

		FOR BHF USE					

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

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

**I. IDPH License ID Number:** 0032979

**Facility Name:** Hitz Memorial Home

**Address:** 201 Belle Street, PO Box 79 Alhambra 62001  
 Number City Zip Code

**County:** Madison

**Telephone Number:** (618) 488-2355 **Fax #** (618) 488-2361

**HFS ID Number:** 371222548001

**Date of Initial License for Current Owners:** 01/01/1968

**Type of Ownership:**

<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	

**In the event there are further questions about this report, please contact:**  
**Name:** Scheffel and Company, P.C. **Telephone Number:** (618) 656-1206

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2006 to 06/30/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Marcia Haslett</u>	
	(Title) <u>Administrator</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Dennis E. Ulrich</u> <u>Certified Professional Accountant</u>	
	(Firm Name & Address) <u>Scheffel and Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, Illinois 62025</u>	
	(Telephone) <u>(618) 656-1206</u> Fax # <u>(618) 656-3536</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Hitz Memorial Home

# 0032979 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,045</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>67</u>	<u>24,455</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			<u>1,844</u>	<u>1,844</u>	8
9	SNF/PED					9
10	ICF	<u>9,184</u>	<u>9,164</u>		<u>18,348</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,184</u>	<u>9,164</u>	<u>1,844</u>	<u>20,192</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.57%

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)

Assisted Living

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 34 and days of care provided 1,844

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: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number      Hitz Memorial Home      #      0032979      Report Period Beginning:      07/01/2006      Ending:      06/30/2007

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	155,442	3,550	5,595	164,587		164,587	(1,476)	163,111			1
2	Food Purchase		125,696		125,696		125,696		125,696			2
3	Housekeeping	50,782	9,388		60,170		60,170		60,170			3
4	Laundry	43,038	7,754	693	51,485		51,485		51,485			4
5	Heat and Other Utilities			92,811	92,811		92,811	(4,211)	88,600			5
6	Maintenance	73,775	2,457	42,977	119,209		119,209		119,209			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>323,037</b>	<b>148,845</b>	<b>142,076</b>	<b>613,958</b>		<b>613,958</b>	<b>(5,687)</b>	<b>608,271</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,040,157	70,467	5,955	1,116,579		1,116,579	(15,200)	1,101,379			10
10a	Therapy		1,667	392,704	394,371		394,371		394,371			10a
11	Activities	56,855	614		57,469		57,469		57,469			11
12	Social Services	42,383		987	43,370		43,370		43,370			12
13	CNA Training			400	400		400		400			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,139,395</b>	<b>72,748</b>	<b>404,846</b>	<b>1,616,989</b>		<b>1,616,989</b>	<b>(15,200)</b>	<b>1,601,789</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	59,769			59,769		59,769		59,769			17
18	Directors Fees											18
19	Professional Services			17,714	17,714		17,714		17,714			19
20	Dues, Fees, Subscriptions & Promotions			20,999	20,999		20,999	(9,930)	11,069			20
21	Clerical & General Office Expenses	55,202	7,897	48,746	111,845		111,845	(18,277)	93,568			21
22	Employee Benefits & Payroll Taxes			222,301	222,301		222,301		222,301			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,727	1,727		1,727		1,727			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,707	88,707		88,707		88,707			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>114,971</b>	<b>7,897</b>	<b>400,194</b>	<b>523,062</b>		<b>523,062</b>	<b>(28,207)</b>	<b>494,855</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,577,403</b>	<b>229,490</b>	<b>947,116</b>	<b>2,754,009</b>		<b>2,754,009</b>	<b>(49,094)</b>	<b>2,704,915</b>			<b>29</b>

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

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

Facility Name & ID Number Hitz Memorial Home #0032979 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			149,399	149,399		149,399	(99,473)	49,926			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,073	146,073		146,073	(70,027)	76,046			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			295,472	295,472		295,472	(169,500)	125,972			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,626		36,626		36,626		36,626			39
40	Barber and Beauty Shops			12,544	12,544		12,544		12,544			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,984	36,984		36,984		36,984			42
43	Other (specify):*	138,208	13,725	138,807	290,740		290,740	(290,740)				43
44	<b>TOTAL Special Cost Centers</b>	138,208	50,351	188,335	376,894		376,894	(290,740)	86,154			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,715,611	279,841	1,430,923	3,426,375		3,426,375	(509,334)	2,917,041			45

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

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,476)	1		4
5	Telephone, TV & Radio in Resident Rooms	(4,211)	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	(9,553)	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				17
18	Fines and Penalties	(2,800)	21		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	(15,477)	21		24
25	Fund Raising, Advertising and Promotional	(8,737)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,193)	20		28
29	Other-Attach Schedule	(465,887)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (509,334)		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (509,334)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Hitz Memorial Home

ID# 0032979

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Assisted Living Salary Expenses:	\$		1
2	Dietary	(37,199)	43	2
3	House Daughters	(75,240)	43	3
4	Administrator	(30)	43	4
5	Supervisor	(25,739)	43	5
6				6
7	Assisted Living Supplies Expenses:			7
8	Housekeeping Supplies	(202)	43	8
9	Food and Supplies	(10,891)	43	9
10	General	(103)	43	10
11	Laundry Supplies	(402)	43	11
12	Maintenance Supplies	(2,045)	43	12
13	Staff Development Supplies	(22)	43	13
14	Personal Care Supplies	(59)	43	14
15				15
16	Assisted Living Other Expenses:			16
17	Administrative	(6,478)	43	17
18	Telephone and Cable TV	(1,940)	43	18
19	Employee Benefits and Payroll Taxes	(34,002)	43	19
20	Insurance	(50,445)	43	20
21	Professional Fees	(1,571)	43	21
22				22
23	Assisted Living and Rental Other Expenses:			23
24	Security Services	(1,278)	43	24
25	Repairs and Maintenance	(6,721)	43	25
26	Utilities	(36,373)	43	26
27				27
28	Assisted Living Mortgage Interest	(60,474)	32	28
29	Non-Care Asset Depreciation	(99,473)	30	29
30				30
31	Resident Personal Purchases	-15200	10	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(465,887)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(1,476)	0	0	0	0	0	0	0	0	0	0	(1,476)	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	(4,211)	0	0	0	0	0	0	0	0	0	0	(4,211)	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>(5,687)</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>(5,687)</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	(15,200)	0	0	0	0	0	0	0	0	0	0	(15,200)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(15,200)</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>(15,200)</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	(9,930)	0	0	0	0	0	0	0	0	0	0	(9,930)	20
21	Clerical & General Office Expenses	(18,277)	0	0	0	0	0	0	0	0	0	0	(18,277)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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>(28,207)</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>(28,207)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(49,094)</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>(49,094)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number Hitz Memorial Home# 0032979 Report Period Beginning:07/01/2006 Ending:

Summary B

06/30/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(99,473)	0	0	0	0	0	0	0	0	0	0	(99,473)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(70,027)	0	0	0	0	0	0	0	0	0	0	(70,027)	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>(169,500)</b>	<b>0</b>	<b>(169,500)</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):*	(290,740)	0	0	0	0	0	0	0	0	0	0	(290,740)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(290,740)</b>	<b>0</b>	<b>(290,740)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(509,334)</b>	<b>0</b>	<b>(509,334)</b>	<b>45</b>									

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

**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
Illinois South Conference of the United Church of Christ	100 %					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

## 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.

Facility Name & ID Number Hitz Memorial Home

# 0032979 Report Period Beginning: 07/01/2006 Ending: 6/30/2007

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of Edwardsville									1										
2	2006 Bond Issue		X	Nursing Facility Mortgage, 38.14%	8/23/2006	596,249	608,396	5/15/2026	6.1600	36,570	2									
3	2006 Bond Issue Cost		X	Issue Cost Amortization	8/23/2006	29,677	28,426			1,251	3									
4	1999 Bond Issue		X	Nursing Facility Mortgage, 36.93%	3/1/1999	1,006,182		paid off	6.3500		4									
5	1999 Bond Issue Cost		X	Issue Cost Amortization	3/1/1999	29,198		written off		14,933	5									
<b>Working Capital</b>																				
6	Bank of Edwardsville		X	Line of Credit	8/23/2006	500,000	444,305	11/1/2007	Prime	34,005	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$ 2,161,306	\$ 1,081,127			\$ 86,759	9									
<b>B. Non-Facility Related*</b>																				
10	Bank of Edwardsville										10									
11	2006 Bond Issue		X	Assisted Living Mortgage, 61.86%	8/23/2006	1,018,290	986,770	5/15/2026	6.1600	59,314	11									
12	1999 Bond Issue		X	Assisted Living Mortgage, 63.07%	3/1/1999	1,718,571		paid off	6.3500		12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$ 2,736,861	\$ 986,770			\$ 59,314	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 4,898,167	\$ 2,067,897			\$ 146,073	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #         

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hitz Memorial Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0032979

CONTACT PERSON REGARDING THIS REPORT Marcia Haslett

TELEPHONE (618) 488-2355 FAX #: (618) 488-2361

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	<u>Not-For-Profit organization, exempt</u>	\$ _____	\$ _____
2. _____	<u>from real estate taxes</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Hitz Memorial Home

# 0032979 Report Period Beginning:

07/01/2006 Ending:

06/30/2007

**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 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).

Assisted Living Facility, 12,944 sq. ft., 26 units

Rental Space, 5,726 sq. ft.

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

Facility Name &amp; ID Number Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

**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	33			1970	\$ 176,881	\$ 4,422	40	\$ 4,422	\$	\$ 162,878	4
5	34			1975	418,286	10,457	40	10,457		333,757	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Improvements			1971	19,945	499	40	499		17,992	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	579	40	579		18,976	11
12	Improvements			1976	81,417	2,035	40	2,035		63,268	12
13	Improvements			1977	6,650	166	40	166		5,057	13
14	Improvements			1979	3,000	75	40	75		2,106	14
15	Improvements and Garage			1980	15,638	391	40	391		10,588	15
16	Improvements			1982	2,416	60	40	60		1,515	16
17	Roof and Improvements			1983	138,325	3,458	40	3,458		83,283	17
18	Roof and Improvements			1984	143,005	3,575	40	3,575		82,824	18
19	Dining Room			1985	28,447	711	40	711		15,883	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		6,081	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		3,817	21
22	Solarium and Architecture Fees			1989	67,025	1,676	40	1,676		30,301	22
23	Remodeling & New Garage			1990	29,672	916	40	916		15,575	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	36,433	497	40	497		23,749	24
25	Sprinkler System/Water Heaters			1994	11,606	718	40	718		10,170	25
26	Roof Repair			1997	22,000	550	40	550		5,500	26
27	Air Conditioner			1998	5,439	136	40	136		1,235	27
28	Tank Replacement			1998	14,313	716	20	716		5,904	28
29	Air Conditioner			1999	3,280	164	20	164		1,339	29
30	Door Alarm			2000	1,164	116	10	116		902	30
31	Door Alarm			2000	1,563	156	10	156		1,081	31
32	Water Heater			2000	4,044	270	15	270		1,842	32
33	Kitchen Sewer Line			2000	2,721	181	15	181		1,224	33
34	Kitchen Fire Suppression System			2002	8,822	588	15	588		2,794	34
35	Door - Oxygen Room			2002	791	79	10	79		369	35
36	Garage Door & Sign			2003	2,171	217	10	217		796	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 Hitz Memorial Home

# 0032979

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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	Fire Protection/Water Heaters	2004	\$ 9,344	\$ 737	15	\$ 737	\$	\$ 2,521	37
38	Garbage Disposal	2004	2,681	268	5	268		670	38
39	Canopy	2005	5,575	372	15	372		867	39
40	Door Alarms	2005	2,544	255	10	255		573	40
41	Solarium	2007	31,589	526	40	526		526	41
42	Water Heater	2007	4,157	104	10	104		104	42
43	Air Conditioner	2007	5,621	47	10	47		47	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,349,945	\$ 36,220		\$ 36,220	\$	\$ 916,204	70

\*\*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	\$ 99,549	\$ 12,018	\$ 12,018	\$	10	\$ 59,761	71
72	Current Year Purchases	14,652	311	311		10	311	72
73	Fully Depreciated Assets	368,022					368,022	73
74								74
75	TOTALS	\$ 482,223	\$ 12,329	\$ 12,329	\$		\$ 428,094	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 Transportation	Van Lift for 2000 Dodge	2000	\$ 5,687	\$	\$	\$	5	\$ 5,687	76
77	Resident Transportation	Dodge Ram Wagon, 2000	2000	26,173				5	26,173	77
78	Resident Transportation	Dodge Top/Rear Door Additions	2003	6,884	1,377	1,377		5	5,163	78
79										79
80	TOTALS			\$ 38,744	\$ 1,377	\$ 1,377	\$		\$ 37,023	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)	\$ 1,916,296	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,926	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,926	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,381,321	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	AL & Rental Bldg Improvements	\$ 3,928,476	\$ 99,240	\$ 1,408,295	86
87	AL & Rental Bldg Equipment	315,168	233	314,254	87
88					88
89	Vehicles	27,065		27,065	89
90	Land - Asst. Living & Rental	25,000			90
91	TOTALS	\$ 4,295,709	\$ 99,473	\$ 1,749,614	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.

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

**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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* 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 checked="" type="checkbox"/> YES <input 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 checked="" 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 checked="" 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		400		400
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	\$	\$ 400	\$	\$ 400
10	SUM OF line 9, col. 1 and 2 (e)	\$	400		

**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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

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

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

Facility Name & ID Number Hitz Memorial Home# 0032979 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

## 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	10a-3	hrs	\$	n/a	\$ 126,270	\$		\$ 126,270	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		n/a	114,870			114,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		n/a	151,564			151,564	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				36,626		36,626	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	<b>TOTAL</b>			\$		\$ 392,704	\$ 36,626		\$ 429,330	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2006

Ending:

06/30/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2007

(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	\$ 232,737	\$	1
2	Cash-Patient Deposits	1,978		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 27,500 )	623,260		3
4	Supply Inventory (priced at cost )	14,710		4
5	Short-Term Investments			5
6	Prepaid Insurance	114,944		6
7	Other Prepaid Expenses	1,200		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 988,829	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,384		13
14	Buildings, at Historical Cost	595,167		14
15	Leasehold Improvements, at Historical Cost	4,683,254		15
16	Equipment, at Historical Cost	863,200		16
17	Accumulated Depreciation (book methods)	(3,130,935)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,677		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,251)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,109,496	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,098,325	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 298,067	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,978		28
29	Short-Term Notes Payable	444,305		29
30	Accrued Salaries Payable	127,660		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	4,748		35
<b>Other Current Liabilities(specify):</b>				
36	<b>Bonds Payable</b>	62,363		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 939,121	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,532,803		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,532,803	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,471,924	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,626,401	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,098,325	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,579,941	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,579,941	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	46,460	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)	\$ 46,460	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,626,401	24 *

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

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2006Ending: 06/30/2007**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,026,643	1
2	Discounts and Allowances for all Levels	(252,836)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,773,807</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	33,846	5
6	Therapy	514,759	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 548,605</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,628	13
14	Non-Patient Meals	1,476	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,000	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	21,154	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 39,258</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	95,870	24
25	Interest and Other Investment Income***	9,553	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 105,423</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	5,742	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,742</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,472,835</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	613,958	31
32	Health Care	1,616,989	32
33	General Administration	523,062	33
<b>B. Capital Expense</b>			
34	Ownership	295,472	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	339,910	35
36	Provider Participation Fee	36,984	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,426,375</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>46,460</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 46,460</b>	<b>43</b>

\* 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.

Facility Name & ID Number Hitz Memorial Home

# 0032979

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

**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	1,794	2,011	\$ 48,813	\$ 24.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,580	2,702	51,333	19.00	3
4	Licensed Practical Nurses	18,587	20,868	339,317	16.26	4
5	CNAs & Orderlies	52,053	55,343	556,194	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,386	2,615	28,875	11.04	9
10	Activity Assistants	3,929	3,881	27,980	7.21	10
11	Social Service Workers	4,853	5,345	42,383	7.93	11
12	Dietician					12
13	Food Service Supervisor	1,734	1,980	26,508	13.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,279	16,259	128,934	7.93	15
16	Dishwashers					16
17	Maintenance Workers	3,456	4,442	73,775	16.61	17
18	Housekeepers	5,873	6,140	50,782	8.27	18
19	Laundry	5,054	4,958	43,038	8.68	19
20	Administrator	1,824	2,163	59,769	27.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,993	4,176	55,202	13.22	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	3,795	4,333	44,500	10.27	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Assisted Living</u>	14,422	16,356	138,208	8.45	33
34	TOTAL (lines 1 - 33)	139,612	153,572	\$ 1,715,611 *	\$ 11.17	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	163	\$ 5,495	1-3	35
36	Medical Director	\$400/mo.	4,800	9-3	36
37	Medical Records Consultant	17	775	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	550	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	17	987	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	208	\$ 12,607		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	32	\$ 1,310	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	32	\$ 1,310		53

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**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			
Marcia Haslett	Administrator	0	\$ 59,769	Workers' Compensation Insurance	\$ 67,172	IDPH License Fee	\$			
				Unemployment Compensation Insurance	12,353	Advertising: Employee Recruitment	2,949			
				FICA Taxes	107,188	Health Care Worker Background Check	2,120			
				Employee Health Insurance	25,030	(Indicate # of checks performed <u>121</u> )				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,000			
				Retirement Plan Contributions	6,597	Promotional & Public Relations	8,737			
				Other Employee Benefits	3,961	Yellow Pages	1,193			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 59,769	TOTAL (agree to Schedule V, line 22, col.8)			\$ 222,301	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,069
(List each licensed administrator separately.)								Less: Public Relations Expense		(8,737)
B. Administrative - Other							Non-allowable advertising		(	
Description			Amount				Yellow page advertising		(1,193)	
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
Scheffel and Company, P.C.	Accounting		\$ 16,214				Out-of-State Travel	\$		
Foley & Lardner	Legal		1,500				In-State Travel			
							Seminar Expense	1,727		
							Entertainment Expense	(		
							(agree to Sch. V, line 24, col. 8)			
							TOTAL	\$ 1,727		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 17,714	TOTAL			\$			
(If total legal fees exceed \$5,000, attach copy of invoices.)										

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Hitz Memorial Home

**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? Yes  
If YES, give association name and amount. CHHSM \$2,425, LSN \$1,500
- (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? 5-40 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,430 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 during this cost report period. \$ 36,984  
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, 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? 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,476
- (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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.