FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0032979

Facility Name: Hitz Memorial Home

Address: 201 Belle St 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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy Tefteller, 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 7/1/16 to 6/30/17 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 Preparation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 E. 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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	2,800	5,498	1,636	9,934	8
9	SNF/PED					9
10	ICF	4,031	1,601	559	6,191	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,831	7,099	2,195	16,125	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.94%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 [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 1,636

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A (Church) Fiscal Year: 6/30/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	159,767	14,420	5,870	180,057		180,057		180,057			1
2	Food Purchase		94,312		94,312		94,312		94,312			2
3	Housekeeping	70,414	9,647		80,061		80,061		80,061			3
4	Laundry	43,971	4,801		48,772		48,772		48,772			4
5	Heat and Other Utilities			66,466	66,466		66,466	(4,521)	61,945			5
6	Maintenance	32,322	8,059	57,084	97,465		97,465		97,465			6
7	Other (specify):* Med Waste/Trash Removal & Security			7,499	7,499		7,499		7,499			7
8	TOTAL General Services	306,474	131,239	136,919	574,632		574,632	(4,521)	570,111			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,157,239	60,332	8,713	1,226,284		1,226,284		1,226,284			10
10a	Therapy											10a
11	Activities	46,712	4,451		51,163	485	51,648		51,648			11
12	Social Services	57,486	346	970	58,802	(485)	58,317		58,317			12
13	CNA Training											13
14	Program Transportation		5,209		5,209		5,209	(1,060)	4,149			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,261,437	70,338	18,683	1,350,458		1,350,458	(1,060)	1,349,398			16
	C. General Administration											
17	Administrative	70,361	223		70,584		70,584		70,584			17
18	Directors Fees											18
19	Professional Services			26,442	26,442		26,442	(300)	26,142			19
20	Dues, Fees, Subscriptions & Promotions			41,855	41,855		41,855	(23,868)	17,987			20
21	Clerical & General Office Expenses	52,217	15,045	37,320	104,582		104,582		104,582			21
22	Employee Benefits & Payroll Taxes			242,047	242,047		242,047		242,047			22
23	Inservice Training & Education			253	253		253		253			23
24	Travel and Seminar			2,263	2,263		2,263		2,263			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,228	79,228		79,228		79,228			26
27	Other (specify):*											27
28	TOTAL General Administration	122,578	15,268	429,408	567,254		567,254	(24,168)	543,086			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,690,489	216,845	585,010	2,492,344		2,492,344	(29,749)	2,462,595			29

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

SEE ACCOUNTANTS' PREPARATION 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: 7/1/16 Ending: 6/30/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			158,344	158,344	(22,029)	136,315	(9,243)	127,072			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,002	70,002		70,002	(20,695)	49,307			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			228,346	228,346	(22,029)	206,317	(29,938)	176,379			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,941	205,241	246,182		246,182		246,182			39
40	Barber and Beauty Shops			8,694	8,694		8,694		8,694			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,297	127,297		127,297		127,297			42
43	Other (specify):* Independent Senior Apartments			88,656	88,656	22,029	110,685		110,685			43
44	**TOTAL Special Cost Centers**		40,941	429,888	470,829	22,029	492,858		492,858			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,690,489	257,786	1,243,244	3,191,519		3,191,519	(59,687)	3,131,832			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Reference	3 BHF USE ONLY	
1	Day Care	$ (300)	19	$	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	(4,521)	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	(125)	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	(20,570)	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	(15,119)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,328)	20		28
29	Other-Attach Schedule	(17,724)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,687)		$	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))**	$ (59,687)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Hitz Memorial Home

ID# 0032979

Report Period Beginning: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset income for transportation	$ (1,060)	14	1
2	Add back half of 2 yr IDPH licenses purchased in 2016	1,990	20	2
3	Eliminate depreciation on capital cost adjustments	(9,243)	30	3
4	Eliminate non-care related collection fees	(8,666)	20	4
5	Eliminate non-allowable fines and penalties	(745)	20	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
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**	(17,724)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	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	(4,521)	0	0	0	0	0	0	0	0	0	0	(4,521)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,521)	0	0	0	0	0	0	0	0	0	0	(4,521)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	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	(300)	0	0	0	0	0	0	0	0	0	0	(300)	19
20	Fees, Subscriptions & Promotions	(23,868)	0	0	0	0	0	0	0	0	0	0	(23,868)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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**	(24,168)	0	0	0	0	0	0	0	0	0	0	(24,168)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,749)	0	0	0	0	0	0	0	0	0	0	(29,749)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home # 0032979 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,243)	0	0	0	0	0	0	0	0	0	0	(9,243)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,695)	0	0	0	0	0	0	0	0	0	0	(20,695)	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**	(29,938)	0	0	0	0	0	0	0	0	0	0	(29,938)	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)**	(59,687)	0	0	0	0	0	0	0	0	0	0	(59,687)	45

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	100					
United Church of Christ						
See attached listing for memebers 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 [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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	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								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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	Bank of Edwardsville		X	Nsg Facility Mortgage-62.57%	$4,749.00	8/17/12	$ 853,381	$ 752,920	8/17/37	4.5000	$ 34,386	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	11/5/16	500,000	345,016	11/5/17		13,345	6
7												7
8												8
9	TOTAL Facility Related				$4,749.00		$ 1,353,381	$ 1,097,936			$ 49,432	9
	B. Non-Facility Related*											
10	Bank of Ewardsville		X	Nsg Facility Mortgage-37.43%	$2,841.00	8/17/12	510,501	450,405	8/17/37	4.5000	20,570	10
11								Eliminate non-care related interest			(20,570)	11
12								Offset Interest Income			(125)	12
13												13
14	TOTAL Non-Facility Related				$2,841.00		$ 510,501	$ 450,405			$ (125)	14
15	TOTALS (line 9+line14)						$ 1,863,882	$ 1,548,341			$ 49,307	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' PREPARATION 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: 7/1/16 Ending: 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:		
	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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' PREPARATION REPORT

2016 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 7/1/16 Ending: 6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,681 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.

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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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				1970	$ 176,881	$	40	$	$	$ 176,881	4
5				1975	418,286		40			418,286	5
6				1991	1,436,697	35,917	40	35,917		950,481	6
7											7
8											8
	Improvement Type**										
9	Improvements			1971	19,945		40			19,945	9
10	Improvements			1972	90		10			90	10
11	Improvements			1974	23,177		40			23,177	11
12	Improvements			1976	81,417		40			81,417	12
13	Improvements			1977	6,650	97	40	97		6,650	13
14	Improvements			1979	3,000	75	40	75		2,856	14
15	Improvements & Garage			1980	15,638	391	40	391		14,498	15
16	Improvements			1982	2,416	60	40	60		2,119	16
17	Roof & Improvements			1983	138,325	3,458	40	3,458		117,865	17
18	Roof & Improvements			1984	143,005	3,575	40	3,575		118,575	18
19	Dining Room			1985	28,447	711	40	711		22,995	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		9,109	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		5,818	21
22	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		47,057	22
23	Remodeling & New Garage			1990	29,672	916	30-40	916		24,737	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	34,886	497	10-40	497		27,176	24
25	Sprinkler System/Water Heaters			1994	7,729		10-15			7,729	25
26	Roof Repair			1997	22,000	550	40	550		11,000	26
27	Air Conditioner			1998	5,439	136	40	136		2,595	27
28	Tank Replacement			1999	14,313	716	20	716		13,061	28
29	Air Conditioner			1999	3,280	164	20	164		2,979	29
30	Door Alarm			1999	1,164		10			1,164	30
31	Door Alarm			2000	1,563		10			1,563	31
32	Kitchen Sewer Line			2000	2,721		15			2,721	32
33	Kitchen Fire Suppression System			2002	8,823	588	15	588		8,675	33
34	Door Oxygen Room			2002	791		10			791	34
35	Garage Door & Sign			2003	2,171		10			2,171	35
36	Fire Protection/Water Heaters			2004	9,344	395	10-15	395		8,750	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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	Canopy	2005	$ 5,575	$ 372	15	$ 372	$	$ 4,584	37
38	Door Alarms	2005	2,547		10			2,547	38
39	Solarium	2006	31,589	790	40	790		8,424	39
40	Water Heater	2007	4,157	312	10	312		4,157	40
41	Air Conditioner	2007	5,621	515	10	515		5,621	41
42	Alarm System	2007	3,030	303	10	303		2,904	42
43	Patio Landscaping	2007	1,909	48	40	48		473	43
44	Ramp Remodel	2008	24,570	614	40	614		5,784	44
45	Flooring	2008	3,854	385	10	385		3,533	45
46	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		13,703	46
47	Water Heater	2008	3,867	387	10	387		3,513	47
48	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		714	48
49	Fire Protection	2009	15,867	1,587	10	1,587		13,619	49
50	12x24 Garage	2009	3,820	255	15	255		1,910	50
51	Heating Unit	2010	1,605	107	15	107		794	51
52	Heating Unit	2010	1,540	154	10	154		1,104	52
53	Heating Unit	2010	1,665	166	10	166		1,179	53
54	Evaporator fan coil, thermostat	2010	2,585	258	10	258		1,809	54
55	Carrier Air Handler, evaporator coil	2010	7,650	765	10	765		5,355	55
56	Install 3 Pan Sink w/drains, plumbing & cabinets	2011	5,941	297	20	297		1,733	56
57	Architecture & Design Fees for wing remodel-SNF suite wing	2011	16,427	657	25	657		3,833	57
58	Contractor's Materials & Labor Cost-SNF suite wing	2011	500	20	25	20		117	58
59	Flooring materials & labor for wing remodel-SNF suite wing	2011	8,439	422	20	422		2,461	59
60	Door Alarms & Wanderguard system-SNF suite wing	2011	9,248	472	15	472		2,751	60
61	Water Heater mixer valve replaced & installed	2011	4,800	480	10	480		2,800	61
62	A/C Unit for Dietary	2012	4,334	867	5	867		4,334	62
63	A/C Unit for Dietary	2012	738	111	5	111		738	63
64	Water Heater mixer valve replaced & installed	2001	3,074		15			3,074	64
65	Boiler	2001	10,629	531	20	531		8,415	65
66	Sprinkler System	2008	7,520	188	40	188		1,692	66
67	Landscaping	1991	1,755	44	40	44		1,155	67
68	Exterior Lights & Sign	1992	2,911		10			2,911	68
69	New Carpet & Installation	2012	3,675	735	5	735		3,368	69
70	TOTAL (lines 4 thru 69)		$ 2,989,937	$ 63,855		$ 63,855	$	$ 2,254,040	70

SEE ACCOUNTANTS' PREPARATION 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: 7/1/16 Ending: 6/30/17

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	
1	Totals from Page 12A, Carried Forward		$ 2,989,937	$ 63,855		$ 63,855	$	$ 2,254,040	1
2	11 A/C Units	2012	11,703	2,156	15	2,156		9,725	2
3	Nurse Station 2 Compressors	2013	2,196	146	15	146		586	3
4	Alarm Door switches,relay, panel,keypad	2013	2,325	232	10	232		872	4
5	Generator- Emergency set	2014	22,450	1,122	20	1,122		3,648	5
6	6 A/C/Heat Units	2014	5,949	1,190	5	1,190		4,107	6
7	5 A/C/Heat Units	2015	3,918	784	5	784		1,948	7
8	Landscaping - North & West Side of Facility	2015	9,820	982	10	982		2,427	8
9	Furnace & AC - Dining Room	2015	7,580	1,516	5	1,516		2,779	9
10	Asco transfer switch	2015	3,400	340	10	340		595	10
11	5 PTAC Units	2015	5,471	1,094	5	1,094		1,737	11
12	Gas Water Heater, 75 Gal	2015	4,116	412	10	412		720	12
13	Flooring	2016	571	57	10	57		71	13
14	Carport	2016	3,942	197	20	197		230	14
15	Alarm keypad, multi ray unit, door switch	2016	757	76	10	76		114	15
16	First Q System - Wanderguard	2016	1,672	167	10	167		195	16
17	Main piping, couplings in residential hallway	2016	1,082	72	15	72		78	17
18	Water Heater	2016	8,400	840	10	840		840	18
19	Smoking Starter Shelter, 4x8	2016	2,172	109	20	109		109	19
20	3 PTAC Units	2016	2,388	319	5	319		319	20
21	Thermostatic Mixing Valves/Plumbing	2016	1,241	114	10	114		114	21
22	Water Pump in Generator	2016	754	63	10	63		63	22
23	New Sidewalk	2016	1,050	35	25	35		35	23
24	Firewall Laundry to Drs. Office	2016	5,253	131	30	131		131	24
25	Kitchen valves/waterlines	2016	517	39	10	39		39	25
26	Pipe in Dry System	2016	1,893	126	10	126		126	26
27	Panels for Fire Protection	2016	2,388	159	10	159		159	27
28	Block Heater	2016	916	53	10	53		53	28
29	Commercial Garbage Disposal	2016	1,384	69	10	69		69	29
30	Water Heater	2017	1,512	63	10	63		63	30
31	Pipes/Fitting Wet System	2017	1,372	46	10	46		46	31
32	Carpet	2017	2,553	128	5	128		128	32
33	AC/Gas Furnace	2017	7,315	81	15	81		81	33
34	TOTAL (lines 1 thru 33)		$ 3,117,997	$ 76,773		$ 76,773	$	$ 2,286,247	34

SEE ACCOUNTANTS' PREPARATION 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: 7/1/16 Ending: 6/30/17

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	
1	Totals from Page 12B, Carried Forward		$ 3,117,997	$ 76,773		$ 76,773	$	$ 2,286,247	1
2	Gutters/Downspouts	2017	3,020		10				2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,121,017	$ 76,773		$ 76,773	$	$ 2,286,247	34

SEE ACCOUNTANTS' PREPARATION 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: 7/1/16 Ending: 6/30/17

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	$ 327,180	$ 40,930	$ 40,930	$	5-40	$ 205,048	71
72	Current Year Purchases	26,083	2,456	2,456		5-15	2,456	72
73	Fully Depreciated Assets	591,842	1,913	1,913		5-10	591,842	73
74								74
75	TOTALS	$ 945,105	$ 45,299	$ 45,299	$		$ 799,346	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 Wagon/Lift	2000	$ 31,860	$	$	$	5	$ 31,860	76
77	Resident Transportation	Dodge Top/Rear Door Additions	2003	6,884				5	6,884	77
78	Resident Transportation	2005 Chevy Turtle Top Van	2015	25,000	5,000	5,000		5	8,333	78
79										79
80	TOTALS			$ 63,744	$ 5,000	$ 5,000	$		$ 47,077	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)	$ 4,175,250	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,072	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)	$ 3,132,670	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.	$ 2,787,385	$ 70,767	$ 1,445,530	86
87	ISL & Rental Building Equipment	19,507	1,235	2,424	87
88					88
89	Land-ISL & Rental Bldg	25,000			89
90					90
91	TOTALS	$ 2,831,892	$ 72,002	$ 1,447,954	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home

STATE OF ILLINOIS
0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	1	2	3	4	5	6	7	8	
	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				40,756		40,756	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See attached schedule				12,039	205,241	185	12,039	205,426	13
14	TOTAL			$	12,039	$ 205,241	$ 40,941	12,039	$ 246,182	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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home **#** 0032979 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/17 **(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	$ (15,159)	$	1
2	Cash-Patient Deposits	4,077		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	954,245		3
4	Supply Inventory (priced at)	12,301		4
5	Short-Term Investments	18,810		5
6	Prepaid Insurance	36,473		6
7	Other Prepaid Expenses	1,373		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,012,120	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,834		13
14	Buildings, at Historical Cost	6,088,816		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,028,355		16
17	Accumulated Depreciation (book methods)	(4,639,978)		17
18	Deferred Charges	(2,640)		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): MPIC Capital Investment	5,350		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,578,737	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,590,857	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 36,240	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,974		28
29	Short-Term Notes Payable	345,015		29
30	Accrued Salaries Payable	91,500		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,409		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	Provider Taxes & EE Garnishments	13,161		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 499,299	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,203,042		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)**	$ 1,203,042	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,702,341	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,888,516	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,590,857	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,037,150	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,037,150	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(148,634)	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)**	$ (148,634)	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)**	$ 1,888,516	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,156,262	1
2	Discounts and Allowances for all Levels	(681,089)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,475,173	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,787	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 402,787	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	8,588	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,724	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,838	23
	D. Non-Operating Revenue		
24	Contributions	42,194	24
25	Interest and Other Investment Income***	125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42,319	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	4,656	28
28a	Rent-Independent Living	57,112	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,768	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,042,885	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	574,632	31
32	Health Care	1,350,458	32
33	General Administration	567,254	33
	B. Capital Expense		
34	Ownership	228,346	34
	C. Ancillary Expense		
35	Special Cost Centers	246,182	35
36	Provider Participation Fee	127,297	36
	D. Other Expenses (specify):		
37	Barber & Beauty Shop	8,694	37
38	Independent Senior Apartments	88,656	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,191,519	40
41	**Income before Income Taxes (line 30 minus line 40)****	(148,634)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (148,634)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,032,043	44
45	Private Pay - Net Inpatient Revenue	1,206,261	45
46	Medicare - Net Inpatient Revenue	823,980	46
47	Other-(specify) Hospice	93,978	47
48	Other-(specify) Discounts and Allowances	(681,089)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,475,173	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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	2,268	2,445	$ 59,119	$ 24.18	1
2	Assistant Director of Nursing	1,828	2,110	50,250	23.82	2
3	Registered Nurses	2,826	2,972	82,851	27.88	3
4	Licensed Practical Nurses	16,640	17,561	312,566	17.80	4
5	CNAs & Orderlies	46,722	49,140	619,752	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,750	4,049	46,712	11.54	9
10	Activity Assistants					10
11	Social Service Workers	4,668	5,218	57,486	11.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,096	14,875	159,767	10.74	15
16	Dishwashers					16
17	Maintenance Workers	2,044	2,274	32,322	14.21	17
18	Housekeepers	8,078	8,312	70,414	8.47	18
19	Laundry	4,234	4,496	43,971	9.78	19
20	Administrator	1,771	2,619	70,361	26.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,263	3,763	52,217	13.88	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	1,853	2,100	32,701	15.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,041	121,934	$ 1,690,489 *	$ 13.86	34

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

** See instructions.

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	141	$ 5,870	1,3	35
36	Medical Director	Contract	9,000	9,3	36
37	Medical Records Consultant	16	1,016	10,3	37
38	Nurse Consultant	Contract	3,480	10,3	38
39	Pharmacist Consultant	Contract	4,218	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	8	485	11,3	44
45	Social Service Consultant	8	485	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	$ 24,554		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' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Tudor	Administrator	0	$ 70,361
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,361

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co., LLC	Accounting	$ 26,400
Taliana, Buckley, Asa & Reames	Legal Fees	300
Taliana, Buckley, Asa & Reames	Legal Fees	(268)
Taliana, Buckley, Asa & Reames	Legal Fees	10
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 26,442

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,482
Unemployment Compensation Insurance	28,167
FICA Taxes	125,687
Employee Health Insurance	42,360
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contributions	6,381
Employee Uniforms	4,986
Employee Recognition	1,984
TOTAL (agree to Schedule V, line 22, col.8)	$ 242,047

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,879
Health Care Worker Background Check	1,339
(Indicate # of checks performed 84)	
Patient Background Checks	
Dues & Subscriptions	7,051
Licenses & Fees	657
Bank Service Charges	4,071
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,987

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,263

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 Services Network (LSN) - $3,726**

(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. $ **19,716** 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. $ **127,297**
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' PREPARATION REPORT

(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 benefits 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

HITZ MEMORIAL HOME
INDEPENDENT SENIOR LIVING
ATTACHMENT TO SCHEDULE XX, PAGE 22, #14
6/30/2017

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
Legal Fee Summary
Attachment to Schedule XIX
6/30/2017

Law Firm	Invoice Date	Description of Services	Allowable Amount	Non-Allowable Amount
Taliana, Buckley, Asa & Reames	7/1/2016	Estate claim filing	10.00	
Taliana, Buckley, Asa & Reames	10/20/2016	Refund of Legal fees - Trust Donation	(268.00)	
Taliana, Buckley, Asa & Reames	11/29/2016	Daycare legal fees	-	300.00
			(258.00)	300.00

HITZ MEMORIAL HOME
ADJUSTMENTS
ATTACHMENT TO SCHEDULE 6
6/30/2017

DESCRIPTION	LINE #	W/P Ref	INCREASE (DECREASE)
INTEREST	32	17 A	(125)
To offset interest income against related expense			
PROGRAM TRANSPORTATON	14	17 B	(1,060)
To offset misc. income rebates/refunds & reimbursments against the related expense accounts			
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	5 A	(15,119)
To eliminate promotional advertising			
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	5 A	(1,328)
To eliminate yellow page ads			
PROFESSIONAL SERVICES	19	19 C	(300)
To eliminate Daycare Legal Fees			
HEAT & OTHER UTILITIES	5	5A	(4,521)
To eliminate Cable T.V.			
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	19Fp2	1,990
Add back half of 2 year IDPH license			
Other - Assisted Living/Stand By Area	32	9p1	(20,570)
To eliminate non-care related interest			
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	5A	(8,666)
To eliminate non-care related collection fees			
PROFESSIONAL SERVICES	20	5A	(745)
To eliminate non-allowable fines & penalties			
DEPRECIATION	30	11Ap2	(9,243)
Eliminate depreciation on capital cost adjustments			
			(59,687)

HITZ MEMORIAL HIME
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2017

DESCRIPTION	LINE #	W/P REF	INCREASE (DECREASE)
ACTIVITIES	11	18B	485
SOCIAL SERVICES	12	18B	(485)

To reclass activities consultant expense to the proper line.

DEPRECIATION	30	11Ap5	(22,029)
OTHER - STAND BY AREA	43	11Ap5	22,029

To reclass ISL depreciation expense allocation.

HITZ MEMORIAL HOME
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2017

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.

Eric L. Augustin
Faye Brown
Christy Eckert
Patty Frank
Mary Klaustermeier
Leonard Luckett
Paco Newman
Dale Noble
Carol Reckman
Allen Schmidt
Jim Schmidt
Rosemary Schultze

Hitz Memorial Home

Attachment to Schedule XIV

6/30/2017

		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			5,102	81,964	185	5,102	82,149
	Licensed Speech Therapist	39,3			1,453	27,342		1,453	27,342
	Licensed Physical Therapist	39,3			5,484	88,974		5,484	88,974
	Laboratory & X-Rays	39,3				6,961		-	6,961
	Total to Schedule XIV, Line 12		-	-	12,039	205,241	185	12,039	205,426

HITZ MEMORIAL HOME
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2017

Transportation Revenue-a/c 40515	1,060	offset to ln 14
Miscellaneous	25	
Resident Refunds	390	
Fundraisers	1,269	
Restitution	1,912	
	4,656	