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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0032979</u></p> <p><b>Facility Name:</b> <u>Hitz Memorial Home</u></p> <p><b>Address:</b> <u>201 Belle Street</u> <u>Alhambra</u> <u>62001</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Madison</u></p> <p><b>Telephone Number:</b> <u>(618) 488-2355</u> <b>Fax #</b> <u>(618) 488-2361</u></p> <p><b>IDPA ID Number:</b> <u>371222548001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/1968</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Scheffel &amp; Company P.C.</u> <b>Telephone Number:</b> <u>(618) 656-1206</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/1999</u> to <u>06/30/2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Marcia Haslett</u></td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Dennis E. Ulrich, Certified Public Accountant</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Scheffel &amp; Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, IL 62025</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 656-1206</u> <b>Fax #</b> <u>(618) 656-3536</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE        ILLINOIS DEPARTMENT OF PUBLIC AID        201 S. Grand Avenue East        Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Marcia Haslett</u>		(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) <u>Dennis E. Ulrich, Certified Public Accountant</u>		(Firm Name & Address) <u>Scheffel &amp; Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, IL 62025</u>		(Telephone) <u>(618) 656-1206</u> <b>Fax #</b> <u>(618) 656-3536</u>
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**Print Preview**

Facility Name & ID Number Hitz Memorial Home

# 0032979 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

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	34	Skilled (SNF)	34	12,410	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,455	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	0	30	1,480	1,510	8
9	SNF/PED					9
10	ICF	13,353	8,159		21,512	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,353	8,189	1,480	23,022	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.14%

D. How many bed-hold days during this year were paid by Public Aid? 149 (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)  
Assisted Living and Child Care

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 01/01/1968

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 9 and days of care provided 1480

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

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

Print Preview

**IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.**

STATE OF ILLINOIS

Facility Name & ID Number **Hitz Memorial Home** # **0032979** Report Period Beginning: **07/01/1999** Ending: **06/30/2000**  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	126,480	5,546	5,265	137,291		137,291	(394)	136,897		1
2	Food Purchase		78,029		78,029		78,029	0	78,029		2
3	Housekeeping	41,238	10,716	2,826	54,780		54,780	0	54,780		3
4	Laundry	71,532	12,698	816	85,046		85,046	0	85,046		4
5	Heat and Other Utilities			70,780	70,780		70,780	(3,321)	67,459		5
6	Maintenance	57,929	3,930	42,279	104,138		104,138	0	104,138		6
7	Other (specify):*							0			7
8	<b>TOTAL General Services</b>	<b>297,179</b>	<b>110,919</b>	<b>121,966</b>	<b>530,064</b>		<b>530,064</b>	<b>(3,715)</b>	<b>526,349</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			4,800	4,800		4,800	0	4,800		9
10	Nursing and Medical Records	904,670	52,766	5,910	963,346		963,346	(10,657)	952,689		10
10a	Therapy		725	59,206	59,931		59,931	0	59,931		10a
11	Activities	55,624			55,624		55,624	0	55,624		11
12	Social Services	27,582	35	3,377	30,994		30,994	0	30,994		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Programs</b>	<b>987,876</b>	<b>53,526</b>	<b>73,293</b>	<b>1,114,695</b>		<b>1,114,695</b>	<b>(10,657)</b>	<b>1,104,038</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	53,637			53,637		53,637	0	53,637		17
18	Directors Fees							0			18
19	Professional Services			18,057	18,057		18,057	0	18,057		19
20	Dues, Fees, Subscriptions & Promotions			13,472	13,472		13,472	(4,018)	9,454		20
21	Clerical & General Office Expenses	64,549	4,644	35,401	104,594		104,594	(14,346)	90,248		21
22	Employee Benefits & Payroll Taxes			202,213	202,213		202,213	0	202,213		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			6,175	6,175		6,175	(2,919)	3,256		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			26,160	26,160		26,160	0	26,160		26
27	Other (specify):*							0			27
28	<b>TOTAL General Administration</b>	<b>118,186</b>	<b>4,644</b>	<b>301,478</b>	<b>424,308</b>		<b>424,308</b>	<b>(21,283)</b>	<b>403,025</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,403,241</b>	<b>169,089</b>	<b>496,737</b>	<b>2,069,067</b>		<b>2,069,067</b>	<b>(35,655)</b>	<b>2,033,412</b>		<b>29</b>

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

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

Print Preview

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			222,326	222,326		222,326	(139,114)	83,212		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			184,276	184,276		184,276	(131,599)	52,677		32
33	Real Estate Taxes							0			33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			668	668		668	0	668		35
36	Other (specify):*							0			36
37	<b>TOTAL Ownership</b>			407,270	407,270		407,270	(270,713)	136,557		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		18,430	107,255	125,685		125,685	0	125,685		39
40	Barber and Beauty Shops			20,886	20,886		20,886	0	20,886		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			36,784	36,784		36,784	0	36,784		42
43	Other (specify):*	83,756	18,328	26,428	128,512		128,512	(128,512)			43
44	<b>TOTAL Special Cost Centers</b>	83,756	36,758	191,353	311,867		311,867	(128,512)	183,355		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,486,997	205,847	1,095,360	2,788,204	0	2,788,204	(434,880)	2,353,324		45

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

Print Preview

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

Facility Name & ID Number **Hitz Memorial Home** # **0032979** STATE OF ILLINOIS Report Period Beginning: **07/01/1999** Page 5 Ending: **16/30/2000**

**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>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,321)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,999)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(2,919)	24		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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,346)	21		24
25	Fund Raising, Advertising and Promotional	(3,471)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(547)	20		28
29	Other-Attach Schedule See Attached Schedule	(398,277)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (434,880)</b>		<b>\$</b>	<b>30</b>

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

Print Preview

**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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (434,880)</b>		<b>37</b>

**\*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						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>



**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home

# 0032979 Report Period Beginning:

07/01/1999

Ending: 06/30/2000

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

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(394)	0	0	0	0	0	0	0	0	0	0	(394)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,321)	0	0	0	0	0	0	0	0	0	0	(3,321)	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>(3,715)</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>(3,715)</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	(10,657)	0	0	0	0	0	0	0	0	0	0	(10,657)	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	Nurse Aide 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>(10,657)</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>(10,657)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,018)	0	0	0	0	0	0	0	0	0	0	(4,018)	20
21	Clerical & General Office Expenses	(14,346)	0	0	0	0	0	0	0	0	0	0	(14,346)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,919)	0	0	0	0	0	0	0	0	0	0	(2,919)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(21,283)</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>(21,283)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(35,655)</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>(35,655)</b>	<b>29</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/1999 Ending:

06/30/2000

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

Print Summary B

	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	(139,114)	0	0	0	0	0	0	0	0	0	0	(139,114)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(131,599)	0	0	0	0	0	0	0	0	0	0	(131,599)	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>(270,713)</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>(270,713)</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):*	(128,512)	0	0	0	0	0	0	0	0	0	0	(128,512)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(128,512)</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>(128,512)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(434,880)</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>(434,880)</b>	<b>45</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THIS WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

**VI. RELATED PARTIES** (Show Page 48 data in  Show Page 49 data in  Show Page 50 data in )

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

OWNER		RELATED PARTY ENTITY		OTHER RELATED PARTY ENTITIES	
Name	Ownership %	Name	City	Name	City
<input type="text"/>	<input type="text"/>				
<input type="text"/>	<input type="text"/>				
<input type="text"/>	<input type="text"/>				
<input type="text"/>	<input type="text"/>				
<input type="text"/>	<input type="text"/>				

**8. For any costs included in this report which are a result of transactions with related organizations (this includes cost management fees, purchase of supplies, and so forth).**

**8. If any costs incurred as a result of transactions with related organizations must be fully detailed in accordance with the instructions on the attachments as provided by this form.**

Schedule V	Line	Item	Account	Name of Related Organization	8. Reference to Attachment for Related Organization Costs/Adjustments	
					Page of Attachment	Operating Year of Related Organization
V	1					
V	2					
V	3					
V	4					
V	5					
V	6					
V	7					
V	8					
V	9					
V	10					
V	11					
V	12					
V	13					
V	14					
V	15					
V	16					
V	17					
V	18					
V	19					
V	20					
V	21					
V	22					
V	23					
V	24					
V	25					
V	26					
V	27					
V	28					
V	29					
V	30					
V	31					
V	32					
V	33					
V	34					
V	35					
V	36					
V	37					
V	38					
V	39					
V	40					
V	41					
V	42					
V	43					
V	44					
V	45					

**Print Preview**

1. Enter the information on pages 5 and 5A.  
 2. For pages 6 thru 48, the information you enter does not need to be sorted by line reference.  
 3. For pages 6 thru 48, a line can be referenced as many times as needed per page.  
 4. For pages 6 thru 48, related organizations costs for therapy must be referenced as line number 10.  
 5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 8 Line 9 Line 10 Line 11 Line 12 Line 13 Line 14 Line 15 Line 16 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 28 Line 29 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 37 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Sum 6

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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.

Print Preview

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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

[Print Preview](#)

**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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$								
2	Bank of Edwardsville																	
3	1999 Bond Issue		X	Nursing Facility Mortgage, 36.93%	03/01/99	1,006,182	902,602	03/01/14		62,730								
4	1999 Bond Issue Cost		X	Issue Cost Amortization	03/01/99	29,198	26,604			1,946								
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$ 1,035,380	\$ 929,206			\$ 64,676								
<b>B. Non-Facility Related*</b>																		
10	Bank of Edwardsville																	
11	1999 Bond Issue		X	Assisted Living Mortgage, 63.07 %	03/01/99	1,718,571	1,541,487			107,132								
12	1999 Bond Issue		X	Child Care Center Mortgage	03/01/99	834,564	0			12,468								
13																		
14	TOTAL Non-Facility Related					\$ 2,553,135	\$ 1,541,487			\$ 119,600								
15	TOTALS (line 9+line14)					\$ 3,588,515	\$ 2,470,693			\$ 184,276								

\* 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.)

Print Preview



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 30,077 B. General Construction Type: Exterior Brick Frame Wood 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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

<u>Assisted Living Facility</u>	<u>12,944 sq. ft.</u>	<u>26 units</u>
<u>Child Care Center</u>	<u>5,726 sq. ft.</u>	

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

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

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1976</u>	<u>\$ 45,384</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 45,384</b>	3

Print Preview

**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.**

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/1999 Ending:

06/30/2000

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	33			1970	\$ 176,881	\$ 11,203	40	\$ 11,203	\$	\$ 131,924	4
5	34			1975	418,286	16,906	40	16,906		260,557	5
6											6
7											7
8											8
<b>PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3</b>											
9	Improvements			1971	19,945	1,286	40	1,286		14,502	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	(3,684)	40	(3,684)		14,920	11
12	Improvements			1976	81,417	3,226	40	3,226		49,020	12
13	Improvements			1977	6,650	420	40	420		3,893	13
14	Improvements			1979	3,000	81	40	81		1,581	14
15	Improvements and Garage			1980	15,638	424	40	424		7,852	15
16	Improvements			1982	2,416	68	40	68		1,092	16
17	Roof and Improvements			1983	138,325	3,747	40	3,747		59,076	17
18	Roof and Improvements			1984	143,005	3,632	40	3,632		57,798	18
19	Dining Room			1985	28,447	1,128	40	1,128		10,905	19
20	Architecture Fees/Roof Repair			1987	12,112	327	40	327		3,962	20
21	Architecture Fees/Improvements			1988	8,001	317	40	317		2,417	21
22	Solarium and Architecture Fees			1989	67,025	1,813	40	1,813		18,572	22
23	Remodeling & New Garage			1990	29,672	1,070	40	1,070		9,162	23
24	Remodeling/Funrace/Control Temps/Architect Fees			1993	36,433	3,061	40	3,061		24,033	24
25	Sprinkler System/ Water Heaters			1994	11,606	804	40	804		4,802	25
26	Roof Repair			1997	22,000	550	40	550		1,650	26
27	Air Conditioner			1998	5,439	136	40	136		283	27
28	Tank Replacement			1998	14,313	716	20	716		895	
29	Air Conditioner			1999	3,280	164	20	164		191	29
30	Door Alarm			2000	1,164	87	10	87		87	30
31											31
32											32
33											33
34											34
35											35
36	<b>PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3</b>				\$ #VALUE!	\$ 47,482		\$ 47,482	\$	\$ 679,264	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.

Print Preview

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/1999

Ending:

06/30/2000

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	
37	Purchased in Prior Years	\$ 442,381	\$ 34,427	\$ 34,427	\$	10	\$ 366,811	37
38	Current Year Purchases	17,564	431	431		10	431	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 459,945	\$ 34,858	\$ 34,858	\$		\$ 367,242	41

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	
42	Resident Transportation	Dodge Ram Wagon, 2000	2000	\$ 26,173	\$ 872	\$ 872	\$	5	\$ 872	42
43										43
44										44
45										45
46	TOTALS			\$ 26,173	\$ 872	\$ 872	\$		\$ 872	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 83,212	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 83,212	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,047,378	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	A.L. & C.C. Bldg & Improv.	\$ 3,907,555	\$ 102,487	\$ 717,002	52
53	A.L. & C.C. Equipment	347,759	34,761	243,231	53
54	Vehicles	50,805	1,866	50,805	54
55	Land-Asst Living & Child Care	25,000			55
56					56
57	TOTALS	\$ 4,331,119	\$ 139,114	\$ 1,011,038	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

Print Preview

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: None

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 Date of Lease	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: \$ 668 Description: Postage machine and scale

(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. \_\_\_\_\_ /2001 \$ \_\_\_\_\_  
13. \_\_\_\_\_ /2002 \$ \_\_\_\_\_  
14. \_\_\_\_\_ /2003 \$ \_\_\_\_\_

\* 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.

Print Preview

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

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

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION: _____</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 AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	ALLOCATION OF COSTS (d)			
	1	2	3	4
	Facility		Contract	Total
	Drop-outs	Completed		
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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Print Preview

Facility Name & ID Number Hitz Memorial Home# 0032979 Report Period Beginning:07/01/1999 Ending: 06/30/2000

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	5				Total Cost (Col. 3 + 5 + 6)		
					Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$	5,380	\$ 59,875	\$	5,380	\$ 59,875	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs		2,432	29,654		2,432	29,654	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs		1,307	17,726		1,307	17,726	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescripts				18,430		18,430	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$	9,119	\$ 107,255	\$ 18,430	9,119	\$ 125,685	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 nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2000 (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	\$ 133,268	\$ 1
2	Cash-Patient Deposits	1,608	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	344,474	3
4	Supply Inventory (priced at )	11,225	4
5	Short-Term Investments		5
6	Prepaid Insurance	68,916	6
7	Other Prepaid Expenses	2,560	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>	\$ 562,051	\$ 10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	194,160	12
13	Land	70,384	13
14	Buildings, at Historical Cost	595,167	14
15	Leasehold Improvements, at Historical Cost	4,563,339	15
16	Equipment, at Historical Cost	902,052	16
17	Accumulated Depreciation (book methods)	(2,058,416)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs	29,198	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,594)	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>	\$ 4,293,290	\$ 24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,855,341	\$ 25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 90,109	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	1,608	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	66,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,232	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
	<b>Other Current Liabilities(specify):</b>		
36	Bond Payable	127,295	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 289,206	\$ 38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable	2,316,794	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>	\$ 2,316,794	\$ 45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,606,000	\$ 46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,249,341	\$ 47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,855,341	\$ 48

\*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,538,284	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,538,284	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	711,057	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 711,057	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,249,341	24 *

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

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Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/1999Ending: 06/30/2000

**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.**

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,847,786	1
2	Discounts and Allowances for all Levels	(296,675)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,551,111	3
<b>B. Ancillary Revenue</b>			
4	Pharmacy	17,783	4
5	Other Care for Outpatients	310	5
6	Therapy	197,633	6
7	Oxygen	112	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 215,838	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,987	13
14	Non-Patient Meals	394	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	13,736	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 28,117	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	692,196	24
25	Interest and Other Investment Income***	11,999	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 704,195	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,499,261	30

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	\$ 530,064	31
32	Health Care	1,114,695	32
33	General Administration	424,308	33
<b>B. Capital Expense</b>			
34	Ownership	407,270	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	275,083	35
36	Provider Participation Fee	36,784	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,788,204	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	711,057	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 711,057	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

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	1,881	2,080	\$ 45,927	\$ 22.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,694	9,137	110,440	12.09	3
4	Licensed Practical Nurses	16,417	18,014	226,371	12.57	4
5	Nurse Aides & Orderlies	49,852	53,012	458,427	8.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,944	2,360	27,503	11.65	9
10	Activity Assistants	3,725	3,953	26,921	6.81	10
11	Social Service Workers	2,481	2,902	33,372	11.50	11
12	Dietician	1,848	2,250	24,803	11.02	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,218	17,358	96,513	5.56	15
16	Dishwashers					16
17	Maintenance Workers	3,424	3,788	61,392	16.21	17
18	Housekeepers	6,088	6,719	56,193	8.36	18
19	Laundry	7,177	7,921	60,123	7.59	19
20	Administrator	2,152	2,336	53,637	22.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,972	4,434	70,421	15.88	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	1,929	2,115	17,201	8.13	31
32	Other Health Care(specify)					32
33	Other(specify)	11,192	12,010	117,753	9.80	33
34	TOTAL (lines 1 - 33)	138,994	150,389	\$ 1,486,997 *	\$ 9.89	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	125	\$ 3,765	1-3	35
36	Medical Director	400/mo	4,800	9-3	36
37	Medical Records Consultant	22	777	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	1,434	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	179	\$ 10,776		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			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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**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?  
If YES, give association name and amount. Life Services Network \$3500
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,814 Line 10-2
- (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 of Public Aid during this cost report period. \$ 36,784  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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? Yes 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 394
- (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? 100%  
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? N/A  
**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? Yes  
Firm Name: Scheffel & Company, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

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Memorial Home

I & Seminar Detail  
06/30/2000

Meetings and Seminars

Name	Title	Date	Location	Seminar	Cost
------	-------	------	----------	---------	------

Total Meetings and Seminars	0
-----------------------------	---

Auto and Travel Expense

Month	Fuel	Repairs & Maintenance
-------	------	-----------------------

1	363	
2	281	
3	278	39
4		
5	800	
6	10	
7	192	
8	223	172
9	227	
10	302	48
11	30	
12	672	23
	3378	282

Total Auto and Travel	3660
-----------------------	------

Total Travel and Seminars	3660
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