

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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>I. IDPH License ID Number: <u>0032979</u></p> <p>Facility Name: <u>Hitz Memorial Home</u></p> <p>Address: <u>201 Belle Street, P.O. 79</u> <u>Alhambra</u> <u>62001</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 488-2355</u> Fax # <u>(618) 488-2361</u></p> <p>HFS ID Number: <u>371222548001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1968</u></p> <p>Type of Ownership:</p> <table border="0"> <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>IRS Exemption Code <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>In the event there are further questions about this report, please contact: Name: <u>Scheffel and Company, P.C.</u> Telephone Number: <u>(618) 656-1206</u> Email Address: _____</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	IRS Exemption Code <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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2008</u> to <u>06/30/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Susan Tudor</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Dennis E. Ulrich</u> <u>Certified Public Accountant</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Scheffel and Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, Illinois 62025</u></td> </tr> <tr> <td>(Telephone) <u>(618) 656-1206</u> Fax # <u>(618) 656-3536</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Susan Tudor</u> (Date) _____		(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Dennis E. Ulrich</u> <u>Certified Public 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>
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Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			1,434	1,434	8
9	SNF/PED					9
10	ICF	9,205	8,219		17,424	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,205	8,219	1,434	18,858	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.11%

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 1,434

Medicare Intermediary Wisconsin Physicians

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/09

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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	165,404	6,734	6,221	178,359		178,359	(544)	177,815		1
2	Food Purchase		164,373		164,373		164,373		164,373		2
3	Housekeeping	62,787	6,755	60	69,602		69,602		69,602		3
4	Laundry	30,706	8,010	1,478	40,194		40,194		40,194		4
5	Heat and Other Utilities			99,679	99,679		99,679	(4,022)	95,657		5
6	Maintenance	76,080	4,888	45,315	126,283		126,283		126,283		6
7	Other (specify):*										7
8	TOTAL General Services	334,977	190,760	152,753	678,490		678,490	(4,566)	673,924		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,073,234	72,220	12,488	1,157,942		1,157,942	(14,012)	1,143,930		10
10a	Therapy		574	172,878	173,452		173,452		173,452		10a
11	Activities	81,459	420	65	81,944		81,944		81,944		11
12	Social Services	64,410		1,123	65,533		65,533		65,533		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,219,103	73,214	191,354	1,483,671		1,483,671	(14,012)	1,469,659		16
	C. General Administration										
17	Administrative	84,625			84,625		84,625		84,625		17
18	Directors Fees										18
19	Professional Services			27,760	27,760		27,760		27,760		19
20	Dues, Fees, Subscriptions & Promotions			17,591	17,591		17,591	(10,032)	7,559		20
21	Clerical & General Office Expenses	39,788	11,830	102,458	154,076		154,076	(54,238)	99,838		21
22	Employee Benefits & Payroll Taxes			214,075	214,075		214,075		214,075		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,508	2,508		2,508		2,508		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,182	73,182		73,182		73,182		26
27	Other (specify):* Donations			408	408		408		408		27
28	TOTAL General Administration	124,413	11,830	437,982	574,225		574,225	(64,270)	509,955		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,678,493	275,804	782,089	2,736,386		2,736,386	(82,848)	2,653,538		29

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

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

Facility Name & ID Number Hitz Memorial Home

#0032979

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			162,970	162,970		162,970	(100,058)	62,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,506	119,506		119,506	(69,148)	50,358			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			282,476	282,476		282,476	(169,206)	113,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,199		51,199		51,199		51,199			39
40	Barber and Beauty Shops		281	15,216	15,497		15,497		15,497			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,984	36,984		36,984		36,984			42
43	Other (specify):*	185,617	12,264	105,699	303,580		303,580	(303,580)	0			43
44	TOTAL Special Cost Centers	185,617	63,744	157,899	407,260		407,260	(303,580)	103,680			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,864,110	339,548	1,222,464	3,426,122		3,426,122	(555,634)	2,870,488			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(544)	1		4
5	Telephone, TV & Radio in Resident Rooms	(4,022)	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	(11,012)	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	(6,435)	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	(47,803)	21		24
25	Fund Raising, Advertising and Promotional	(9,119)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(913)	20		28
29	Other-Attach Schedule	(475,786)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (555,634)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (555,634)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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Hitz Memorial HomeID# 0032979Report Period Beginning: 07/01/2008Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Assisted Living Salary Expenses:	\$		1
2	Dietary	(40,692)	43	2
3	House Daughters	(109,520)	43	3
4	Administrator	(30)	43	4
5	Supervisor	(24,695)	43	5
6	LPN	(10,680)	43	6
7				7
8	Assisted Living Supplies Expenses:			8
9	Housekeeping Supplies	(180)	43	9
10	Food and Supplies	(10,138)	43	10
11	Laundry Supplies	(76)	43	11
12	Maintenance Supplies	(1,871)	43	12
13				13
14				14
15				15
16	Assisted Living Other Expenses:			16
17	Administrative	(5,464)	43	17
18	Telephone and Cable TV	(1,697)	43	18
19	Employee Benefits and Payroll Taxes	(20,190)	43	19
20	Insurance	(43,664)	43	20
21	Miscellaneous Expense	(1,228)	43	21
22				22
23				23
24	Assisted Living and Rental Other Expenses:			24
25	Security Services	(429)	43	25
26	Repairs and Maintenance	(2,927)	43	26
27	Utilities	(30,099)	43	27
28				28
29				29
30	Assisted Living Mortgage Interest	(58,136)	32	30
31	Non-Care Asset Depreciation	-100058	30	31
32				32
33	Resident Personal Purchases	-14012	10	33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(475,786)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(544)	0	0	0	0	0	0	0	0	0	0	(544)	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	(4,022)	0	0	0	0	0	0	0	0	0	0	(4,022)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,566)	0	(4,566)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(14,012)	0	0	0	0	0	0	0	0	0	0	(14,012)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(14,012)	0	(14,012)	16									
	C. General Administration													
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	(10,032)	0	0	0	0	0	0	0	0	0	0	(10,032)	20
21	Clerical & General Office Expenses	(54,238)	0	0	0	0	0	0	0	0	0	0	(54,238)	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	TOTAL General Administration	(64,270)	0	(64,270)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,848)	0	(82,848)	29									

STATE OF ILLINOIS

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2008 Ending:

Summary B

06/30/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(100,058)	0	0	0	0	0	0	0	0	0	0	(100,058)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(69,148)	0	0	0	0	0	0	0	0	0	0	(69,148)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(169,206)	0	0	0	0	0	0	0	0	0	0	(169,206)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(303,580)	0	0	0	0	0	0	0	0	0	0	(303,580)	43
44	TOTAL Special Cost Centers	(303,580)	0	0	0	0	0	0	0	0	0	0	(303,580)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(555,634)	0	0	0	0	0	0	0	0	0	0	(555,634)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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:

07/01/2008

Ending:

06/30/2009

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:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of Edwardsville									1									
2	2006 Bond Issue	X	Nursing Facility Mortgage, 41.08%		08/23/2006	709,864	640,497	05/15/2026	6.1600	40,837									
3	2006 Bond Issue Cost	X	Issue Cost Amortization		08/23/2006	29,677	24,978			1,945									
4										4									
5										5									
Working Capital																			
6	Bank of Edwardsville	X	Line of Credit		08/23/2006	500,000	405,331	08/01/2010	Prime	18,588									
7										7									
8										8									
9	TOTAL Facility Related					\$ 1,239,541	\$ 1,070,806			\$ 61,370									
B. Non-Facility Related*																			
10	Bank of Edwardsville									10									
11	2006 Bond Issue	X	Assisted Living Mortgage, 58.92%		08/23/2006	1,018,290	911,808	05/15/2026	6.1600	58,136									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$ 1,018,290	\$ 911,808			\$ 58,136									
15	TOTALS (line 9+line14)					\$ 2,257,831	\$ 1,982,614			\$ 119,506									

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.)

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

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>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 45,384	3

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	\$	\$ 171,722	4
5	34			1975	418,286	10,457	40	10,457		354,672	5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1971	19,945	499	40	499		18,989	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	579	40	579		20,135	11
12	Improvements			1976	81,417	2,035	40	2,035		67,339	12
13	Improvements			1977	6,650	166	40	166		5,389	13
14	Improvements			1979	3,000	75	40	75		2,256	14
15	Improvements and Garage			1980	15,638	391	40	391		11,370	15
16	Improvements			1982	2,416	60	40	60		1,636	16
17	Roof and Improvements			1983	138,325	3,458	40	3,458		90,200	17
18	Roof and Improvements			1984	143,005	3,575	40	3,575		89,974	18
19	Dining Room			1985	28,447	711	40	711		17,305	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		6,687	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		4,217	21
22	Solarium and Architecture Fees			1989	67,025	1,676	40	1,676		33,652	22
23	Remodeling & New Garage			1990	29,672	916	40	916		17,407	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	36,433	497	40	497		24,744	24
25	Sprinkler System/Water Heaters			1994	11,606	718	40	718		11,606	25
26	Roof Repair			1997	22,000	550	40	550		6,600	26
27	Air Conditioner			1998	5,439	136	40	136		1,507	27
28	Tank Replacement			1998	14,313	716	20	716		7,335	28
29	Air Conditioner			1999	3,280	164	20	164		1,667	29
30	Door Alarm			2000	1,164	116	10	116		1,135	30
31	Water Heater			2000	1,563	156	10	156		1,393	31
32	Kitchen Sewer Line			2000	4,044	270	15	270		2,381	32
33	Kitchen Fire Suppression System			2000	2,721	181	15	181		1,587	33
34	Kitchen Fire Suppression System			2002	8,823	588	15	588		3,970	34
35	Door-Oxygen Room			2002	791	79	10	79		527	35
36	Garage Door & Sign			2003	2,171	217	10	217		1,230	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:

07/01/2008 Ending: 06/30/2009

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		\$ 3,995	37
38	Garbage Disposal	2004	2,681	268	10	268		1,206	38
39	Canopy	2005	5,575	372	15	372		1,611	39
40	Door Alarms	2005	2,544	255	10	255		1,083	40
41	Solarium	2007	31,589	790	40	790		2,106	41
42	Water Heater	2007	4,157	416	10	416		935	42
43	Air Conditioner	2007	5,621	562	10	562		1,171	43
44	Alarm System	2007	3,030	303	10	303		480	44
45	Ramp Remodel	2008	24,570	614	40	614		871	45
46	Flooring	2008	3,854	385	10	385		450	46
47	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		1,634	47
48	Water Heater	2008	3,867	387	10	387		419	48
49	Air Conditioner	2008	1,166	117	10	117		117	49
50	Patio Landscaping	2007	1,909	48	40	48		92	50
51	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		85	51
52	Fire Protection	2009	15,867	926	10	926		926	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)		\$ 1,467,696	\$ 41,679		\$ 41,679	\$	\$ 995,903	70

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

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	\$ 163,768	\$ 19,707	\$ 19,707		10	\$ 79,566	71
72	Current Year Purchases	15,421	1,182	1,182		10	1,182	72
73	Fully Depreciated Assets	357,913				10	357,913	73
74								74
75	TOTALS	\$ 537,102	\$ 20,889	\$ 20,889			\$ 438,661	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	344	344		5	6,884	78
79										79
80	TOTALS			\$ 38,744	\$ 344	\$ 344			\$ 38,744	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)	\$ 2,088,926	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,912	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)	\$ 1,473,308	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	\$ 3,939,011	\$ 99,469	\$ 1,607,005	86
87	AL & Rental Bldg Equipment	319,440	589	315,228	87
88					88
89	Vehicles	27,065		27,065	89
90	Land - Asst. Living & Rental	25,000			90
91	TOTALS	\$ 4,310,516	\$ 100,058	\$ 1,949,298	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	n/a	\$ 65,153					\$ 65,153					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		n/a	25,033					25,033					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		n/a	82,692					82,692					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							51,199					51,199	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$		\$ 172,878			\$ 51,199		\$ 224,077					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: 07/01/2008Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 238,674	\$	1
2	Cash-Patient Deposits	1,132		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>87,200</u>)	363,153		3
4	Supply Inventory (priced at <u>cost</u>)	20,804		4
5	Short-Term Investments			5
6	Prepaid Insurance	91,199		6
7	Other Prepaid Expenses	2,626		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 717,588	\$	10
B. Long-Term Assets				
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	4,811,540		15
16	Equipment, at Historical Cost	922,351		16
17	Accumulated Depreciation (book methods)	(3,422,606)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,677		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,699)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,001,814	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,719,402	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 177,289	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,132		28
29	Short-Term Notes Payable	405,331		29
30	Accrued Salaries Payable	148,177		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	3,977		35
Other Current Liabilities(specify):				
36	<u>Bonds Payable</u>	65,118		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 801,024	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,487,187		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,487,187	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,288,211	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,431,191	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,719,402	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,439,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,439,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,363)	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)	\$ (8,363)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,431,191	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,098,062	1
2	Discounts and Allowances for all Levels	(219,967)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,878,095	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	60,891	5
6	Therapy	190,200	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 251,091	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,065	13
14	Non-Patient Meals	544	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,000	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	16,612	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 39,221	23
D. Non-Operating Revenue			
24	Contributions	192,629	24
25	Interest and Other Investment Income***	11,012	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 203,641	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	45,842	28
28a	<u>Loss on Disposal of Property and Equipment</u>	(131)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,711	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,417,759	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	678,490	31
32	Health Care	1,483,671	32
33	General Administration	574,225	33
B. Capital Expense			
34	Ownership	282,476	34
C. Ancillary Expense			
35	Special Cost Centers	370,276	35
36	Provider Participation Fee	36,984	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,426,122	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,363)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,363)	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.

Facility Name & ID Number **Hitz Memorial Home**

0032979

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07/01/2008

Ending:

06/30/2009

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	1,752	2,058	\$ 51,823	\$ 25.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,043	3,354	69,758	20.80	3
4	Licensed Practical Nurses	16,462	17,485	303,882	17.38	4
5	CNAs & Orderlies	53,682	57,124	609,508	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,373	7,613	81,459	10.70	9
10	Activity Assistants					10
11	Social Service Workers	4,763	5,463	64,410	11.79	11
12	Dietician					12
13	Food Service Supervisor	1,742	2,174	25,572	11.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,929	16,128	139,832	8.67	15
16	Dishwashers					16
17	Maintenance Workers	3,815	4,934	76,080	15.42	17
18	Housekeepers	6,750	7,344	62,787	8.55	18
19	Laundry	3,841	3,957	30,706	7.76	19
20	Administrator	2,496	3,281	84,625	25.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,767	2,544	39,788	15.64	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	2,953	3,299	38,263	11.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Assisted Living</u>	18,854	17,445	185,617	10.64	33
34	TOTAL (lines 1 - 33)	142,222	154,203	\$ 1,864,110 *	\$ 12.09	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	204	\$ 6,090	1-3	35
36	Medical Director	\$400/month	4,800	9-3	36
37	Medical Records Consultant	13	696	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	55	3,543	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	23	970	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	295	\$ 16,099		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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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	\$ 57,845	Workers' Compensation Insurance	\$ 47,358	IDPH License Fee	\$	
Susan Tudor	Administrator	0	26,780	Unemployment Compensation Insurance	11,501	Advertising: Employee Recruitment	3,092	
				FICA Taxes	127,580	Health Care Worker Background Check	556	
				Employee Health Insurance	13,387	(Indicate # of checks performed <u>55</u>)		
				Employee Meals		Yellow Pages	913	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	3,911	
				Retirement Plan Contributions	14,249	Promotional & Public Relations	9,119	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 84,625					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense	2,508
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Scheffel and Company, P.C.	Accounting		\$ 20,026				line 24, col. 8)	
Taliana, Rubin & Buckley	Legal		264					
Doreen Gregory	Designer		3,575					
Heyl, Royster, Voelker & Allen	Legal		3,895					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,760					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2008 Ending: 06/30/2009**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 \$2,702; LSN \$1,600; INHAA \$100
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,916 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. \$ 544
- (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: _____
- (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.