

Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning: 7/1/13 Ending: 6/30/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,843	5,169	1,313	10,325	8
9	SNF/PED					9
10	ICF	4,951	1,406	573	6,930	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,794	6,575	1,886	17,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.56%

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)
Independent Senior Apartments, 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 1,313

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: N/A (church) Fiscal Year: 6/30/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	139,795	11,832	5,540	157,167		157,167		157,167		1
2	Food Purchase		100,864		100,864		100,864		100,864		2
3	Housekeeping	79,635	9,843		89,478		89,478		89,478		3
4	Laundry	31,463	4,639		36,102		36,102		36,102		4
5	Heat and Other Utilities			68,333	68,333		68,333	(4,508)	63,825		5
6	Maintenance	35,778	3,389	49,061	88,228		88,228	(2,465)	85,763		6
7	Other (specify):* Med Waste/Trash Removal & Security			9,839	9,839		9,839		9,839		7
8	TOTAL General Services	286,671	130,567	132,773	550,011		550,011	(6,973)	543,038		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	984,640	54,285	11,617	1,050,542		1,050,542	(4,200)	1,046,342		10
10a	Therapy										10a
11	Activities	56,905	2,096		59,001	402	59,403		59,403		11
12	Social Services	65,046	557	805	66,408	(402)	66,006		66,006		12
13	CNA Training										13
14	Program Transportation		7,710		7,710		7,710	(1,900)	5,810		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,106,591	64,648	21,422	1,192,661		1,192,661	(6,100)	1,186,561		16
	C. General Administration										
17	Administrative	64,886	821		65,707		65,707		65,707		17
18	Directors Fees										18
19	Professional Services			25,728	25,728		25,728		25,728		19
20	Dues, Fees, Subscriptions & Promotions			38,235	38,235		38,235	(24,158)	14,077		20
21	Clerical & General Office Expenses	39,311	14,540	73,517	127,368		127,368	(38)	127,330		21
22	Employee Benefits & Payroll Taxes			221,888	221,888		221,888		221,888		22
23	Inservice Training & Education			1,260	1,260		1,260		1,260		23
24	Travel and Seminar			1,974	1,974		1,974		1,974		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,156	71,156		71,156		71,156		26
27	Other (specify):*										27
28	TOTAL General Administration	104,197	15,361	433,758	553,316		553,316	(24,196)	529,120		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,497,459	210,576	587,953	2,295,988		2,295,988	(37,269)	2,258,719		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:

7/1/13

Ending:

6/30/14

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			145,678	145,678	(16,315)	129,363	(10,110)	119,253			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,837	86,837		86,837	(31,873)	54,964			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			232,515	232,515	(16,315)	216,200	(41,983)	174,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,658	191,450	233,108		233,108		233,108			39
40	Barber and Beauty Shops			7,845	7,845		7,845		7,845			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,349	133,349		133,349		133,349			42
43	Other (specify):* Independent Senior Apartments		323	75,959	76,282	16,315	92,597		92,597			43
44	TOTAL Special Cost Centers		41,981	408,603	450,584	16,315	466,899		466,899			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,497,459	252,557	1,229,071	2,979,087		2,979,087	(79,252)	2,899,835			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

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

0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14

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	\$ (4,200)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,508)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,572)	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	(22,301)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,679)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,367)	20		28
29	Other-Attach Schedule	(20,625)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,252)		\$	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))	\$ (79,252)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Hitz Memorial Home

ID# 0032979

Report Period Beginning: 7/1/13

Ending: 6/30/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Med. Record copies reimb.	\$ (38)	21	1
2	Offset income for transportation	(1,900)	14	2
3	Offset refund for maint. Supplies	(2,465)	6	3
4	Eliminate half of 2 yr. IDPH license purchased in 2014	(1,990)	20	4
5	Eliminate non-care related collection fees	(3,547)	20	5
6	Eliminate non-allowable fines and penalties	(575)	20	6
7	Eliminate depreciation on capital cost adjustments	(10,110)	30	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,625)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14

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	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	(4,508)	0	0	0	0	0	0	0	0	0	0	(4,508)	5
6	Maintenance	(2,465)	0	0	0	0	0	0	0	0	0	0	(2,465)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,973)	0	(6,973)	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	(4,200)	0	0	0	0	0	0	0	0	0	0	(4,200)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,900)	0	0	0	0	0	0	0	0	0	0	(1,900)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,100)	0	(6,100)	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	(24,158)	0	0	0	0	0	0	0	0	0	0	(24,158)	20
21	Clerical & General Office Expenses	(38)	0	0	0	0	0	0	0	0	0	0	(38)	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	(24,196)	0	(24,196)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,269)	0	(37,269)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(10,110)	0	0	0	0	0	0	0	0	0	0	(10,110)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,873)	0	0	0	0	0	0	0	0	0	0	(31,873)	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	(41,983)	0	(41,983)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(79,252)	0	(79,252)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois Southern Conference of the United Church of Christ	100					
See attached listing for members of the 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

7/1/13

Ending:

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/13 Ending: 6/30/14

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:

7/1/13

Ending: 6/30/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of Edwardsville		X	Nsg Facility Mortgage-62.57%	\$4,540.00	8/17/12	\$ 853,381	\$ 817,645	8/17/37	4.5000	\$ 37,280	1								
2									Loan Cost Amortization		1,701	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Bank of Edwardsville		X	Line of Credit	N/A	9/1/13	500,000	376,192	9/1/14	4.2500	16,367	6								
7	Bank of Edwardsville		X	Line of Credit	N/A	9/1/13	300,000	207,903	9/1/14	4.2500	9,188	7								
8												8								
9	TOTAL Facility Related				\$4,540.00		\$ 1,653,381	\$ 1,401,740			\$ 64,536	9								
B. Non-Facility Related*																				
10	Bank of Edwardsville		X	Nsg Facility Mortgage-37.43%	\$3,050.00	8/17/12	510,501	489,124			22,301	10								
11									Eliminated non-care realted interest		(22,301)	11								
12									Offset Interest Income		(9,572)	12								
13												13								
14	TOTAL Non-Facility Related				\$3,050.00		\$ 510,501	\$ 489,124			\$ (9,572)	14								
15	TOTALS (line 9+line14)						\$ 2,163,882	\$ 1,890,864			\$ 54,964	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 2013 report.				\$	<u>N/A-Exempt</u> 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 2014 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:	2009	_____	8		
	2010	_____	9		
	2011	_____	10		
	2012	_____	11		
	2013	_____	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hitz Memorial Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0032979

CONTACT PERSON REGARDING THIS REPORT _____

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning:

7/1/13 Ending:

6/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,841 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

ISL Space, 5,180 sq. ft.

Rental Space, 5,726 sq. ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Row 1: Facility, 1976, \$45,384, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), \$45,384, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1970	\$ 176,881		40			
5			1975	418,286	10457	40	10457		583,838
6			1991	1,436,697	35917	40	35917		842,729
7									
8									
Improvement Type**									
9	Improvements		1971	19,945		40			19,945
10	Improvements		1972	90		10			90
11	Improvements		1974	23,177	579	40	579		23,032
12	Improvements		1976	81,417	2,035	40	2,035		77,516
13	Improvements		1977	6,650	166	40	166		6,221
14	Improvements		1979	3,000	75	40	75		2,631
15	Improvements & Garage		1980	15,638	391	40	391		13,325
16	Improvements		1982	2,416	60	40	60		1,938
17	Roof & Improvements		1983	138,325	3,458	40	3,458		107,490
18	Roof & Improvements		1984	143,005	3,575	40	3,575		107,850
19	Dining Room		1985	28,447	711	40	711		20,861
20	Architecture Fees/Roof Repair		1987	12,112	303	40	303		8,201
21	Architecture Fees/Improvements		1988	8,001	200	40	200		5,217
22	Solarium & Architecture Fees		1989	67,025	1,676	40	1,676		42,030
23	Remodeling & New Garage		1990	29,672	916	30-40	916		21,988
24	Remodeling/Furnace/Control Temps/Architect Fees		1993	36,433	497	10-40	497		27,231
25	Sprinkler System/Water Heaters		1994	7,729		10-15			7,729
26	Roof Repair		1997	22,000	550	40	550		9,350
27	Air Conditioner		1998	5,439	136	40	136		2,187
28	Tank Replacement		1999	14,313	716	20	716		10,914
29	Air Conditioner		1999	3,280	164	20	164		2,487
30	Door Alarm		1999	1,164		10			1,164
31	Door Alarm		2000	1,563		10			1,563
32	Kitchen Sewer Line		2000	2,721	181	15	181		2,494
33	Kitchen Fire Suppression System		2002	8,823	588	15	588		6,911
34	Door Oxygen Room		2002	791		10			791
35	Garage Door & Sign		2003	2,171	72	10	72		2,171
36	Fire Protection/Water Heaters		2004	9,344	623	10 - 15	623		7,564

*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:

7/1/13

Ending:

6/30/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Garbage Disposal	2004	\$ 2,680	\$ 268	10	\$ 268	\$	\$ 2,546	37
38	Canopy	2005	5,575	372	15	372		3,469	38
39	Door Alarms	2005	2,547	255	10	255		2,356	39
40	Solarium	2006	31,589	790	40	790		6,055	40
41	Water Heater	2007	4,157	416	10	416		3,014	41
42	Air Conditioner	2007	5,621	562	10	562		3,982	42
43	Alarm System	2007	3,030	303	10	303		1,995	43
44	Patio Landscaping	2007	1,909	48	40	48		330	44
45	Ramp Remodel	2008	24,570	614	40	614		3,941	45
46	Flooring	2008	3,854	385	10	385		2,377	46
47	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		9,177	47
48	Water Heater	2008	3,867	387	10	387		2,352	48
49	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		478	49
50	Fire Protection	2009	15,867	1,587	10	1,587		8,859	50
51	12x24 Garage	2009	3,820	255	15	255		1,146	51
52	Heating Unit	2010	1,605	107	15	107		472	52
53	Heating Unit	2010	1,540	154	10	154		642	53
54	Heating Unit	2010	1,665	166	10	166		680	54
55	Evaporator fan coil, thermostat	2010	2,585	259	10	259		1,034	55
56	Carrier Air Handler, evaporator coil	2010	7,650	765	10	765		3,060	56
57	Install 3 Pan Sink w/drains, plumbing & cabinets	2011	5,941	297	20	297		842	57
58	Architecture & Design Fees for wing remodel-SNF suite wing	2011	16,427	657	25	657		1,862	58
59	Contractor's Materials & Labor Cost-SNF suite wing	2011	500	20	25	20		57	59
60	Flooring materials & labor for wing remodel-SNF suite wing	2011	8,439	422	20	422		1,196	60
61	Door Alarms & Wanderguard system-SNF suite wing	2011	9,248	472	15	472		1,336	61
62	Water Heater mixer valve replaced & installed	2011	4,800	480	10	480		1,360	62
63	A/C Unit for Dietary	2012	4,334	867	5	867		1,734	63
64	A/C Unit for Dietary	2012	738	148	5	148		332	64
65	Water Heater mixer valve replaced & installed	2001	3,074	205	15	205		2,698	65
66	Boiler	2001	10,629	531	20	531		6,820	66
67	Sprinkler System	2008	7,520	188	40	188		1,128	67
68	Landscaping	1991	1,755	44	40	44		1,024	68
69	Exterior Lights & Sign	1992	2,911		10			2,911	69
70	TOTAL (lines 4 thru 69)		\$ 2,990,489	\$ 77,658		\$ 77,658	\$	\$ 2,048,723	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:

7/1/13

Ending:

6/30/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,990,489	\$ 77,658		\$ 77,658	\$	\$ 2,048,723	1
2	2012	3,675	735	5	735		1,164	2
3	2012	11,704	2,156	5-15	2,156		3,259	3
4	2013	2,196	146	15	146		146	4
5	2013	2,325	174	10	174		174	5
6	2014	22,450	281	20	281		281	6
7	2014	5,949	537	5	537		537	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,038,788	\$ 81,687		\$ 81,687	\$	\$ 2,054,284	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 267,402	\$ 34,465	\$ 34,465	\$	5-40	\$ 116,424	71
72	Current Year Purchases	29,650	1,416	1,416		'5-12	1,416	72
73	Fully Depreciated Assets	710,887	469	469		5-10	710,887	73
74								74
75	TOTALS	\$ 1,007,939	\$ 36,350	\$ 36,350	\$		\$ 828,727	75

D. Vehicle Costs. (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	1,216	1,216		5	5,776	79
80	TOTALS			\$ 44,824	\$ 1,216	\$ 1,216	\$		\$ 44,520	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)	\$ 4,136,935	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,253	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,253	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)	\$ 2,927,531	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	ISL & Rental Building Impr.	\$ 2,480,657	\$ 62,666	\$ 1,252,131	86
87	ISL & Rental Bldg Equipment	2,684		2,684	87
88					88
89	Land-ISL & Rental Bldg	25,000			89
90					90
91	TOTALS	\$ 2,508,341	\$ 62,666	\$ 1,254,815	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.	_____ /2015	\$ _____
13.	_____ /2016	\$ _____
14.	_____ /2017	\$ _____

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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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 prescrpts				41,408		41,408	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached Schedule</u>				10,816	191,450	250	10,816	191,700	13
14	TOTAL			\$	10,816	\$ 191,450	\$ 41,658	10,816	\$ 233,108	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

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	\$ (6,754)	\$	1
2	Cash-Patient Deposits	2,704		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	530,830		3
4	Supply Inventory (priced at)	15,237		4
5	Short-Term Investments	22,177		5
6	Prepaid Insurance	16,507		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 580,701	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	87,964		13
14	Buildings, at Historical Cost	5,710,727		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,055,446		16
17	Accumulated Depreciation (book methods)	(4,212,236)		17
18	Deferred Charges	(5,700)		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>Loan Cost</u>)	5,385		22
23	Other(specify): <u>MPIC Capital Investment</u>	5,350		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,646,936	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,227,637	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 45,164	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,952		28
29	Short-Term Notes Payable	584,095		29
30	Accrued Salaries Payable	71,262		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,387		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>Provider Taxes</u>	23,569		36
37	<u>Garnishments</u>	373		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 749,802	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,306,769		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,306,769	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,056,571	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,171,066	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,227,637	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,053,759	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,053,759	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	117,307	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)	\$ 117,307	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)	\$ 1,171,066	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,896,429	1
2	Discounts and Allowances for all Levels	(327,523)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,568,906	3
B. Ancillary Revenue			
4	Day Care	4,200	4
5	Other Care for Outpatients		5
6	Therapy	395,450	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 399,650	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	7,985	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,969	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,703	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 56,657	23
D. Non-Operating Revenue			
24	Contributions	53,932	24
25	Interest and Other Investment Income***	9,572	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63,504	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	1,911	27
28	<u>Miscellaneous</u>	5,766	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,677	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,096,394	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	550,011	31
32	Health Care	1,192,661	32
33	General Administration	553,316	33
B. Capital Expense			
34	Ownership	232,515	34
C. Ancillary Expense			
35	Special Cost Centers	233,108	35
36	Provider Participation Fee	133,349	36
D. Other Expenses (specify):			
37	<u>Barber & Beauty Shop</u>	7,845	37
38	<u>Independent Senior Apartments</u>	76,282	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,979,087	40
41	Income before Income Taxes (line 30 minus line 40)**	117,307	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 117,307	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,190,592	44
45	Private Pay - Net Inpatient Revenue	1,064,481	45
46	Medicare - Net Inpatient Revenue	581,505	46
47	Other-(specify) <u>Independent Senior Apartments-Private</u>	59,851	47
48	Other-(specify) <u>Discounts and Allowances</u>	(327,523)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,568,906	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,062	2,118	\$ 49,882	\$ 23.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,931	2,090	43,599	20.86	3
4	Licensed Practical Nurses	18,097	18,743	333,418	17.79	4
5	CNAs & Orderlies	47,268	49,441	534,649	10.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,017	4,459	56,905	12.76	9
10	Activity Assistants					10
11	Social Service Workers	4,952	5,546	65,046	11.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,427	14,263	139,795	9.80	15
16	Dishwashers					16
17	Maintenance Workers	2,715	2,920	35,778	12.25	17
18	Housekeepers	9,296	9,652	79,634	8.25	18
19	Laundry	3,159	3,355	31,463	9.38	19
20	Administrator	1,780	2,080	64,886	31.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,508	2,858	39,311	13.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,915	2,082	23,093	11.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,127	119,607	\$ 1,497,459 *	\$ 12.52	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	139	\$ 5,540	1,3	35
36	Medical Director	Contract	9,000	9,3	36
37	Medical Records Consultant	16	956	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,534	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	402	11,3	44
45	Social Service Consultant	7	403	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	168	\$ 20,835		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. 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	
Susan Tudor	Administrator	0	\$ 64,886	Workers' Compensation Insurance	\$ 37,170	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	55,845	Advertising: Employee Recruitment	2,718	
				FICA Taxes	113,019	Health Care Worker Background Check (Indicate # of checks performed <u>77</u>)	1,227	
				Employee Health Insurance	8,009	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	2,602	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	737	
				Retirement Plan Contributions	3,722	Bank Service Charges	4,803	
				Employee Uniforms	3,791			
				Employee Recognition	332			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,886			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 221,888	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,077	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C.J. Schlosser & Co., LLC	Accounting		\$ 25,283			\$	Out-of-State Travel	\$
Roy D. Anderson Attorney at Law	Legal Fees		445					
							In-State Travel	
							Seminar Expense	1,974
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 25,728	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,974

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014	14 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# 0032979

Report Period Beginning:

7/1/13

Ending:

6/30/14**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. Life Servcies Network (LSN) - \$2,168
- (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. \$ 16,881 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. \$ 133,349
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? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

Hitz Memorial Home
 Attachment to Schedule XIV
 6/30/2014

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5 +6)
Line #	Service	Schuler V Line & Column Reference	Units of Service	Cost	Units of Service	Cost	Cost		
12	Other:								
	Licensed Occupational Therapist	39,3			4,616	77,438	250	4,616	77,688
	Licensed Speech Therapist	39,3			1,346	26,590		1,346	26,590
	Licensed Physical Therapist	39,3			4,854	81,378		4,854	81,378
	Laboratory & X-Rays	39,3				6,044		-	6,044
	Specialty Mattresses/Overlays	39,3						-	-
	Total to Schedule XIV, Line 12		-	-	10,816	191,450	250	10,816	191,700

HITZ MEMORIAL HOME
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2014

Copy Records-State of Illinois	38	offset ln 21
Transportation Revenue-a/c#4850	1,900	offset to ln 14
Refund from Tech Electronics	2,465	offset to ln 6
Vending	316	no cost to offset
Miscellaneous	2	
Recycled Scrap Metal cashed in	139	
Insurance Reimbursement	1,555	
Resident Refunds	(150)	
Cash for NH week	(500)	
Garnishment Fees-a/c#4965	1	
	<u>5,766</u>	

HITZ MEMORIAL HOME
INDEPENDENT SENIOR LIVING
ATTACHMENT TO SCHEDULE XX, PAGE 23, #14
6/30/2014

The Independent Senior Living (ISL) apartments make up 5,180 square feet of the building. All costs related to the ISL area are on Schedule V, line 43 of the cost report. The mortgage interest allocated to the ISL area is eliminated on Schedule VI, line 14 and detailed on Schedule IX, line 10. All fixed assets associated with the ISL area are detailed on Schedule XI, section F.

HITZ MEMORIAL HOME
 ADJUSTMENTS
 ATTACHMENT TO SCHEDULE 6
 6/30/2014

6 A

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>W/P Ref</u>	<u>INCREASE (DECREASE)</u>
INTEREST To offset interest income against related expense	32	17 A	(9,572)
NURSING & MEDICAL RECORDS To offset daycare income	10	17 A	(4,200)
CLERICAL & GENERAL OFFICE	21	17 B	(38)
PROGRAM TRANSPORTATION	14	17 B	(1,900)
MAINTENANCE To offset misc. income rebates/refunds & reimbursments against the related expense accounts	6	17 B	(2,465)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate promotional advertising	20	5 A	(16,679)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate yellow page ads	20	5 A	(1,367)
HEAT & OTHER UTILITIES To eliminate Cable T.V.	5	5A	(4,508)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS Eliminate half of 2 year IDPH license	20	19Fp2	(1,990)
Other - Assisted Living/Stand By Area To eliminate non-care related interest	32	9p1	(22,301)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate non-care related collection fees	20	5A	(3,547)
Other - Assisted Living/Stand By Area To eliminate non-allowable fines & penalties	20	5A	(575)
DEPRECIATION Eliminate depreciation on capital cost adjustments	30	11Ap2	(10,110)
			(79,252)

HITZ MEMORIAL HIME
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2014

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>W/P REF</u>	<u>INCREASE (DECREASE)</u>
ACTIVITIES	11	18B	402
SOCIAL SERVICES	12	18B	(402)

To reclass activities consultant expense to the proper line.

DEPRECIATION	30	11Ap5	(16,315)
OTHER - STAND BY AREA	43	11Ap5	16,315

To reclass ISL depreciation expense allocation.

HITZ MEMORIAL HOME
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2014

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.

Al Wilkening
Shirley Carroll
Linda Diesen
Rosemary Schultze
Rev. Jerry Amiri
Kay Grotefendt
Carol Hess
Mary Klostermeier
Richard Ullman
Amy Hemann
Allen Schmidt
Paco Newman