		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code ______
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ______
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other ______

In the event there are further questions about this report, please contact:
Name: Cindy Tefteller, C.J. Schlosser & Co., LL(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 7/1/19 to 6/30/20 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)	MaKenzie Wilson
	(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.
	(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: 7/1/19 Ending: 6/30/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,078	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,522	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,409	5,934	1,966	9,309	8
9	SNF/PED					9
10	ICF	3,158	2,958	1,180	7,296	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,567	8,892	3,146	16,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.71%

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 1,966

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A (Church) Fiscal Year: 6/30/20

* 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: 7/1/19** **Ending: 6/30/20**

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	227,342	20,568	5,910	253,820		253,820		253,820			1
2	Food Purchase		104,399		104,399		104,399		104,399			2
3	Housekeeping	108,704	10,909		119,613		119,613		119,613			3
4	Laundry	46,217	5,898		52,115		52,115		52,115			4
5	Heat and Other Utilities			73,640	73,640		73,640	(5,597)	68,043			5
6	Maintenance	31,732	592	78,401	110,725		110,725		110,725			6
7	Other (specify):* Med Waste/Trash Removal & Security			12,003	12,003		12,003		12,003			7
8	**TOTAL General Services**	413,995	142,366	169,954	726,315		726,315	(5,597)	720,718			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	1,280,072	71,022	6,424	1,357,518		1,357,518		1,357,518			10
10a	Therapy											10a
11	Activities	37,043	1,087		38,130	354	38,484		38,484			11
12	Social Services	36,147	801	708	37,656	(354)	37,302		37,302			12
13	CNA Training											13
14	Program Transportation		4,692		4,692		4,692	(4,030)	662			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,353,262	77,602	17,132	1,447,996		1,447,996	(4,030)	1,443,966			16
	C. General Administration											
17	Administrative	72,275			72,275		72,275		72,275			17
18	Directors Fees											18
19	Professional Services			37,442	37,442		37,442		37,442			19
20	Dues, Fees, Subscriptions & Promotions			33,629	33,629		33,629	(19,166)	14,463			20
21	Clerical & General Office Expenses	41,451	9,515	50,603	101,569		101,569		101,569			21
22	Employee Benefits & Payroll Taxes			268,549	268,549		268,549		268,549			22
23	Inservice Training & Education			5,986	5,986		5,986		5,986			23
24	Travel and Seminar			95	95		95		95			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,120	99,120		99,120		99,120			26
27	Other (specify):*											27
28	**TOTAL General Administration**	113,726	9,515	495,424	618,665		618,665	(19,166)	599,499			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,880,983	229,483	682,510	2,792,976		2,792,976	(28,793)	2,764,183			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: 7/1/19 Ending: 6/30/20

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			142,908	142,908	(21,625)	121,283	(8,745)	112,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,608	51,608		51,608	(18,846)	32,762			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			194,516	194,516	(21,625)	172,891	(27,591)	145,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,022	279,276	329,298		329,298		329,298			39
40	Barber and Beauty Shops			4,746	4,746		4,746		4,746			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,847	124,847		124,847		124,847			42
43	Other (specify):* Independent Senior Apartments			80,326	80,326	21,625	101,951		101,951			43
44	TOTAL Special Cost Centers		50,022	489,195	539,217	21,625	560,842		560,842			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,880,983	279,505	1,366,221	3,526,709		3,526,709	(56,384)	3,470,325			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: 7/1/19 Ending: 6/30/20

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	$		$	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	(5,597)	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				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	(18,846)	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	(1,430)	20		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	(15,746)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,765)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,384)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 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))**	$ (56,384)		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

BHF USE ONLY

48		49		50		51		52	

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Hitz Memorial Home

ID# 0032979

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset income for transportation	$ (4,030)	14	1
2	Eliminate 2020 IDPH fee paid in 2019	(1,990)	20	2
3	Eliminate depreciation on capital cost adjustments	(8,745)	30	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
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**	(14,765)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	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)	
	A. General Services													
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	(5,597)	0	0	0	0	0	0	0	0	0	0	(5,597)	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**	(5,597)	0	0	0	0	0	0	0	0	0	0	(5,597)	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	(4,030)	0	0	0	0	0	0	0	0	0	0	(4,030)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,030)	0	0	0	0	0	0	0	0	0	0	(4,030)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(19,166)	0	0	0	0	0	0	0	0	0	0	(19,166)	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**	(19,166)	0	0	0	0	0	0	0	0	0	0	(19,166)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,793)	0	0	0	0	0	0	0	0	0	0	(28,793)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(8,745)	0	0	0	0	0	0	0	0	0	0	(8,745)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,846)	0	0	0	0	0	0	0	0	0	0	(18,846)	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**	(27,591)	0	0	0	0	0	0	0	0	0	0	(27,591)	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)**	(56,384)	0	0	0	0	0	0	0	0	0	0	(56,384)	45

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 lising for members of the Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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: 7/1/19 Ending: 6/30/20

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
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16								16
17								17
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19								19
20								20
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26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 7/1/19 Ending: 6/30/20

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: 7/1/19 Ending: 6/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		X	Nsg Facility Mortgage - 62.57%	$4,749.00	8/17/12	$ 853,381	$ 684,623	8/17/37	4.5000	$ 31,503	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		X	Line of Credit	N/A	1/15/19	50,000		1/5/20		1,259	6
7												7
8												8
9	TOTAL Facility Related				$4,749.00		$ 903,381	$ 684,623			$ 32,762	9
	B. Non-Facility Related*											
10	Busey Bank		X	Nsg Facility Mortgage - 37.43%	$2,841.00	8/17/12	510,501	409,548	8/17/37	4.5000	18,846	10
11								Eliminate non-care related interest			(18,846)	11
12												12
13												13
14	TOTAL Non-Facility Related				$2,841.00		$ 510,501	$ 409,548			$	14
15	TOTALS (line 9+line14)						$ 1,413,882	$ 1,094,171			$ 32,762	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: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 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 2020 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:		Line
2015		8
2016		9
2017		10
2018		11
2019		12

Line	FOR BHF USE ONLY		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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

2019 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 ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 7/1/19 Ending: 6/30/20

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.
Rental Space, 5,726 sq. ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	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: 7/1/19 Ending: 6/30/20

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		1,058,234	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		40			6,650	13
14	Improvements			1979	3,000		40			3,000	14
15	Improvements & Garage			1980	15,638	358	40	358		15,638	15
16	Improvements			1982	2,416	60	40	60		2,300	16
17	Roof & Improvements			1983	138,325	3,458	40	3,458		128,239	17
18	Roof & Improvements			1984	143,005	3,575	40	3,575		129,301	18
19	Dining Room			1985	28,447	711	40	711		25,128	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		10,018	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		6,418	21
22	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		52,084	22
23	Remodeling & New Garage			1990	29,672	916	30-40	916		27,485	23
24	Remodeling/Furnace/Control Temps Architect Fees			1993	27,992	497	10-40	497		21,775	24
25	Sprinkler System/Water Heaters			1994	6,896		10-15			6,896	25
26	Roof Repair			1997	22,000	550	40	550		12,650	26
27	Air Conditioner			1998	5,439	136	40	136		3,003	27
28	Tank Replacement			1999	14,313		20			14,313	28
29	Air Conditioner			1999	3,280		20			3,280	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		15			8,823	33
34	Door Oxygen Room			2002	791		10			791	34
35	Garage Door & Sign			2003	1,691		10			1,691	35
36	Fire Protection/Water Heaters			2004	9,344		10-15			9,344	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: 7/1/19 Ending: 6/30/20

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	$ 248	15	$ 248	$	$ 5,575	37
38	Door Alarms	2005	2,547		10			2,547	38
39	Solarium	2006	31,589	790	40	790		10,793	39
40	Water Heater	2007	4,157		10			4,157	40
41	Air Conditioner	2007	5,621		10			5,621	41
42	Alarm System	2007	3,030		10			3,030	42
43	Patio Landscaping	2007	1,909	48	40	48		616	43
44	Ramp Remodel	2008	24,570	614	40	614		7,627	44
45	Flooring	2008	3,854		10			3,854	45
46	Nursing Station Remodel	2008	60,345	1,508	40	1,508		18,229	46
47	Water Heater	2008	3,867		10			3,867	47
48	Architect Fees - Nurses Station Remodeling	2008	3,142	78	40	78		949	48
49	Fire Protection	2009	15,867		10			15,867	49
50	12x24 Garage	2009	3,820	255	15	255		2,674	50
51	Heating Unit	2010	1,605	107	15	107		1,115	51
52	Heating Unit	2010	1,540	128	10	128		1,540	52
53	Heating Unit	2010	1,665	153	10	153		1,665	53
54	Evaporator fan coil, thermostat	2010	2,585	259	10	259		2,585	54
55	Carrier Air Handler, evaporator coil	2010	7,650	765	10	765		7,650	55
56	Install 3 Pan Sink w/ drains, plumbing & cabinets	2011	5,941	297	20	297		2,624	56
57	Architect & Design Fees for wing remodel - SNF suite wing	2011	16,427	657	25	657		5,804	57
58	Contractor's Materials & Labor Cost - SNF suite wing	2011	500	20	25	20		177	58
59	Flooring materials & labor for wing remodel - SNF quite wing	2011	8,439	422	20	422		3,727	59
60	Door Alarms & Wanderguard system - SNF suite wing	2011	9,248	472	15	472		4,165	60
61	Water Heater mixer valve replaced & installed	2011	4,800	480	10	480		4,240	61
62	A/C Unit for Dietary	2012	4,334		5			4,334	62
63	A/C Unit for Dietary	2012	738		5			738	63
64	Water Heater mixer valve replaced & installed	2001	3,074		15			3,074	64
65	Boiler	2001	10,629	531	20	531		10,009	65
66	Sprinkler System	2008	7,520	188	40	188		2,256	66
67	Landscaping	1991	1,755	44	40	44		1,287	67
68	Exterior Lights & Sign	1992	2,911		10			2,911	68
69	New Carpet & Installation	2012	3,675		5			3,675	69
70	TOTAL (lines 4 thru 69)		$ 2,981,730	$ 56,421		$ 56,421	$	$ 2,421,287	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: 7/1/19 Ending: 6/30/20

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		$ 2,981,730	$ 56,421		$ 56,421	$	$ 2,421,287	1
2	11 A/C Units	2012	11,703	93	15	93		10,994	2
3	Nurse Station 2 Compressors	2013	2,196	146	15	146		1,025	3
4	Alarm Door switches, relay, panel, keypad	2013	2,325	233	10	233		1,569	4
5	Generator - Emergency set	2014	22,450	1,122	20	1,122		7,016	5
6	6 A/C/Heat Units	2014	5,949		5			5,949	6
7	5 A/C/Heat Units	2015	3,918	404	5	404		3,918	7
8	Landscaping - North & West Side of Facility	2015	9,820	982	10	982		5,373	8
9	Furnace & AC - Dining Room	2015	7,580	1,516	5	1,516		7,327	9
10	Asco transfer switch	2015	3,400	340	10	340		1,615	10
11	5 PTAC Units	2015	5,471	1,094	5	1,094		5,020	11
12	Gas Water Heater, 75 Gal	2015	4,116	412	10	412		1,955	12
13	Flooring	2016	571	57	10	57		243	13
14	Carport	2016	3,942	197	20	197		821	14
15	Alarm keypad, multi ray unit, door switch	2016	757	76	10	76		341	15
16	First Q System - Wangerguard	2016	1,672	167	10	167		697	16
17	Main piping, couplings in residential hallway	2016	1,082	72	15	72		294	17
18	Water Heater	2016	8,400	840	10	840		3,360	18
19	Smoking Starter Shelter, 4x8	2016	2,172	109	20	109		434	19
20	3 PTAC Units	2016	2,388	478	5	478		1,751	20
21	Thermostatic Mixing Valves/Plumbing	2016	1,241	124	10	124		486	21
22	Water Pump in Generator	2016	754	75	10	75		289	22
23	New Sidewalk	2016	1,050	42	25	42		161	23
24	Firewall Laundry to Drs. Office	2016	5,253	175	30	175		657	24
25	Kitchen valves/waterlines	2016	517	52	10	52		194	25
26	Pipe in Dry System	2016	1,893	189	10	189		694	26
27	Panels for Fire Protection	2016	2,388	239	10	239		876	27
28	Block Heater	2016	916	92	10	92		328	28
29	Commercial Garbage Disposal	2016	1,384	138	10	138		484	29
30	Water Heater	2017	1,512	151	10	151		517	30
31	Pipes/Fitting Wet System	2017	1,372	137	10	137		457	31
32	Carpet	2017	2,553	510	5	510		1,659	32
33	A/C Gas Furnace	2017	7,315	488	15	488		1,544	33
34	TOTAL (lines 1 thru 33)		$ 3,109,790	$ 67,171		$ 67,171	$	$ 2,489,335	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: 7/1/19 Ending: 6/30/20

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		$ 3,109,790	$ 67,171		$ 67,171	$	$ 2,489,335	1
2	Gutters/Downspouts	2017	3,020	302	10	302		906	2
3	Attic Vent Fan	2017	841	56	15	56		168	3
4	Dry System Pressure Switch	2017	562	56	10	56		169	4
5	New Sinks in Bathrooms	2017	3,073	154	20	154		435	5
6	PTAC - Frigidare Standard	2017	699	140	5	140		373	6
7	HVAC - Kitchen	2018	4,000	267	15	267		644	7
8	Max-Metal Signs	2018	800	80	10	80		193	8
9	Keypads	2018	1,075	108	10	108		233	9
10	Fire Panel - Hall 2 (1 of 2)	2018	13,829	1,383	10	1,383		2,881	10
11	Fan Motor/Blade AC System	2018	1,262	252	5	252		505	11
12	Fire Panel - Hall 2 (2 of 2)	2018	28,305	2,830	10	2,830		5,425	12
13	Signs/Frames	2018	690	69	10	69		132	13
14	Signs/Frames	2018	530	53	10	53		102	14
15	A/C System	2018	7,519	501	15	501		961	15
16	Water Heater 100 Gal	2018	4,205	421	10	421		806	16
17	HVAC	2018	1,361	91	15	91		166	17
18	Signs/Frames	2018	760	76	10	76		133	18
19	Hall 1 Wiring	2018	3,975	265	15	265		442	19
20	2 PTAC Units	2018	960	192	5	192		272	20
21	1 PTAC Unit	2019	515	103	5	103		129	21
22	Wanderguard	2019	27,101	1,807	15	1,807		2,258	22
23	Radiator	2019	3,721	372	10	372		465	23
24	Generator	2019	1,010	101	10	101		118	24
25	Blower/Thermostat in Trane Unit	2019	1,727	144	10	144		144	25
26	Lennox A/C Unit and Handler	2019	10,284	857	10	857		857	26
27	Lennox Gas Furnace/AC	2019	9,958	387	15	387		387	27
28	11 PTAC Units	2020	9,660	554	5	554		554	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,251,232	$ 78,792		$ 78,792	$	$ 2,509,193	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: 7/1/19 Ending: 6/30/20

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	$ 233,347	$ 26,846	$ 26,846	$	5-15	$ 132,173	71
72	Current Year Purchases	25,771	1,900	1,900		5-15	1,900	72
73	Fully Depreciated Assets	700,312				5-15	700,312	73
74								74
75	TOTALS	$ 959,430	$ 28,746	$ 28,746	$		$ 834,385	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	2000	$ 26,173	$	$	$	5	$ 26,173	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	23,333	78
79										79
80	TOTALS			$ 58,057	$ 5,000	$ 5,000	$		$ 56,390	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)	$ 4,314,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,538	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,538	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)	$ 3,399,968	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	$ 70,748	$ 1,658,434	86
87	ISL & Rental Building Equipment	18,318	1,235	4,939	87
88					88
89	Land - ISL & Rental Bldg	25,000			89
90					90
91	TOTALS	$ 2,830,703	$ 71,983	$ 1,663,373	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 7/1/19 Ending: 6/30/20

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

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		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				49,312		49,312	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				279,276	710		279,986	13
14	TOTAL			$		$ 279,276	$ 50,022		$ 329,298	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: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/20 (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	$ 510,748	$	1
2	Cash-Patient Deposits	5,014		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 20,000)	325,243		3
4	Supply Inventory (priced at)	23,815		4
5	Short-Term Investments	15,620		5
6	Prepaid Insurance	12,929		6
7	Other Prepaid Expenses	1,776		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 895,145	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	93,402		13
14	Buildings, at Historical Cost	6,194,561		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,065,706		16
17	Accumulated Depreciation (book methods)	(5,149,576)		17
18	Deferred Charges	(5,281)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,198,812	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,093,957	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,986	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,867		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,626		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,462		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	Other Accrued Expenses	24,788		36
37	Deferred Grant Revenue	140,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 373,229	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,094,171		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)**	$ 1,094,171	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,467,400	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,626,557	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,093,957	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,815,485	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,815,485	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(188,928)	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)**	$ (188,928)	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)**	$ 1,626,557	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 3,293,059	1
2	Discounts and Allowances for all Levels	(771,730)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,521,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	507,158	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 507,158	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	116,641	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,733	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,100	16
17	Sale of Drugs	48,730	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,580	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 190,784	23
	D. Non-Operating Revenue		
24	Contributions	43,823	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,823	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	7,569	28
28a	Rent - Independent Living	67,118	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 74,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,337,781	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	726,315	31
32	Health Care	1,447,996	32
33	General Administration	618,665	33
	B. Capital Expense		
34	Ownership	194,516	34
	C. Ancillary Expense		
35	Special Cost Centers	329,298	35
36	Provider Participation Fee	124,847	36
	D. Other Expenses (specify):		
37	Barber & Beauty Shop	4,746	37
38	Independent Senior Apartments	80,326	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,526,709	40
41	**Income before Income Taxes (line 30 minus line 40)****	(188,928)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (188,928)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 598,642	44
45	Private Pay - Net Inpatient Revenue	1,647,859	45
46	Medicare - Net Inpatient Revenue	898,691	46
47	Other-(specify) Hospice	147,867	47
48	Other-(specify) Discounts and Allowances	(771,730)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,521,329	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: 7/1/19 Ending: 6/30/20

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	2,032	2,080	$ 67,025	$ 32.22	1
2	Assistant Director of Nursing	211	464	6,637	14.30	2
3	Registered Nurses	5,943	6,104	170,328	27.90	3
4	Licensed Practical Nurses	12,722	13,167	277,325	21.06	4
5	CNAs & Orderlies	50,688	52,832	718,254	13.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,477	2,557	37,043	14.49	10
11	Social Service Workers	2,445	2,722	36,147	13.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,955	17,727	227,342	12.82	15
16	Dishwashers					16
17	Maintenance Workers	2,093	2,131	31,732	14.89	17
18	Housekeepers	11,088	11,309	108,704	9.61	18
19	Laundry	4,029	4,258	46,217	10.85	19
20	Administrator	1,737	2,080	72,275	34.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,804	3,209	41,451	12.92	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	2,438	2,828	40,503	14.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,662	123,468	$ 1,880,983 *	$ 15.23	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	133	$ 5,910	1, 3	35
36	Medical Director	40	10,000	9, 3	36
37	Medical Records Consultant	16	1,131	10, 3	37
38	Nurse Consultant	Contract	3,658	10, 3	38
39	Pharmacist Consultant	Contract	1,635	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	354	11, 3	44
45	Social Service Consultant	8	354	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	205	$ 23,042		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

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Susan Tudor	Administrator	0	$	72,275
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	72,275

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	$	37,442
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	37,442

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	29,567
Unemployment Compensation Insurance		10,476
FICA Taxes		139,370
Employee Health Insurance		73,660
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Retirement Plan Contributions		9,322
Employee Recognition & Uniforms		6,154
TOTAL (agree to Schedule V, line 22, col.8)	$	268,549

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		699
Health Care Worker Background Check		957
(Indicate # of checks performed)		
Patient Background Checks		
Dues & Subscriptions		6,925
Licenses & Fees		619
Bank Service Charges		3,273
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)	$	14,463

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		95
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	95

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/19 Ending: 6/30/20

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) - $3,294

(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? 10 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 15,625 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. $ 124,847
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 out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

HITZ MEMORIAL HOME
INDEPENDENT SENIOR LIVING
ATTACHMENT TO SCHEDULE XX, PAGE 22, #14
6/30/2020

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
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2020

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
Patty Frank
Terri Hosto
Dave Kalish
Debbie Passig
Carol Reckman
Lori Schafer
Jim Schmidt
Margie Schmidt
Jim Schultze
Rick Suhre