

Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	2,793	3,841	1,517	8,151	8
9	SNF/PED					9
10	ICF	5,537	2,803		8,340	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,330	6,644	1,517	16,491	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.43%

D. How many bed-hold days during this year were paid by the Department? None (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, Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/1968

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 34 and days of care provided 1,517

Medicare Intermediary Wisconsin Physicians

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A (church) Fiscal Year: 06/30/2010

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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	151,545	8,994	5,810	166,349	(44,448)	121,901		121,901		1
2	Food Purchase		142,287		142,287	(30,048)	112,239	(864)	111,375		2
3	Housekeeping	88,400	6,065		94,465	(21,603)	72,862		72,862		3
4	Laundry	22,772	6,595		29,367	(5,937)	23,430		23,430		4
5	Heat and Other Utilities			85,740	85,740	(228)	85,512	(4,644)	80,868		5
6	Maintenance	74,405	6,767	26,745	107,917	(25,050)	82,867	(200)	82,667		6
7	Other (specify):* Med Waste/Trash Removal & Security			18,172	18,172	(2,943)	15,229		15,229		7
8	TOTAL General Services	337,122	170,708	136,467	644,297	(130,257)	514,040	(5,708)	508,332		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,013,389	55,274	4,235	1,072,898		1,072,898	(9,774)	1,063,124		10
10a	Therapy		270	166,141	166,411		166,411		166,411		10a
11	Activities	78,613	919		79,532	(20,933)	58,599		58,599		11
12	Social Services	39,860		760	40,620	(380)	40,240		40,240		12
13	CNA Training										13
14	Program Transportation		2,121		2,121		2,121	(2,020)	101		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,131,862	58,584	175,936	1,366,382	(21,313)	1,345,069	(11,794)	1,333,275		16
	C. General Administration										
17	Administrative	76,724	4,266		80,990	(10,846)	70,144	(2,003)	68,141		17
18	Directors Fees										18
19	Professional Services			19,176	19,176	(2,501)	16,675	(66)	16,609		19
20	Dues, Fees, Subscriptions & Promotions			35,590	35,590	2,558	38,148	(22,705)	15,443		20
21	Clerical & General Office Expenses	38,030	14,022	19,735	71,787	(7,737)	64,050	(61)	63,989		21
22	Employee Benefits & Payroll Taxes			212,380	212,380	16,462	228,842	(1,662)	227,180		22
23	Inservice Training & Education			537	537	250	787		787		23
24	Travel and Seminar			3,066	3,066	(502)	2,564		2,564		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,826	80,826	529	81,355	(1,212)	80,143		26
27	Other (specify):*										27
28	TOTAL General Administration	114,754	18,288	371,310	504,352	(1,787)	502,565	(27,709)	474,856		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,583,738	247,580	683,713	2,515,031	(153,357)	2,361,674	(45,211)	2,316,463		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:

07/01/2009

Ending:

06/30/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			62,955	62,955		62,955		62,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,325	116,325	(68,538)	47,787	(7,819)	39,968			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			179,280	179,280	(68,538)	110,742	(7,819)	102,923			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,427	12,235	64,662		64,662		64,662			39
40	Barber and Beauty Shops			11,785	11,785		11,785		11,785			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,984	36,984		36,984		36,984			42
43	Other (specify):* Asst Living	179,357	13,558	193,951	386,866	221,895	608,761		608,761			43
44	TOTAL Special Cost Centers	179,357	65,985	254,955	500,297	221,895	722,192		722,192			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,763,095	313,565	1,117,948	3,194,608		3,194,608	(53,030)	3,141,578			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ (8,526)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(864)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,644)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(664)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,819)	32		10
11	Discounts, Allowances, Rebates & Refunds	(584)	10		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	(8,124)	20		18
19	Entertainment				19
20	Contributions	(50)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(66)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,348)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,233)	20		28
29	Other-Attach Schedule	(7,108)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,030)		\$	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))	\$ (53,030)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Hitz Memorial HomeID# 0032979Report Period Beginning: 07/01/2009Ending: 06/30/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Reimbursement for copies of medical records	\$ (20)	21	1
2	Offset overpayment of AFLAC, Pension, & 941	(1,662)	22	2
3	Offset misc. insurance refunds	(1,212)	26	3
4	Offset postage reimbursement & office supply rebate	(41)	21	4
5	Offset refunds & rebates for maintenance supplies	(200)	6	5
6	Offset employee purchases of supplies	(172)	17	6
7	Offset income from sale of oils & candles	(1,781)	17	7
8	Offset income for transportation	(2,020)	14	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,108)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(864)	0	0	0	0	0	0	0	0	0	0	(864)	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	(4,644)	0	0	0	0	0	0	0	0	0	0	(4,644)	5
6	Maintenance	(200)	0	0	0	0	0	0	0	0	0	0	(200)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,708)	0	(5,708)	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	(9,774)	0	0	0	0	0	0	0	0	0	0	(9,774)	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	(2,020)	0	0	0	0	0	0	0	0	0	0	(2,020)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(11,794)	0	(11,794)	16									
	C. General Administration													
17	Administrative	(2,003)	0	0	0	0	0	0	0	0	0	0	(2,003)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(66)	0	0	0	0	0	0	0	0	0	0	(66)	19
20	Fees, Subscriptions & Promotions	(22,705)	0	0	0	0	0	0	0	0	0	0	(22,705)	20
21	Clerical & General Office Expenses	(61)	0	0	0	0	0	0	0	0	0	0	(61)	21
22	Employee Benefits & Payroll Taxes	(1,662)	0	0	0	0	0	0	0	0	0	0	(1,662)	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	(1,212)	0	0	0	0	0	0	0	0	0	0	(1,212)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,709)	0	(27,709)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,211)	0	(45,211)	29									

STATE OF ILLINOIS

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2009 Ending:

Summary B

06/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,819)	0	0	0	0	0	0	0	0	0	0	(7,819)	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	(7,819)	0	0	0	0	0	0	0	0	0	0	(7,819)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(53,030)	0	0	0	0	0	0	0	0	0	0	(53,030)	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	100.00					
See Attached Listing of members of Board of Directors						

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:

07/01/2009

Ending:

06/30/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	Bk of Edwardsville-2006 Bonds		X	Nsg Facility Mortgage-41.08%	\$5,438.00	8/23/06	\$ 709,864	\$ 611,552	5/15/2026	6.1600	\$ 39,116	1							
2							Bond Issue Cost Amortization				1,060	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Bk of Edwardsville		X	Line of Credit	N/A	8/23/06	500,000	449,758	8/01/10	4.5000	20,045	6							
7							Allocated to Asst. Living, ln 43				(12,434)	7							
8												8							
9	TOTAL Facility Related				\$5,438.00		\$ 1,209,864	\$ 1,061,310			\$ 47,787	9							
B. Non-Facility Related*																			
10	Bk of Edwardsville-2006 Bonds		X	Asst Living Mortgage-58.92%	\$7,798.00	8/23/06	1,018,290	877,135	5/15/06	6.1600	56,104	10							
11											(7,819)	11							
12							Allocated to Asst. Living, ln 43				(56,104)	12							
13												13							
14	TOTAL Non-Facility Related				\$7,798.00		\$ 1,018,290	\$ 877,135			\$ (7,819)	14							
15	TOTALS (line 9+line14)						\$ 2,228,154	\$ 1,938,445			\$ 39,968	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

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

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

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, 12944 sq. ft., 25 licensed units

Rental Space, 5726 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	\$	\$ 176,144	4
5	34			1975	418,286	10,457	40	10,457		365,129	5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1971	19,945	499	40	499		19,488	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	579	40	579		20,715	11
12	Improvements			1976	81,417	2,035	40	2,035		69,374	12
13	Improvements			1977	6,650	166	40	166		5,556	13
14	Improvements			1979	3,000	75	40	75		2,331	14
15	Improvements & Garage			1980	15,638	391	40	391		11,761	15
16	Improvements			1982	2,416	60	40	60		1,696	16
17	Roof & Improvements			1983	138,325	3,458	40	3,458		93,658	17
18	Roof & Improvements			1984	143,005	3,575	40	3,575		93,549	18
19	Dining Room			1985	28,447	711	40	711		18,017	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		6,990	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		4,417	21
22	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		35,328	22
23	Remodeling & New Garage			1990	29,672	916	30-40	916		18,323	23
24	Remodeling /Furnace/Control Temps/Architect Fees			1993	36,433	497	10-40	497		25,242	24
25	Sprinkler System/Water Heaters			1994	11,606		10-15			11,606	25
26	Roof Repair			1997	22,000	550	40	550		7,150	26
27	Air Conditioner			1998	5,439	136	40	136		1,643	27
28	Tank Replacement			1999	14,313	716	20	716		8,051	28
29	Air Conditioner			1999	3,280	164	20	164		1,831	29
30	Door Alarm			1999	1,164	29	10	29		1,164	30
31	Door Alarm			2000	1,563	156	10	156		1,550	31
32	Water Heater			2000	4,044	270	15	270		2,651	32
33	Kitchen Sewer Line			2000	2,721	181	15	181		1,769	33
34	Kitchen Fire Suppression System			2002	8,823	588	15	588		4,558	34
35	Door Oxygen Room			2002	791	79	10	79		606	35
36	Garage Door & Sign			2003	2,171	217	10	217		1,447	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2009 Ending: 06/30/2010

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	10-15	\$ 737	\$	\$ 4,731	37
38	Garbage Disposal	2004	2,681	268	10	268		1,474	38
39	Canopy	2005	5,575	372	15	372		1,982	39
40	Door Alarms	2005	2,544	255	10	255		1,337	40
41	Solarium	2006	31,589	790	40	790		2,896	41
42	Water Heater	2007	4,157	416	10	416		1,351	42
43	Air Conditioner	2007	5,621	562	10	562		1,733	43
44	Alarm System	2007	3,030	303	10	303		783	44
45	Patio Landscaping	2007	1,909	48	40	48		139	45
46	Ramp Remodel	2008	24,570	614	40	614		1,485	46
47	Flooring	2008	3,854	385	10	385		835	47
48	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		3,143	48
49	Water Heater	2008	3,867	387	10	387		806	49
50	Air Conditioner	2008	1,166	117	10	117		233	50
51	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		164	51
52	Fire Protection	2008	15,867	1,587	10	1,587		2,512	52
53	Carpet	2009	1,547	90	10	90		90	53
54	Freezer Door	2009	1,704	99	10	99		99	54
55	Heating Unit	2009	1,495	75	10	75		75	55
56	12x24 Garage	2009	3,820	127	15	127		127	56
57	Architecture Fees	2010	10,925		20				57
58	Heating Unit	2010	1,605	44	15	44		44	58
59	Heating Unit	2010	1,540	26	10	26		26	59
60	Heating Unit	2010	1,665	14	10	14		14	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)		\$ 1,491,997	\$ 42,010		\$ 42,010	\$	\$ 1,037,913	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/2009

Ending:

06/30/2010

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	\$ 141,219	\$ 14,694	\$ 14,694		5-15	\$ 62,087	71
72	Current Year Purchases	10,867	724	724		10	724	72
73	Fully Depreciated Assets	430,000	4,615	4,615		5-10	430,000	73
74								74
75	TOTALS	\$ 582,086	\$ 20,033	\$ 20,033	\$		\$ 492,811	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	2000 Dodge Ram Wagon	2000	\$ 26,173	\$	\$		5	\$ 26,173	76
77	Resident Transportation	Van Lift for 2000 Dodge	2000	5,687				5	5,687	77
78	Resident Transportation	Dodge Top/Rear Door Additions	2003	6,884				5	6,884	78
79	Resident Transportation	2003 Chevy 15 Passenger Van	2009	6,080	912	912		5	912	79
80	TOTALS			\$ 44,824	\$ 912	\$ 912	\$		\$ 39,656	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 2,164,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,955	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,955	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)	\$ 1,570,380	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	\$ 3,943,243	\$ 99,859	\$ 1,710,312	86
87	AL & Rental Bldg Equipment	281,091	283	277,946	87
88					88
89	Vehicles	27,065		27,065	89
90	Land- Assisted Living & Rental	25,000			90
91	TOTALS	\$ 4,276,399	\$ 100,142	\$ 2,015,323	91

G. Construction-in-Progress

	Description	Cost	
92	N/A		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: \$ N/A 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	<u>N/A</u>		\$	\$	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a,3	hrs			3,781	\$ 67,162	\$ 217	3,781	\$ 67,379						1
2	Licensed Speech and Language Development Therapist	10a,3	hrs			1,103	20,429		1,103	20,429						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a,3	hrs			4,389	78,550	53	4,389	78,603						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					52,427		52,427						9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Lab & X-Rays</u>	39,3					12,235			12,235						12
13	Other (specify):															13
14	TOTAL				\$	9,273	\$ 178,376	\$ 52,697	9,273	\$ 231,073						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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2009Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010

(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	\$ 85,108	\$	1
2	Cash-Patient Deposits	503		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>68,659</u>)	287,659		3
4	Supply Inventory (priced at <u>Cost</u>)	23,006		4
5	Short-Term Investments	162,907		5
6	Prepaid Insurance	83,499		6
7	Other Prepaid Expenses	2,605		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 645,287	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	87,976		13
14	Buildings, at Historical Cost	5,395,712		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	957,001		16
17	Accumulated Depreciation (book methods)	(3,585,703)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Bond Fees</u>)	23,918		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,878,904	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,524,191	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 224,182	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	503		28
29	Short-Term Notes Payable	449,758		29
30	Accrued Salaries Payable	120,988		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			35
Other Current Liabilities(specify):				
36	<u>Payroll Taxes & Garnishments</u>	9,570		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 805,001	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,488,687		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)	\$ 1,488,687	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,293,688	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,230,503	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,524,191	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,431,191	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,431,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(200,688)	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)	\$ (200,688)	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)	\$ 1,230,503	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2009Ending: 06/30/2010

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,726,565	1
2	Discounts and Allowances for all Levels	(219,981)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,506,584	3
B. Ancillary Revenue			
4	Day Care	8,526	4
5	Other Care for Outpatients		5
6	Therapy	176,252	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 184,778	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	100,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,398	13
14	Non-Patient Meals	864	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,350	16
17	Sale of Drugs	52,269	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,332	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 190,213	23
D. Non-Operating Revenue			
24	Contributions	76,910	24
25	Interest and Other Investment Income***	7,819	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84,729	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	16,280	27
28	<u>Miscellaneous</u>	<u>11,336</u>	<u>28</u>
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,616	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,993,920	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	644,297	31
32	Health Care	1,366,382	32
33	General Administration	504,352	33
B. Capital Expense			
34	Ownership	179,280	34
C. Ancillary Expense			
35	Special Cost Centers	463,313	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)*	\$ 3,194,608	40
41	Income before Income Taxes (line 30 minus line 40)**	(200,688)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (200,688)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A-(church) 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

0032979

Report Period Beginning: **07/01/2009**

Ending:

06/30/2010

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	1,780	2,144	\$ 53,232	\$ 24.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,380	3,573	74,546	20.86	3
4	Licensed Practical Nurses	17,014	18,002	320,202	17.79	4
5	CNAs & Orderlies	46,650	49,487	532,145	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,357	8,048	78,613	9.77	9
10	Activity Assistants					10
11	Social Service Workers	2,888	3,306	39,860	12.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,157	17,163	151,545	8.83	15
16	Dishwashers					16
17	Maintenance Workers	3,436	4,944	74,405	15.05	17
18	Housekeepers	10,286	10,511	88,400	8.41	18
19	Laundry	2,656	2,787	22,772	8.17	19
20	Administrator	2,189	3,919	76,724	19.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,772	2,914	38,030	13.05	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	2,596	2,961	33,264	11.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Assisted Living</u>	14,696	17,194	179,357	10.43	33
34	TOTAL (lines 1 - 33)	128,857	146,953	\$ 1,763,095 *	\$ 12.00	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	166	\$ 5,810	1,3	35
36	Medical Director	Contract	4,800	9,3	36
37	Medical Records Consultant	16	920	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,315	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	6	380	11,3	44
45	Social Service Consultant	6	380	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	\$ 15,605		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	None	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2009Ending: 06/30/2010**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. AAHSA \$853,CHHSM \$2588,LSN \$2388
- (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? N/A
- (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? N/A
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,674 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. N/A
- (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. N/A
- (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? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 864
- (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. \$ 0
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

HITZ MEMORIAL HOME
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2010

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>W/P Ref</u>	<u>INCREASE (DECREASE)</u>
ACTIVITIES	11	18B	380
SOCIAL SERVICES	12	18B	(380)
To reclass Activities Consultant expense to proper line			
DUES, FEES, SUBS & PROMOS	20	19G	60
TRAVEL & SEMINAR	24	19G	(60)
To reclass dues to proper line			
EMPLOYEE BENEFITS	22	6 B	470
ADMINISTRATIVE	17	6 B	(470)
To reclass employee relations expenses to proper line			
DIETARY	1	5 C	(44,448)
FOOD PURCHASE	2	5 C	(30,048)
HOUSEKEEPING	3	5 C	(21,603)
LAUNDRY	4	5 C	(5,937)
HEAT & OTHER UTILITIES	5	5 C	(228)
MAINTENANCE	6	5 C	(25,050)
OTHER GENERAL SERVICES	7	5 C	(2,943)
ACTIVITIES	11	5 C	(21,313)
ADMINISTRATIVE	17	5 C	(10,376)
PROFESSIONAL FEES	19	5 C	(2,501)
DUES, FEES, SUBS & PROMOS	20	5 C	2,498
CLERICAL & GENERAL OFFICE	21	5 C	(7,737)
EMPLOYEE BENEFITS & PR TAXES	22	5 C	15,992
INSERVICE TRAINING & EDUCATION	23	5 C	250
TRAVEL AND SEMINAR	24	5 C	(442)
INSURANCE-PROP., LIAB.,MALPRACTICE	26	5 C	529
INTEREST	32	5 C	(68,538)
OTHER SPECIAL COST CENTERS (ASST. LIVING)	43	5 C	221,895

To correct allocation of expenses to the Asst. Living facility

HITZ MEMORIAL HOME
 MISCELLANEOUS INCOME
 ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
 6/30/2010

Copy Records	20		offset In 21
Candles (total received \$1218. \$399 is the profit in donations above)	819		offset In 17 (expense for the candles is in Misc. Exp)
Essential Oils	962		offset to In 17 (expense is in Misc. Exp.)
McKesson VIP Program Rebate	244		Total =
Rebate-McKesson	314	}	584 offset In 10
Payment for Pads	26		
Refund-AFLAC EE deductions (Ins.)	332	}	Total =
Refund-Overpayment from Pension Boards (EE Pension)	655		1,662 offset In 22
Refund-2009 Form 941	675		
Dividend-CNA Co.-Property/Liab. Ins	757	}	Total =
Refund-Progressive insurance (auto)	455		1,212 offset In 26
Refund from Quill	31		Total =
Postage	10	}	41 offset In 21
Refund-State Industrial Prod	196		Total =
Rebate-Glidden (Paint)	4	}	200 offset In 6
EE Purchases (Per Kathy, EE's buy various supplies periodically)	664		offset to In 10
EE Purchases (Per Kathy, EE's buy various supplies periodically)	172		offset to In 17 (this is the amt of EE Purchases exp. in the Misc. Exp. Acct grouped on In 17
Transportation Revenue-a/c#4850	2,020		offset against transportation expense on In 14
Sale of Villager	250		no cost to offset (not on Depr. Schedule)
Vending	1,255		no cost to offset
Essential Oils	370		all cost has already been offset-see above
Payroll Misposts reclassified here	259		
Batteries	10		
Cashed Check	10		
Application Fees -a/c#4780	500		
Garnishment Fees-a/c#4965	326		
	11,336		

HITZ MEMORIAL HOME
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
6/30/2010

<u>Seminar Participant</u>	<u>Job Title</u>	<u>Dates</u>	<u>City</u>	<u>Title of Seminar</u>	<u>Sponsor</u>	<u>Cost</u>
Becky Baney	LPN-Care Plans	10/13-10/14/09	Springfield, IL	Pioneer Coalition Summit	WCIAAAA	125
Becky Searcy	LPN-Care Plans	10/13-10/14/09	Springfield, IL	Pioneer Coalition Summit	WCIAAAA	125
Sandy Ergle	DON	10/13-10/14/09	Springfield, IL	Pioneer Coalition Summit	WCIAAAA	125
Susan Tudor	Administrator	10/13-10/14/09	Springfield, IL	Pioneer Coalition Summit	WCIAAAA	125
Meredith Sharp	Social Services	10/13-10/14/09	Springfield, IL	Pioneer Coalition Summit	WCIAAAA	125
Angela Schumacher	RN	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Kim Hanvey	Activities	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Mary Landry	Activities	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Mary Wilson	Housekeeper	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Bunnie Bone	Laundry/Housekeeper	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Meredith Sharp	Social Services	11/4/2009	Granite City, IL	Life Enrichment Through Activities-Fresh Look at Dementia	Alzheimers Association	50
Sandy Ergle	DON	8/11/2009	Springfield, IL	HFS Medicaid Audit Results from Surveyors	LSN	95
Becky Searcy	LPN-Care Plans	8/11/2009	Springfield, IL	HFS Medicaid Audit Results from Surveyors	LSN	95
Becky Baney	LPN-Care Plans	8/11/2009	Springfield, IL	HFS Medicaid Audit Results from Surveyors	LSN	95
Cheryl Sickage	Medical Records/CNA	8/11/2009	Springfield, IL	HFS Medicaid Audit Results from Surveyors	LSN	95
Cheryl Sickage	Social Services	1/19-1/20/10	Breese, IL	Social Service Director Basic Training Course	Outcome Services of IL	153
Susan Tudor	Administrator	4/27/2010	Shiloh, IL	Food for Thought	IL Pioneer Coalition, IL Dept of Public Health	39
Patty Ashley	Dietary Manager	4/27/2010	Shiloh, IL	Food for Thought	IL Pioneer Coalition, IL Dept of Public Health	39
Susan Tudor	Administrator	6/9-6/10/10	East Peoria, IL	IL Nursing Home Administrators Conference	INHAA	95
Sandy Ergle	DON	6/16-6/17/10	Springfield, IL	MDS RAC-CT 3.0 Certification	LSN	450
Becky Searcy	LPN-Care Plans	6/16-6/17/10	Springfield, IL	MDS RAC-CT 3.0 Certification	LSN	450
Sandy Ergle	DON	6/15/2010	Edwardsville, IL	MDS 3.0 Software Training	LTC Solutions	150
Becky Searcy	LPN-Care Plans	6/15/2010	Edwardsville, IL	MDS 3.0 Software Training	LTC Solutions	150
						2831
Dietary Worker Certification Courses (5 people)						175
Less Asst. Living Allocation						(442)
Total Travel & Seminar, Line 24						<u>2564</u>

HITZ MEMORIAL HOME
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2010

The following are members of the Board of Directors.
NO Board member directly provided services to the nursing home.
NO Board member had an ownership interest with a business that
conducted transactions with the nursing home during the period.

Lewis Knackstedt
Lillian Daiber
Janet Blair
Shirley Carroll
Rich Akins
Carol Amiri
Rev. Nancy Cahalan
Leonard Lockett
Ronald Mindrup
Ida Nuernberger
Richard Ullman
John Riggs