURSE	1,425	1,349	1,369	1,340	1,297	584	606	643	665	634	642	621	11,175	10
ACCOUNTING	(69)	(65)	(66)	(65)	(63)	33	34	36	37	36	36	35	(80)	19
WORK COMP INS	102	96	98	96	93	88	91	96	100	95	96	93	1,144	22
SUPPLIES	117	111	112	110	107	162	167	178	184	175	178	172	1,772	21
TELEPHONE	250	237	240	235	227	287	298	316	327	312	316	305	3,347	21
EMPL BENEFITS	1,941	1,837	1,864	1,825	1,766	787	816	865	896	854	865	836	15,152	22
PAYROLL TAXES	624	591	600	587	568	429	445	472	489	466	472	456	6,200	22
TRAVEL	52	49	50	49	47	97	100	106	110	105	106	103	973	24
IN SERVICE	42	40	41	40	38	173	179	190	196	187	190	183	1,499	23
MEDICAL CONSULT	190	180	182	179	173	172	178	189	195	186	189	182	2,195	9
MACHINE RENTAL	733	693	703	689	666	667	691	733	759	724	733	708	8,500	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	140	132	134	132	127	28	29	31	32	31	31	30	879	26
DEPRECIATION	49	46	47	46	45	199	206	219	226	216	219	211	1,729	30
RENT	760	719	730	715	691	604	626	664	687	656	664	642	8,158	34
MAINTENANCE	279	264	268	263	254	189	196	208	216	206	208	201	2,753	6
FEES & PUBLICAT	30	28	29	28	27	11	11	12	12	12	12	11	223	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL DIRECTOF	0	0	0	0	0	0	0	0	0	0	0	0	0	9
TOTAL	12,007	11,363	11,527	11,289	10,921	\$10,045	\$10,416	\$11,047	\$11,435	\$10,906	\$11,047	\$10,671	\$132,675	
FIXED ASSETS	0	0	0	0	0	0	0	0	0	0	0	0	132,675	
EQUIP - PRIOR	12,354	11,692	11,861	11,616	11,238	11,158	11,570	12,271	12,702	12,115	12,271	11,854	11,892	
EQUIP - CURR	3,928	3,818	3,873	3,793	3,670	3,644	3,778	4,007	4,148	3,956	4,007	3,871	3,875	
EQUIP - FULLY DEP	4,769	4,514	4,579	4,484	4,338	4,307	4,467	4,737	4,904	4,677	4,737	4,576	4,591	
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	1,217	1,152	1,169	1,144	1,107	1,099	1,140	1,209	1,252	1,194	1,209	1,168	1,172	

NURSING HOME MANAGERS COST ALLOCATION AUGUST 2009

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	18.10%	21.86%	26.14%	14.62%	19.28%	100.00%
SALARIES-ADMIN	\$0	\$2,234	\$2,698	\$3,226	\$1,805	\$2,379	\$13,343
SALARIES-CLERIC	0	3,520	4,252	5,083	2,844	3,749	19,448
SALARIES-CONTR	0	(413)	(499)	(597)	(334)	(440)	(2,893)
SALARIES-NURSE	0	1,022	1,223	2,058	1,152	1,519	7,875
ACCOUNTING	0	(85)	(85)	(100)	(56)	(73)	(381)
WORK COMP INS	0	102	123	169	95	108	503
SUPPLIES	0	117	141	169	95	125	647
TELEPHONE	0	250	323	391	202	268	1,381
EMP. BENEFITS	0	1,941	2,345	2,803	1,568	2,067	10,724
PAYROLL TAXES	0	624	754	902	506	665	3,450
TRAVEL	0	150	183	224	124	162	743
IN SERVICE	0	42	51	61	34	45	233
MEDICAL CONSULT	0	190	230	274	154	201	1,050
MACHINE RENTAL	0	733	885	1,058	592	790	4,047
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP/LIAB.WORK	0	140	169	202	113	149	773
DEPRECIATION	0	49	59	71	40	52	271
RENT	0	790	918	1,096	614	809	4,159
MAINTENANCE	0	279	337	403	226	297	1,543
FEES & PUBLIC	0	30	36	43	24	32	165
ADVERTISING	0	0	0	0	0	0	0
TOTAL	\$0	\$12,007	\$14,502	\$17,338	\$9,701	\$12,786	\$66,334

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	16.90%	21.85%	26.52%	15.67%	19.01%	100.00%
SALARIES-ADMIN	\$0	\$1,450	\$1,869	\$2,268	\$1,340	\$1,626	\$8,554
SALARIES-CLERIC	0	2,300	2,783	3,333	1,811	2,300	11,915
SALARIES-CONTR	0	1,085	1,398	1,697	1,003	1,217	\$6,401
SALARIES-NURSE	0	600	731	848	560	679	\$3,374
ACCOUNTING	0	34	44	53	32	38	\$201
WORK COMP INS	0	91	117	142	84	102	\$537
SUPPLIES	0	167	216	262	155	198	\$868
TELEPHONE	0	298	384	465	275	334	\$1,755
EMP. BENEFITS	0	819	1,052	1,276	754	915	\$4,813
PAYROLL TAXES	0	445	574	696	411	499	\$2,626
TRAVEL	0	100	129	157	93	112	\$591
IN SERVICE	0	179	221	269	165	201	\$1,056
MEDICAL CONSULT	0	178	229	278	165	200	\$1,050
MACHINE RENTAL	0	691	851	1,062	639	775	\$4,078
OWNERS COMP	0	0	0	0	0	0	\$0
INS-PROP/LIAB.WORK	0	29	38	46	27	33	\$174
DEPRECIATION	0	206	266	323	189	231	\$1,195
RENT	0	626	807	980	579	707	\$3,694
MAINTENANCE	0	196	252	307	182	220	\$1,156
FEES & PUBLIC	0	11	14	17	10	13	\$66
ADVERTISING	0	0	0	0	0	0	\$0
TOTAL	\$0	\$10,416	\$13,426	\$16,236	\$9,628	\$11,662	\$61,447

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	17.13%	22.65%	25.95%	14.81%	19.43%	100.00%
SALARIES-ADMIN	\$0	\$2,114	\$2,800	\$3,303	\$1,828	\$2,399	\$13,343
SALARIES-CLERIC	0	3,331	4,411	5,047	2,879	3,779	19,448
SALARIES-CONTR	0	(391)	(518)	(593)	(338)	(444)	(2,893)
SALARIES-NURSE	0	1,346	1,786	2,044	1,166	1,530	7,875
ACCOUNTING	0	(85)	(85)	(100)	(56)	(73)	(381)
WORK COMP INS	0	102	123	169	95	108	503
SUPPLIES	0	111	147	168	96	126	647
TELEPHONE	0	250	323	391	202	268	1,381
EMP. BENEFITS	0	1,837	2,432	2,783	1,588	2,084	10,724
PAYROLL TAXES	0	591	783	895	511	670	3,450
TRAVEL	0	149	183	224	124	162	743
IN SERVICE	0	40	53	61	35	45	233
MEDICAL CONSULT	0	189	232	272	159	204	1,050
MACHINE RENTAL	0	693	818	1,050	599	787	4,047
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP/LIAB.WORK	0	132	176	202	114	150	773
DEPRECIATION	0	46	61	70	40	53	271
RENT	0	716	828	1,000	622	816	4,159
MAINTENANCE	0	254	300	360	226	300	1,543
FEES & PUBLIC	0	28	37	43	24	32	165
ADVERTISING	0	0	0	0	0	0	0
TOTAL	\$0	\$11,363	\$15,045	\$17,213	\$9,821	\$12,891	\$66,334

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	17.98%	22.22%	25.91%	15.07%	18.81%	100.00%
SALARIES-ADMIN	\$0	\$1,538	\$1,901	\$2,216	\$1,289	\$1,609	\$8,554
SALARIES-CLERIC	0	2,401	3,203	4,501	2,861	3,558	11,915
SALARIES-CONTR	0	1,151	1,422	1,658	965	1,204	\$6,401
SALARIES-NURSE	0	643	794	958	539	672	\$3,374
ACCOUNTING	0	36	45	52	30	36	\$201
WORK COMP INS	0	96	119	139	81	101	\$537
SUPPLIES	0	169	220	266	152	196	\$868
TELEPHONE	0	316	390	465	265	330	\$1,755
EMP. BENEFITS	0	850	1,070	1,247	720	908	\$4,813
PAYROLL TAXES	0	472	584	690	396	494	\$2,626
TRAVEL	0	106	131	153	89	111	\$591
IN SERVICE	0	199	255	315	193	233	\$1,056
MEDICAL CONSULT	0	189	233	272	158	198	\$1,050
MACHINE RENTAL	0	733	906	1,057	615	787	\$4,078
OWNERS COMP	0	0	0	0	0	0	\$0
INS-PROP/LIAB.WORK	0	31	39	45	26	33	\$174
DEPRECIATION	0	219	270	315	183	229	\$1,195
RENT	0	664	821	957	557	695	\$3,694
MAINTENANCE	0	208	258	300	176	218	\$1,156
FEES & PUBLIC	0	12	15	17	10	12	\$66
ADVERTISING	0	0	0	0	0	0	\$0
TOTAL	\$0	\$11,047	\$13,655	\$15,922	\$9,262	\$11,561	\$61,447

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	17.38%	22.46%	26.15%	14.67%	19.32%	100.00%
SALARIES-ADMIN	\$0	\$2,144	\$2,774	\$3,228	\$1,811	\$2,385	\$13,343
SALARIES-CLERIC	0	3,380	4,371	5,086	2,853	3,758	19,448
SALARIES-CONTR	0	(397)	(513)	(597)	(338)	(441)	(2,893)
SALARIES-NURSE	0	1,365	1,770	2,060	1,155	1,522	7,875
ACCOUNTING	0	(85)	(85)	(100)	(56)	(73)	(381)
WORK COMP INS	0	102	127	166	95	108	503
SUPPLIES	0	112	145	169	95	125	647
TELEPHONE	0	250	327	391	202	267	1,381
EMP. BENEFITS	0	1,864	2,411	2,805	1,573	2,072	10,724
PAYROLL TAXES	0	600	776	902	506	667	3,450
TRAVEL	0	150	183	224	124	162	743
IN SERVICE	0	40	54	61	35	45	233
MEDICAL CONSULT	0	189	232	272	159	204	1,050
MACHINE RENTAL	0	693	818	1,050	599	787	4,047
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP/LIAB.WORK	0	134	174	202	114	150	773
DEPRECIATION	0	47	61	71	40	52	271
RENT	0	716	828	1,000	622	816	4,159
MAINTENANCE	0	256	347	404	226	298	1,543
FEES & PUBLIC	0	29	37	43	24	32	165
ADVERTISING	0	0	0	0	0	0	0
TOTAL	\$0	\$11,527	\$14,911	\$17,248	\$9,731	\$12,817	\$66,334

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	17.75%	21.90%	25.99%	15.37%	19.88%	100.00%
SALARIES-ADMIN	\$0	\$1,592	\$1,853	\$2,234	\$1,237	\$1,638	\$8,554
SALARIES-CLERIC	0	2,376	3,203	4,541	2,735	3,522	11,915
SALARIES-CONTR	0	1,191	1,387	1,672	926	1,225	\$6,401
SALARIES-NURSE	0	661	774	933	511	664	\$3,374
ACCOUNTING	0	37	44	53	29	39	\$201
WORK COMP INS	0	100	116	140	78	103	\$537
SUPPLIES	0	168	214	258	143	186	\$868
TELEPHONE	0	327	380	458	254	336	\$1,755
EMP. BENEFITS	0	850	1,104	1,257	760	957	\$4,813
PAYROLL TAXES	0	489	609	696	380	503	\$2,626
TRAVEL	0	110	128	154	85	113	\$591
IN SERVICE	0	197	252	276	153	202	\$1,056
MEDICAL CONSULT	0	195	227	274	152	201	\$1,050
MACHINE RENTAL	0	759	884	1,065	599	781	\$4,078
OWNERS COMP	0	0	0	0	0	0	\$0
INS-PROP/LIAB.WORK	0	32	38	45	25	33	\$174
DEPRECIATION	0	226	284	318	183	233	\$1,195
RENT	0	687	800	965	534	707	\$3,694
MAINTENANCE	0	216	251	303	168	222	\$1,156
FEES & PUBLIC	0	12	14	17	10	13	\$66
ADVERTISING	0	0	0	0	0	0	\$0
TOTAL	\$0	\$11,435	\$13,312	\$16,000	\$9,262	\$11,561	\$61,447

ALLOPERCENT	DADR	HLP	JVILLE	MEAD	MENARD	SUNRISE	TOTAL
	0.00%	17.38%	22.46%	26.15%	14.67%	19.32%	100.00%
SALARIES-ADMIN	\$0	\$2,144	\$2,774	\$3,228	\$1,811	\$2,385	\$13,343
SALARIES-CLERIC	0	3,380	4,371	5,086	2,853	3,758	19,448
SALARIES-CONTR	0	(397)	(513)	(597)	(338)	(441)	(2,893)
SALARIES-NURSE							

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	1,651	2,186	2,501		1,427	1,873	9,638
OCTOBER	1,707	2,208	2,569		1,441	1,898	9,823
NOVEMBER	1,597	2,165	2,407		1,414	1,801	9,384
DECEMBER	1,572	2,197	2,468		1,503	1,808	9,548
TOTAL	20,928	26,280	29,575	0	17,629	21,825	116,237 116,237

OCCUPIED DAYS 2010	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,593	2,173	2,620		1,497	1,862	9,745
FEBRUARY	1,481	1,909	2,317		1,369	1,661	8,737
MARCH	1,720	2,126	2,479		1,442	1,800	9,567
APRIL	1,700	1,979	2,386		1,321	1,749	9,135
MAY	1,689	2,084	2,388		1,463	1,892	9,516
JUNE	1,598	2,026	2,292		1,268	1,705	8,889
JULY	1,633	2,138	2,475		1,446	1,711	9,403
AUGUST	1,597	2,178	2,451		1,441	1,724	9,391
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	13,011	16,613	19,408	0	11,247	14,104	74,383 74,383

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%
AUGUST	18.10%	21.86%	26.14%	14.62%	19.28%	100.00%
SEPTEMBER	17.13%	22.68%	25.95%	14.81%	19.43%	100.00%
OCTOBER	17.38%	22.48%	26.15%	14.67%	19.32%	100.00%
NOVEMBER	17.02%	23.07%	25.65%	15.07%	19.19%	100.00%
DECEMBER	16.46%	23.01%	25.85%	15.74%	18.94%	100.00%

ALLOCATION PERCENTAGE 2010	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	16.35%	22.30%	26.89%	15.36%	19.11%	100.00%
FEBRUARY	16.95%	21.85%	26.52%	15.67%	19.01%	100.00%
MARCH	17.98%	22.22%	25.91%	15.07%	18.81%	100.00%
APRIL	18.61%	21.66%	26.12%	14.46%	19.15%	100.00%
MAY	17.75%	21.90%	25.09%	15.37%	19.88%	100.00%
JUNE	17.98%	22.79%	25.78%	14.26%	19.18%	100.00%
JULY	17.37%	22.74%	26.32%	15.38%	18.20%	100.00%
AUGUST	17.01%	23.19%	26.10%	15.34%	18.36%	100.00%