

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0032979 Facility Name: Hitz Memorial Home Address: 201 Belle St Box 79 Alhambra 62001 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: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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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:

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,444</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,078</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>67</u>	<u>24,522</u>	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	<u>3,510</u>	<u>5,247</u>	<u>1,898</u>	<u>10,655</u>	8
9	SNF/PED					9
10	ICF	<u>5,278</u>	<u>194</u>	<u>1,086</u>	<u>6,558</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,788</u>	<u>5,441</u>	<u>2,984</u>	<u>17,213</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.19%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Independent Senior Apartments, Day Care.

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 34 and days of care provided 1,898

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: N/A (Church) Fiscal Year: 6/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/15 Ending: 6/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	148,561	12,506	6,645	167,712		167,712		167,712			1
2	Food Purchase		100,228		100,228		100,228		100,228			2
3	Housekeeping	85,247	9,655		94,902		94,902		94,902			3
4	Laundry	34,276	3,449		37,725		37,725		37,725			4
5	Heat and Other Utilities			70,462	70,462		70,462	(4,573)	65,889			5
6	Maintenance	32,484	3,613	54,210	90,307		90,307		90,307			6
7	Other (specify):* Med Waste/Trash Removal & Security			9,945	9,945		9,945		9,945			7
8	TOTAL General Services	300,568	129,451	141,262	571,281		571,281	(4,573)	566,708			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,098,348	73,824	9,472	1,181,644		1,181,644	(720)	1,180,924			10
10a	Therapy											10a
11	Activities	44,082	2,620		46,702	513	47,215		47,215			11
12	Social Services	56,213	1,133	1,026	58,372	(513)	57,859		57,859			12
13	CNA Training											13
14	Program Transportation		6,098		6,098		6,098	(1,600)	4,498			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,198,643	83,675	19,498	1,301,816		1,301,816	(2,320)	1,299,496			16
	C. General Administration											
17	Administrative	67,939	871		68,810		68,810		68,810			17
18	Directors Fees											18
19	Professional Services			27,722	27,722		27,722		27,722			19
20	Dues, Fees, Subscriptions & Promotions			38,398	38,398		38,398	(21,828)	16,570			20
21	Clerical & General Office Expenses	46,745	11,156	39,521	97,422		97,422		97,422			21
22	Employee Benefits & Payroll Taxes			235,839	235,839		235,839		235,839			22
23	Inservice Training & Education			961	961		961		961			23
24	Travel and Seminar			285	285		285		285			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,883	72,883		72,883		72,883			26
27	Other (specify):*											27
28	TOTAL General Administration	114,684	12,027	415,609	542,320		542,320	(21,828)	520,492			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,613,895	225,153	576,369	2,415,417		2,415,417	(28,721)	2,386,696			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			149,613	149,613	(16,204)	133,409	(10,110)	123,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,367	73,367		73,367	(21,717)	51,650			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			222,980	222,980	(16,204)	206,776	(31,827)	174,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,191	242,797	295,988		295,988		295,988			39
40	Barber and Beauty Shops			8,523	8,523		8,523		8,523			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,360	130,360		130,360		130,360			42
43	Other (specify):* Independent Senior Apartments			79,454	79,454	16,204	95,658		95,658			43
44	TOTAL Special Cost Centers		53,191	461,134	514,325	16,204	530,529		530,529			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,613,895	278,344	1,260,483	3,152,722		3,152,722	(60,548)	3,092,174			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

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	\$ (720)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,573)	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	(492)	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	(21,225)	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	(18,029)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,809)	20		28
29	Other-Attach Schedule	(13,700)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,548)		\$	30

BHF USE ONLY							
48		49		50		51	

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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (60,548)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset income for transportation	\$ (1,600)	14	1
2	Eliminate half of 2 yr. IDPH license purchased in 2016	(1,990)	20	2
3	Eliminate depreciation on capital cost adjustments	(10,110)	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	(13,700)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,573)	0	0	0	0	0	0	0	0	0	0	(4,573)	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	(4,573)	0	0	0	0	0	0	0	0	0	0	(4,573)	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	(720)	0	0	0	0	0	0	0	0	0	0	(720)	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	(1,600)	0	0	0	0	0	0	0	0	0	0	(1,600)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,320)	0	0	0	0	0	0	0	0	0	0	(2,320)	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	(21,828)	0	0	0	0	0	0	0	0	0	0	(21,828)	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	(21,828)	0	0	0	0	0	0	0	0	0	0	(21,828)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(28,721)	0	0	0	0	0	0	0	0	0	0	(28,721)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(10,110)	0	0	0	0	0	0	0	0	0	0	(10,110)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,717)	0	0	0	0	0	0	0	0	0	0	(21,717)	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	(31,827)	0	0	0	0	0	0	0	0	0	0	(31,827)	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)	(60,548)	0	0	0	0	0	0	0	0	0	0	(60,548)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of Edwardsville		X	Nsg Facility Mortgage-62.57%	\$4,749.00	8/7/12	\$ 853,381	\$ 775,523	8/17/37	4.5000	\$ 35,481	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	12/1/15	500,000	192,774	11/5/16		11,842	6	
7	Bank of Edwardsville		X	Line of Credit	N/A	12/1/15	300,000		11/5/16		3,118	7	
8												8	
9	TOTAL Facility Related				\$4,749.00		\$ 1,653,381	\$ 968,297			\$ 52,142	9	
	B. Non-Facility Related*												
10	Bank of Edwardsville		X	Nsg Facility Mortgage-37.43%	\$2,841.00	8/17/12	510,501	463,926	8/17/37	4.5000	21,225	10	
11								Eliminate non-care related interest			(21,225)	11	
12								Offset Interest Income			(492)	12	
13												13	
14	TOTAL Non-Facility Related				\$2,841.00		\$ 510,501	\$ 463,926			\$ (492)	14	
15	TOTALS (line 9+line14)						\$ 2,163,882	\$ 1,432,223			\$ 51,650	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 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

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

37,841

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

☒ 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:

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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1970	\$ 176,881	\$	40	\$		\$ 176,881	4
5				1975	418,286	871	40	871		418,286	5
6				1991	1,436,697	35,917	40	35,917		914,564	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	1,866	40	1,866		81,417	12
13	Improvements			1977	6,650	166	40	166		6,553	13
14	Improvements			1979	3,000	75	40	75		2,781	14
15	Improvements & Garage			1980	15,638	391	40	391		14,107	15
16	Improvements			1982	2,416	60	40	60		2,059	16
17	Roof & Improvements			1983	138,325	3,458	40	3,458		114,406	17
18	Roof & Improvements			1984	143,005	3,575	40	3,575		115,000	18
19	Dining Room			1985	28,447	711	40	711		22,284	19
20	Architecture Fees/Roof Repair			1987	12,112	303	40	303		8,806	20
21	Architecture Fees/Improvements			1988	8,001	200	40	200		5,618	21
22	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		45,382	22
23	Remodeling & New Garage			1990	29,672	916	30-40	916		23,820	23
24	Remodeling/Furnace/Control Temps/Architect Fees			1993	36,433	497	10-40	497		28,226	24
25	Sprinkler System/Water Heaters			1994	7,729		10-15			7,729	25
26	Roof Repair			1997	22,000	550	40	550		10,450	26
27	Air Conditioner			1998	5,439	136	40	136		2,459	27
28	Tank Replacement			1999	14,313	716	20	716		12,345	28
29	Air Conditioner			1999	3,280	164	20	164		2,815	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	45	15	45		2,721	32
33	Kitchen Fire Suppression System			2002	8,823	588	15	588		8,087	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		8,355	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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Garbage Disposal	2004	\$ 2,680	\$	10	\$	\$	2,680	37
38	Canopy	2005	5,575	372	15	372		4,212	38
39	Door Alarms	2005	2,547		10			2,547	39
40	Solarium	2006	31,589	790	40	790		7,634	40
41	Water Heater	2007	4,157	416	10	416		3,845	41
42	Air Conditioner	2007	5,621	562	10	562		5,106	42
43	Alarm System	2007	3,030	303	10	303		2,601	43
44	Patio Landscaping	2007	1,909	48	40	48		426	44
45	Ramp Remodel	2008	24,570	614	40	614		5,170	45
46	Flooring	2008	3,854	385	10	385		3,148	46
47	Nursing Station Remodeling	2008	60,345	1,509	40	1,509		12,195	47
48	Water Heater	2008	3,867	387	10	387		3,126	48
49	Architect Fees - Nurses Station Remodeling	2008	3,142	79	40	79		635	49
50	Fire Protection	2009	15,867	1,587	10	1,587		12,032	50
51	12x24 Garage	2009	3,820	255	15	255		1,655	51
52	Heating Unit	2010	1,605	107	15	107		687	52
53	Heating Unit	2010	1,540	154	10	154		950	53
54	Heating Unit	2010	1,665	167	10	167		1,013	54
55	Evaporator fan coil, thermostat	2010	2,585	258	10	258		1,551	55
56	Carrier Air Handler, evaporator coil	2010	7,650	765	10	765		4,590	56
57	Install 3 Pan Sink w/drains, plumbing & cabinets	2011	5,941	297	20	297		1,436	57
58	Architecture & Design Fees for wing remodel-SNF suite wing	2011	16,427	657	25	657		3,176	58
59	Contractor's Materials & Labor Cost-SNF suite wing	2011	500	20	25	20		97	59
60	Flooring materials & labor for wing remodel-SNF suite wing	2011	8,439	422	20	422		2,039	60
61	Door Alarms & Wanderguard system-SNF suite wing	2011	9,248	472	15	472		2,279	61
62	Water Heater mixer valve replaced & installed	2011	4,800	480	10	480		2,320	62
63	A/C Unit for Dietary	2012	4,334	867	5	867		3,467	63
64	A/C Unit for Dietary	2012	738	148	5	148		627	64
65	Water Heater mixer valve replaced & installed	2001	3,074	171	15	171		3,074	65
66	Boiler	2001	10,629	531	20	531		7,883	66
67	Sprinkler System	2008	7,520	188	40	188		1,504	67
68	Landscaping	1991	1,755	44	40	44		1,112	68
69	Exterior Lights & Sign	1992	2,911		10			2,911	69
70	TOTAL (lines 4 thru 69)		\$ 2,990,489	\$ 66,331		\$ 66,331	\$	2,191,780	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:

7/1/15

Ending:

6/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,990,489	\$ 66,331		\$ 66,331	\$	\$ 2,191,780	1
2	New Carpet & Installation	2012	3,675	735	5	735		2,634	2
3	11 A/C Units	2012	11,703	2,155	15	2,155		7,570	3
4	Nurse Station 2 Compressors	2013	2,196	146	15	146		439	4
5	Alarm Door switches,relay, panel,keypad	2013	2,325	233	10	233		639	5
6	Generator- Emergency set	2014	22,450	1,122	20	1,122		2,526	6
7	6 A/C/Heat Units	2014	5,949	1,190	5	1,190		2,917	7
8	5 A/C/Heat Units	2015	3,918	784	5	784		1,164	8
9	Landscaping - North & West Side of Facility	2015	9,820	982	10	982		1,445	9
10	Furnace & AC - Dining Room	2015	7,580	1,263	5	1,263		1,263	10
11	Asco transfer switch	2015	3,400	255	10	255		255	11
12	5 PTAC Units	2015	5,471	643	5	643		643	12
13	Gas Water Heater, 75 Gal	2015	4,116	309	10	309		308	13
14	Flooring	2016	571	14	10	14		14	14
15	Carport	2016	3,942	33	20	33		33	15
16	Alarm keypad, multi ray unit, door switch	2016	757	38	10	38		38	16
17	First Q System - Wanderguard	2016	1,672	28	10	28		28	17
18	Main piping, couplings in residential hallway	2016	1,082	6	15	6		6	18
19	Water Heater	2016	8,400		10				19
20	Smoking Starter Shelter, 4x8	2016	2,172		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	TOTAL (lines 1 thru 33)		\$ 3,091,688	\$ 76,267		\$ 76,267	\$	\$ 2,213,702	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 327,286	\$ 41,650	\$ 41,650	\$	5-40	\$ 188,480	71
72	Current Year Purchases	30,214	1,045	1,045		5-15	1,045	72
73	Fully Depreciated Assets	691,531	1,004	1,004		5-10	691,531	73
74								74
75	TOTALS	\$ 1,049,031	\$ 43,699	\$ 43,699	\$		\$ 881,056	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
77	Resident Transportation	Dodge Top/Rear Door Additions	2003	6,884				5	6,884
78	Resident Transportation	2003 Chevy 15 Passenger Van	2009	6,080				5	6,080
79	Resident Transportation	2005 Chevy Turtle Top Van	2015	25,000	3,333	3,333		5	3,333
80	TOTALS			\$ 69,824	\$ 3,333	\$ 3,333	\$		\$ 48,157

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	4,255,927
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	123,299
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	123,299
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,142,915

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.	\$ 2,483,109	\$ 62,309	\$ 1,376,707
87	ISL & Rental Building Equipment	3,094		2,684
88				
89	Land-ISL & Rental Bldg	25,000		
90				
91	TOTALS	\$ 2,511,203	\$ 62,309	\$ 1,379,391

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
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

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.

YESNO

		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:

YESNO

Terms:*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YESNO
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

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

☒ 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.)

12345678										
	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				52,836		52,836	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				13,796	242,797	355	13,796	243,152	13
14	TOTAL			\$	13,796	\$ 242,797	\$ 53,191	13,796	\$ 295,988	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 44,619	\$	1
2	Cash-Patient Deposits	4,283		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	968,497		3
4	Supply Inventory (priced at)	8,896		4
5	Short-Term Investments	20,110		5
6	Prepaid Insurance	22,138		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Fire Damages - Deferred</u>	175,872		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,244,415	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	97,784		13
14	Buildings, at Historical Cost	5,756,260		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,121,949		16
17	Accumulated Depreciation (book methods)	(4,572,417)		17
18	Deferred Charges	(3,640)		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan Costs</u>	1,984		22
23	Other(specify): <u>MPIC Capital Investment</u>	5,350		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,407,270	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,651,685	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 47,075	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,181		28
29	Short-Term Notes Payable	192,774		29
30	Accrued Salaries Payable	75,249		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,305		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Provider Taxes & EE Garnishments</u>	14,946		36
37	<u>Due to State of Illinois</u>	26,556		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 375,086	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,239,449		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)	\$ 1,239,449	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,614,535	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,037,150	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,651,685	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,278,834	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,278,834	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	758,316	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)	\$ 758,316	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)	\$ 2,037,150	24

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 7/1/15

Ending:

6/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,207,443	1
2	Discounts and Allowances for all Levels	(482,194)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,725,249	3
	B. Ancillary Revenue		
4	Day Care	720	4
5	Other Care for Outpatients		5
6	Therapy	475,390	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 476,110	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	8,523	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	55,134	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 73,603	23
	D. Non-Operating Revenue		
24	Contributions	271,709	24
25	Interest and Other Investment Income***	492	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 272,201	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	300,197	27
28	<u>Miscellaneous</u>	1,522	28
28a	<u>Rent-Independent Living</u>	62,156	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 363,875	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,911,038	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	571,281	31
32	Health Care	1,301,816	32
33	General Administration	542,320	33
	B. Capital Expense		
34	Ownership	222,980	34
	C. Ancillary Expense		
35	Special Cost Centers	295,988	35
36	Provider Participation Fee	130,360	36
	D. Other Expenses (specify):		
37	<u>Barber & Beauty Shop</u>	8,523	37
38	<u>Independent Senior Apartments</u>	79,454	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,152,722	40
41	Income before Income Taxes (line 30 minus line 40)**	758,316	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 758,316	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,224,605	44
45	Private Pay - Net Inpatient Revenue	950,348	45
46	Medicare - Net Inpatient Revenue	889,968	46
47	Other-(specify) <u>Hospice</u>	142,522	47
48	Other-(specify) <u>Discounts and Allowances</u>	(482,194)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,725,249	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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,712	1,752	\$ 57,547	\$ 32.85	1
2	Assistant Director of Nursing	1,759	2,051	47,582	23.20	2
3	Registered Nurses	4,547	4,714	106,529	22.60	3
4	Licensed Practical Nurses	15,738	16,595	277,704	16.73	4
5	CNAs & Orderlies	49,349	51,743	577,289	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,927	5,240	44,082	8.41	9
10	Activity Assistants					10
11	Social Service Workers	3,784	4,226	56,213	13.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,141	15,776	148,561	9.42	15
16	Dishwashers					16
17	Maintenance Workers	2,160	2,429	32,484	13.37	17
18	Housekeepers	8,674	9,006	85,247	9.47	18
19	Laundry	3,380	3,562	34,276	9.62	19
20	Administrator	1,752	2,567	67,939	26.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,978	3,453	46,745	13.54	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	1,907	2,108	31,697	15.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,808	125,222	\$ 1,613,895 *	\$ 12.89	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	166	\$ 6,645	1,3	35
36	Medical Director	Contract	9,000	9,3	36
37	Medical Records Consultant	16	1,082	10,3	37
38	Nurse Consultant	Contract	3,608	10,3	38
39	Pharmacist Consultant	Contract	4,782	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	513	11,3	44
45	Social Service Consultant	8	513	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 26,143		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Susan Tudor	Administrator	0	\$ 67,939	Workers' Compensation Insurance		\$ 35,690	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		45,114	Advertising: Employee Recruitment	2,391	
				FICA Taxes		120,944	Health Care Worker Background Check	1,195	
				Employee Health Insurance		26,134	(Indicate # of checks performed 75)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	5,288	
				Retirement Plan Contributions		6,488	Licenses & Fees	1,267	
				Employee Uniforms		602	Bank Service Charges	4,439	
				Employee Recognition		867			
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 235,839	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,570	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number <u>Hitz Memorial Home</u>	STATE OF ILLINOIS # <u>0032979</u>	Report Period Beginning: <u>7/1/15</u>	Ending: <u>6/30/16</u>
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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) - \$2,167

(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. \$ 21,710 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. \$ 130,360
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
 c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

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

SEE ACCOUNTANTS' PREPARATION REPORT

HITZ MEMORIAL HOME
INDEPENDENT SENIOR LIVING
ATTACHMENT TO SCHEDULE XX, PAGE 22, #14
6/30/2016

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
6/30/2016

Law Firm	Invoice Date	Description of Services	Allowable Amount	Non-Allowable Amount
Lowenbaum Law	10/31/2015	Employment Law Compliance Audit	1,146.25	
Taliana, Buckley, Asa & Reames	4/11/2016	Consultation Fee - Trust Donation	100.00	
Taliana, Buckley, Asa & Reames	5/13/2016	Legal fee - Trust Donation	500.00	
Taliana, Buckley, Asa & Reames	5/26/2016	Court Fees - Trust Donation	88.00	
Taliana, Buckley, Asa & Reames	6/23/2016	Legal fees - Trust Donation	268.00	
			2,102.25	-

HITZ MEMORIAL HOME
ADJUSTMENTS
ATTACHMENT TO SCHEDULE 6
6/30/2016

6 A

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>W/P Ref</u>	<u>INCREASE (DECREASE)</u>
INTEREST To offset interest income against related expense	32	17 A	(492)
NURSING & MEDICAL RECORDS To offset daycare income	10	17 A	(720)
PROGRAM TRANSPORTATON To offset misc. income rebates/refunds & reimbursments against the related expense accounts	14	17 B	(1,600)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate promotional advertising	20	5 A	(18,029)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate yellow page ads	20	5 A	(1,809)
HEAT & OTHER UTILITIES To eliminate Cable T.V.	5	5A	(4,573)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS Eliminate half of 2 year IDPH license	20	19Fp2	(1,990)
Other - Assisted Living/Stand By Area To eliminate non-care related interest	32	9p1	(21,225)
DEPRECIATION Eliminate depreciation on capital cost adjustments	30	11Ap2	(10,110)
			(60,548)

HITZ MEMORIAL HIME
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2016

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>W/P REF</u>	<u>INCREASE (DECREASE)</u>
ACTIVITIES	11	18B	513
SOCIAL SERVICES	12	18B	(513)

To reclass activities consultant expense to the proper line.

DEPRECIATION	30	11Ap5	(16,204)
OTHER - STAND BY AREA	43	11Ap5	16,204

To reclass ISL depreciation expense allocation.

HITZ MEMORIAL HOME
LIST OF BOARD MEMBERS
ATTACHMENT TO SCHEDULE VII
6/30/2016

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.

Linda Diesen
Rosemary Schultze
Rev. Jerry Amiri
Carol Hess
Mary Klaustermeier
Allen Schmidt
Paco Newman
Christy Eckert
Eric L. Augustin
Leonard Lockett
Carol Reckman

Hitz Memorial Home
 Attachment to Schedule XIV
 6/30/2016

		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			5,939	97,107	355	5,939	97,462
	Licensed Speech Therapist	39,3			1,385	28,446		1,385	28,446
	Licensed Physical Therapist	39,3			6,472	108,847		6,472	108,847
	Laboratory & X-Rays	39,3				8,397		-	8,397
Total to Schedule XIV, Line 12			-	-	13,796	242,797	355	13,796	243,152

HITZ MEMORIAL HOME
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2016

Transportation Revenue-a/c#4850	1,600	offset to ln 14
Miscellaneous	(208)	
Sale of Old Bricks & Rock	400	no cost to offset
Resident Refunds	(290)	
Application Fees -a/c#4780	20	
	<u>1,522</u>	