		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0032979

Facility Name: Hitz Memorial Home

Address: 201 Belle Street, P.O. Box 79 (Number) Alhambra (City) 62001 (Zip Code)

County: Madison

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 (c) 3

In the event there are further questions about this report, please contact:
Name: Terry Dooling, C.J. Schlosser & Co., LLC **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2010 to 06/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Susan Tudor
(Title) Administrator

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,876	3,930	1,068	7,874	8
9	SNF/PED					9
10	ICF	6,020	2,201		8,221	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,896	6,131	1,068	16,095	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.81%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 1,068

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: N/A (church) Fiscal Year: 06/30/2011

* 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: 07/01/2010 Ending: 06/30/2011

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,241	13,925	5,233	172,399	(37,670)	134,729		134,729			1
2	Food Purchase		120,163		120,163	(16,766)	103,397	(177)	103,220			2
3	Housekeeping	84,829	6,400		91,229	(19,889)	71,340		71,340			3
4	Laundry	16,849	7,546	22	24,417	(4,334)	20,083		20,083			4
5	Heat and Other Utilities			81,384	81,384	(1,481)	79,903	(6,383)	73,520			5
6	Maintenance	77,201	6,757	48,432	132,390	(29,168)	103,222		103,222			6
7	Other (specify):* Med Waste/Trash Removal & Security			14,627	14,627	(2,450)	12,177		12,177			7
8	TOTAL General Services	332,120	154,791	149,698	636,609	(111,758)	524,851	(6,560)	518,291			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	938,664	50,304	5,154	994,122		994,122	(10,618)	983,504			10
10a	Therapy		257	185,247	185,504		185,504		185,504			10a
11	Activities	82,223	1,967		84,190	(17,918)	66,272		66,272			11
12	Social Services	40,049	154	1,311	41,514	(656)	40,858		40,858			12
13	CNA Training											13
14	Program Transportation		1,230		1,230		1,230	(2,635)	(1,405)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,060,936	53,912	195,712	1,310,560	(18,574)	1,291,986	(13,253)	1,278,733			16
	C. General Administration											
17	Administrative	72,917	4,817		77,734	(8,443)	69,291	(1,757)	67,534			17
18	Directors Fees											18
19	Professional Services			21,855	21,855	(2,413)	19,442	(807)	18,635			19
20	Dues, Fees, Subscriptions & Promotions			40,058	40,058	(889)	39,169	(21,609)	17,560			20
21	Clerical & General Office Expenses	40,107	13,700	15,342	69,149	(6,899)	62,250	(20)	62,230			21
22	Employee Benefits & Payroll Taxes			195,577	195,577	8,296	203,873	(13,409)	190,464			22
23	Inservice Training & Education			812	812	(89)	723		723			23
24	Travel and Seminar			902	902	(106)	796		796			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,612	72,612	2,432	75,044		75,044			26
27	Other (specify):*											27
28	TOTAL General Administration	113,024	18,517	347,158	478,699	(8,111)	470,588	(37,602)	432,986			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,506,080	227,220	692,568	2,425,868	(138,443)	2,287,425	(57,415)	2,230,010			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: 07/01/2010 Ending: 06/30/2011

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,833	56,833		56,833		56,833			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			112,645	112,645	(66,370)	46,275	(1,965)	44,310			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			169,478	169,478	(66,370)	103,108	(1,965)	101,143			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,561	7,954	48,515		48,515		48,515			39
40	Barber and Beauty Shops			8,885	8,885		8,885		8,885			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,037	36,037		36,037		36,037			42
43	Other (specify):* **Asst. Living**	144,316	15,280	170,454	330,050	204,813	534,863		534,863			43
44	**TOTAL Special Cost Centers**	144,316	55,841	223,330	423,487	204,813	628,300		628,300			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,650,396	283,061	1,085,376	3,018,833		3,018,833	(59,380)	2,959,453			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: 07/01/2010 Ending: 06/30/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$ (9,330)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(177)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,383)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(785)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,965)	32		10
11	Discounts, Allowances, Rebates & Refunds	(503)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(807)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,495)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,119)	20		28
29	Other-Attach Schedule	(18,816)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,380)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (59,380)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Hitz Memorial Home
ID# 0032979
Report Period Beginning: 07/01/2010
Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset reimbursement for copies of medical records	$ (20)	21	1
2	Offset income for sale of candles and renovation sale	(894)	17	2
3	Offset NHRMA refund	(13,409)	22	3
4	Offset employee purchases of supplies	(270)	17	4
5	Offset reimbursements from residents for various items	(593)	17	5
6	Offset income for transportation	(2,635)	14	6
7	Eliminate half of 2 year IDPH license	(995)	20	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**	(18,816)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(177)	0	0	0	0	0	0	0	0	0	0	(177)	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	(6,383)	0	0	0	0	0	0	0	0	0	0	(6,383)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,560)	0	0	0	0	0	0	0	0	0	0	(6,560)	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	(10,618)	0	0	0	0	0	0	0	0	0	0	(10,618)	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	(2,635)	0	0	0	0	0	0	0	0	0	0	(2,635)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(13,253)	0	0	0	0	0	0	0	0	0	0	(13,253)	16
	C. General Administration													
17	Administrative	(1,757)	0	0	0	0	0	0	0	0	0	0	(1,757)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(807)	0	0	0	0	0	0	0	0	0	0	(807)	19
20	Fees, Subscriptions & Promotions	(21,609)	0	0	0	0	0	0	0	0	0	0	(21,609)	20
21	Clerical & General Office Expenses	(20)	0	0	0	0	0	0	0	0	0	0	(20)	21
22	Employee Benefits & Payroll Taxes	(13,409)	0	0	0	0	0	0	0	0	0	0	(13,409)	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**	(37,602)	0	0	0	0	0	0	0	0	0	0	(37,602)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,415)	0	0	0	0	0	0	0	0	0	0	(57,415)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	(1,965)	0	0	0	0	0	0	0	0	0	0	(1,965)	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**	(1,965)	0	0	0	0	0	0	0	0	0	0	(1,965)	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)**	(59,380)	0	0	0	0	0	0	0	0	0	0	(59,380)	45

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 South Conference of the	100					
United Church of Christ						
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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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: 07/01/2010 Ending: 06/30/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 07/01/2010 Ending: 6/30/2011

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 07/01/2010 Ending: 06/30/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	$ 586,164	5/15/2026	6.1600	$ 37,445	1
2								Bond Issue Cost Amortization			1,503	2
3												3
4												4
5												5
	Working Capital											
6	Bk of Edwardsville		X	Line of Credit	N/A	8/23/06	500,000	394,076	09/01/11	4.5000	19,991	6
7								Allocated to Asst. Living, ln 43			(12,664)	7
8												8
9	TOTAL Facility Related				$5,438.00		$ 1,209,864	$ 980,240			$ 46,275	9
	B. Non-Facility Related*											
10	Bk of Edwardsville-2006 Bonds		X	Nsg Facility Mortgage-58.92%	$7,798.00	8/23/06	1,018,290	840,719	5/15/2026	6.1600	53,706	10
11									Interest Income Offset		(1,965)	11
12								allocated to Asst. Living ln 43			(53,706)	12
13												13
14	TOTAL Non-Facility Related				$7,798.00		$ 1,018,290	$ 840,719			$ (1,965)	14
15	TOTALS (line 9+line14)						$ 2,228,154	$ 1,820,959			$ 44,310	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.)

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Not-For-Profit organization, exempt	$	$
2.		from real estate taxes.	$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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? [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).

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 [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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1976	$ 45,384	1
2					2
3	TOTALS			$ 45,384	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	33			1970	$ 176,881	$ 737	40	$ 737	$	$ 176,881	4
5	34			1975	418,286	10,457	40	10,457		375,586	5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1971	19,945	457	40	457		19,945	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177	579	40	579		21,294	11
12	Improvements			1976	81,417	2,035	40	2,035		71,410	12
13	Improvements			1977	6,650	166	40	166		5,722	13
14	Improvements			1979	3,000	75	40	75		2,406	14
15	Improvements & Garage			1980	15,638	391	40	391		12,152	15
16	Improvements			1982	2,416	60	40	60		1,757	16
17	Roof & Improvements			1983	138,325	3,458	40	3,458		97,116	17
18	Roof & Improvements			1984	143,005	3,575	40	3,575		97,124	18
19	Dining Room			1985	28,447	711	40	711		18,728	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		7,292	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		4,617	21
22	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		37,004	22
23	Remodeling & New Garage			1990	29,672	916	30-40	916		19,240	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	36,433	497	' 10-40	497		25,739	24
25	Sprinkler System/Water Heaters			1994	7,729		10-15			7,729	25
26	Roof Repair			1997	22,000	550	40	550		7,700	26
27	Air Conditioner			1998	5,439	136	40	136		1,779	27
28	Tank Replacement			1999	14,313	716	20	716		8,767	28
29	Air Conditioner			1999	3,280	164	20	164		1,995	29
30	Door Alarm			1999	1,164		10			1,164	30
31	Door Alarm			2000	1,563	13	10	13		1,563	31
32	Kitchen Sewer Line			2000	2,721	181	15	181		1,950	32
33	Kitchen Fire Suppression System			2002	8,823	588	15	588		5,146	33
34	Door Oxygen Room			2002	791	79	10	79		685	34
35	Garage Door & Sign			2003	2,171	217	10	217		1,664	35
36	Fire Protection/Water Heaters			2004	9,344	737	10 - 15	737		5,468	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: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Garbage Disposal	2004	$ 2,681	$ 268	10	$ 268	$	$ 1,742	37
38	Canopy	2005	5,575	372	15	372		2,354	38
39	Door Alarms	2005	2,544	255	10	255		1,592	39
40	Solarium	2006	31,589	790	40	790		3,685	40
41	Water Heater	2007	4,157	416	10	416		1,767	41
42	Air Conditioner	2007	5,621	562	10	562		2,295	42
43	Alarm System	2007	3,030	303	10	303		1,086	43
44	Patio Landscaping	2007	1,909	48	40	48		187	44
45	Ramp Remodel	2008	24,570	614	40	614		2,099	45
46	Flooring	2008	3,854	385	10	385		1,221	46
47	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		4,652	47
48	Water Heater	2008	3,867	387	10	387		1,192	48
49	Air Conditioner	2008	1,166	117	10	117		350	49
50	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		242	50
51	Fire Protection	2008	15,867	1,587	10	1,587		4,099	51
52	Carpet	2009	1,547	155	10	155		245	52
53	Freezer Door	2009	1,704	170	10	170		270	53
54	heating Unit	2009	1,495	149	10	149		224	54
55	12x24 Garage	2009	3,820	255	15	255		382	55
56	Heating Unit	2010	1,605	107	15	107		151	56
57	Heating Unit	2010	1,540	154	10	154		180	57
58	Heating Unit	2010	1,665	167	10	167		180	58
59	Evaporator fan coil, thermostat	2010	2,585	258	10	258		258	59
60	Carrier Air Handler, evaporator coil	2010	7,650	765	10	765		765	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)		$ 1,483,386	$ 39,546		$ 39,546	$	$ 1,070,931	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: 07/01/2010 Ending: 06/30/2011

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	$ 121,220	$ 12,694	$ 12,694	$	5-15	$ 47,063	71
72	Current Year Purchases	36,946	1,177	1,177		5-10	1,177	72
73	Fully Depreciated Assets	453,268	2,200	2,200		5-10	453,268	73
74								74
75	TOTALS	$ 611,434	$	$ 16,071	$		$ 501,508	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	2,128	79
80	TOTALS			$ 44,824	$ 1,216	$ 1,216	$		$ 40,872	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,185,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,762	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,833	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)	$ 1,613,311	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	A/L & Rental Bldg Improvements	$ 3,943,243	$ 99,859	$ 1,810,171	86
87	A/L & Rental Bldg Equipment	251,240	291	247,622	87
88					88
89	Land-Assisted Living & Rental	25,000			89
90					90
91	TOTALS	$ 4,219,483	$ 100,150	$ 2,057,793	91

G. Construction-in-Progress

	Description	Cost	
92	Building Improvements	$ 235,081	92
93			93
94			94
95		$ 235,081	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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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	N/A		$	$	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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	4,150	$ 78,133	$ 257	4,150	$ 78,390	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,131	23,550		1,131	23,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		4,429	83,565		4,429	83,565	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				40,561		40,561	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Rays	39,3				7,954			7,954	12
13	Other (specify):									13
14	TOTAL			$	9,710	$ 193,202	$ 40,818	9,710	$ 234,020	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 # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (37,790)	$	1
2	Cash-Patient Deposits	235		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,500)	132,777		3
4	Supply Inventory (priced at Cost)	20,133		4
5	Short-Term Investments	96,619		5
6	Prepaid Insurance	28,647		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)**	$ 240,621	$	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	5,626,320		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	925,296		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges	(3,671,105)		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 Bond Fees	23,415		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,991,902	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,232,523	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 124,614	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	235		28
29	Short-Term Notes Payable	394,075		29
30	Accrued Salaries Payable	66,766		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	Payroll Taxes & Garnishments	9,117		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 594,807	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,426,883		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)**	$ 1,426,883	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,021,690	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,210,833	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,232,523	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,230,503	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,230,503	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(19,670)	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)**	$ (19,670)	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)**	$ 1,210,833	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,662,019	1
2	Discounts and Allowances for all Levels	(143,616)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,518,403	3
	B. Ancillary Revenue		
4	Day Care	9,330	4
5	Other Care for Outpatients		5
6	Therapy	215,338	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 224,668	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	8,774	13
14	Non-Patient Meals	177	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,400	16
17	Sale of Drugs	32,981	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	21,709	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 172,041	23
	D. Non-Operating Revenue		
24	Contributions	57,693	24
25	Interest and Other Investment Income***	1,965	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,658	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	2,067	27
28	Miscellaneous	22,326	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,393	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,999,163	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	636,609	31
32	Health Care	1,310,560	32
33	General Administration	478,699	33
	B. Capital Expense		
34	Ownership	169,478	34
	C. Ancillary Expense		
35	Special Cost Centers	387,450	35
36	Provider Participation Fee	36,037	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,018,833	40
41	**Income before Income Taxes (line 30 minus line 40)****	(19,670)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (19,670)	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: 07/01/2010 Ending: 06/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,701	2,162	$ 53,711	$ 24.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,226	2,371	49,679	20.95	3
4	Licensed Practical Nurses	18,101	19,421	336,201	17.31	4
5	CNAs & Orderlies	41,452	44,286	467,524	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,602	6,560	82,223	12.53	9
10	Activity Assistants					10
11	Social Service Workers	3,737	4,009	40,049	9.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,514	17,650	153,241	8.68	15
16	Dishwashers					16
17	Maintenance Workers	4,050	4,475	77,201	17.25	17
18	Housekeepers	9,490	10,106	84,829	8.39	18
19	Laundry	1,916	1,999	16,849	8.43	19
20	Administrator	2,340	2,903	72,917	25.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,784	3,137	40,107	12.79	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	2,613	2,901	31,549	10.88	31
32	Other Health Care(specify)					32
33	Other(specify) Assisted Living	10,430	12,255	144,316	11.78	33
34	TOTAL (lines 1 - 33)	122,956	134,235	$ 1,650,396 *	$ 12.29	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	150	$ 5,233	1,3	35
36	Medical Director	Contract	4,000	9,3	36
37	Medical Records Consultant	16	895	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,259	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	11	656	11,3	44
45	Social Service Consultant	10	655	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	187	$ 15,698		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

** See instructions.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marcia Haslett	Administrator	0	$ 18,639
Susan Tudor	Administrator	0	54,278
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,917

B. Administrative - Other

Description	Amount
None	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Clerk of the Circuit Court of Madiso	Legal Fees	$ 40
C.J. Schlosser & Co., LLC	Accounting	19,941
Taliana, Rubin & Buckley	Legal Fees-Collections	807
Scheffel & Company, P.C.	Accounting	1,067
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,855

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,063
Unemployment Compensation Insurance	10,240
FICA Taxes	114,371
Employee Health Insurance	10,970
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contributions	11,991
Employee Relations Expense	98
Employee Uniforms	731
TOTAL (agree to Schedule V, line 22, col.8)	$ 190,464

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,710
Health Care Worker Background Check (Indicate # of checks performed 80)	1,260
Patient Background Checks	
Dues & Subscriptions	5,483
Licenses & Fees	4,474
Bank Service Charges	3,638
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,560

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	902
Less: Allocation to Assisted Living	(106)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 796

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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 # 0032979 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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. **LSN $1,832, AAHSA $1,183, $CHHSM $2,588**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **19,497** 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 fo
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 Departmen
during this cost report period. $ **36,037**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **177**

(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 fo
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 othe
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
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

HITZ MEMORIAL HIME
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2011

DESCRIPTION	LINE #	W/P REF	INCREASE (DECREASE)
ACTIVITIES	11	18B	656
SOCIAL SERVICES	12	18B	(656)

To reclass activities consultant expense to the proper line.

DIETARY	1	5C	(37,670)
FOOD PURCHASE	2	5C	(16,766)
HOUSEKEEPING	3	5C	(19,889)
LAUNDRY	4	5C	(4,334)
HEAT & OTHER UTILITIES	5	5C	(1,481)
MAINTENANCE	6	5C	(29,168)
OTHER GENERAL SERVICES	7	5C	(2,450)
ACTIVITES	11	5C	(18,574)
ADMINISTRATIVE	17	5C	(8,443)
PROFESSIONAL FEES	19	5C	(2,413)
DUES, FEES, SUBS & PROMOS	20	5C	(889)
CLERICAL & GENERAL OFFICE	21	5C	(6,899)
EMPLOYEE BENEFITS & PAYROLL TAXES	22	5C	8,296
INSERVICE TRAINING & EDUCATION	23	5C	(89)
TRAVEL & SEMINAR	24	5C	(106)
INSURANCE-PROP., LIAB., MALPRACTICE	26	5C	2,432
INTEREST	32	5C	(66,370)
OTHER SPECIAL COST CENTERS (ASST. LIVING)	43	5C	204,813

To correct allocation expenses to the Asst. Living facility

HITZ MEMORIAL HOME
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2011

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.

Ronald Mindrup
Lillian Daiber
Shirley Carroll
Janet Blair
Rich Akins
Carol Amiri
Rev. Jerry Amiri
Linda Diesen
Carol Hess
Leonard Luckett
Sterling Schoen
Richard Ullman

HITZ MEMORIAL HOME
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2011

Copy Records-State of Illinois	20	offset ln 21
Candles (total received $708. $213 is the profit in donations above)	495	offset ln 17 (expense for the candles is in Misc. Exp)
Rebate-McKesson	470	Total =
Rebate-Med Assets	33	503 offset to ln 10
Refund-RSL Health Ins.	160	
Refund-Overpayment from Pension Boards (EE Pension)	119	Total =
Refund-NHRMA (workers comp)	12,953	13,409 offset to ln 22
Refund-2010 Form 941	178	
EE Purchases (Per Kathy, EE's buy various supplies periodically)	785	offset to ln 10
EE Purchases (Per Kathy, EE's buy various supplies periodically)	270	offset to ln 17 (this is the amt of EE Purchases exp. in the Misc. Exp. Acct grouped on ln 17
Transportation Revenue	65	Total =
Transportation Revenue-a/c#4850	2,570	2,635 offset to ln 14
Reimbursements from Residents (for various items)	593	offset to ln 17 (expense in Misc. Exp)
Renovation Sale (total received $945. $546 is the profit in donations abov	399	offset to ln 17 (expense in Misc. Exp)
Vending	1,329	no cost to offset
Sale of Old T.V.	30	
Recycled Cans	14	
Payroll Misposts reclassed here	523	
Recycled Scrap Metal cashed in	61	
Application Fees -a/c#4780	400	
Garnishment Fees-a/c#4965	149	
Forfeited deposits on A/L apartments	400	
Hospice adjustment from 2010	310	
	22,326	