

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0010058</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Illinois Knights Templar Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>08/01/2010</u> to <u>07/31/2011</u> 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.																																																	
Address: <u>450 Fulton Street, P.O. Box 49</u> <u>Paxton</u> <u>60957</u>																																																			
NumberCityZip Code																																																			
County: <u>Ford</u>																																																			
Telephone Number: <u>(217) 379-2116</u> Fax # <u>(217) 379-3000</u>																																																			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer																																																	
Date of Initial License for Current Owners: <u>8/1/1954</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) (3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>				☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c) (3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____	
☒	VOLUNTARY, NON-PROFIT			☐	PROPRIETARY	☐	GOVERNMENTAL																																												
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		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>Michael W. Martin</u>		Telephone Number: <u>(217) 258-8888</u>																																																	
Email Address: _____																																																			

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Illinois Knights Templar Home

0010058 Report Period Beginning: 08/01/2010 Ending: 07/31/2011

III. STATISTICAL DATA

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

	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>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</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>8,376</u>	<u>12,059</u>	<u>2,290</u>	<u>22,725</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,376</u>	<u>12,059</u>	<u>2,290</u>	<u>22,725</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.01%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? 0 (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) N/A

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 ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 5/1/54

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 75 and days of care provided 2,290

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 07/31/2011 Fiscal Year: 07/31/2011

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

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2010 Ending: 07/31/2011

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	237,095	17,290	7,484	261,869		261,869		261,869			1
2	Food Purchase		155,926		155,926		155,926	(10,319)	145,607			2
3	Housekeeping	146,812	11,557		158,369		158,369		158,369			3
4	Laundry	36,194	9,873		46,067		46,067		46,067			4
5	Heat and Other Utilities			89,119	89,119		89,119		89,119			5
6	Maintenance	111,343	17,263	66,358	194,964		194,964	2,580	197,544			6
7	Other (specify):*											7
8	TOTAL General Services	531,444	211,909	162,961	906,314		906,314	(7,739)	898,575			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,320,219	87,446	9,782	1,417,447		1,417,447		1,417,447			10
10a	Therapy		974	391,467	392,441		392,441		392,441			10a
11	Activities	44,095	4,964	4,898	53,957		53,957	(1,381)	52,576			11
12	Social Services	55,960	7	2,905	58,872		58,872		58,872			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,420,274	93,391	421,052	1,934,717		1,934,717	(1,381)	1,933,336			16
	C. General Administration											
17	Administrative	85,091			85,091		85,091		85,091			17
18	Directors Fees											18
19	Professional Services			176,817	176,817		176,817		176,817			19
20	Dues, Fees, Subscriptions & Promotions			21,240	21,240		21,240	(445)	20,795			20
21	Clerical & General Office Expenses	167,778	18,550	22,110	208,438		208,438	(572)	207,866			21
22	Employee Benefits & Payroll Taxes			765,933	765,933		765,933	(6,065)	759,868			22
23	Inservice Training & Education			536	536		536		536			23
24	Travel and Seminar			4,730	4,730		4,730	1,381	6,111			24
25	Other Admin. Staff Transportation			5,467	5,467		5,467	(1,381)	4,086			25
26	Insurance-Prop.Liab.Malpractice			100,706	100,706		100,706		100,706			26
27	Other (specify):*											27
28	TOTAL General Administration	252,869	18,550	1,097,539	1,368,958		1,368,958	(7,082)	1,361,876			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,204,587	323,850	1,681,552	4,209,989		4,209,989	(16,202)	4,193,787			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			125,357	125,357		125,357	57,163	182,520			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,442	8,442		8,442		8,442			35
36	Other (specify):*											36
37	TOTAL Ownership			133,799	133,799		133,799	57,163	190,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,928		72,928		72,928		72,928			39
40	Barber and Beauty Shops	5,633	1,149	7,053	13,835		13,835		13,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):* Non-Allow Costs	17,641	32,804	184,914	235,359		235,359	(235,359)				43
44	TOTAL Special Cost Centers	23,274	106,881	233,030	363,185		363,185	(235,359)	127,826			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,227,861	430,731	2,048,381	4,706,973		4,706,973	(194,398)	4,512,575			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	57,163	30		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				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	(8,835)	43		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	(3,985)	43		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 See Pg 5A	(238,741)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (194,398)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (194,398)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0010058

08/01/2010

07/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Offset meal income	\$ (5,958)	2	1
2	Offset pilgrimage income	(4,361)	2	2
3	Offset Miscellaneous revenue	(572)	21	3
4	Offset miscellaneous activities revenue	(1,381)	11	4
5	Disallow chamber/rotary dues	(445)	20	5
6	Disallow Medicare ancillary expenses	(128,387)	43	6
7	Disallow banquet expenses	(309)	43	7
8	Disallow CLU cost	(52,985)	43	8
9	Disallow TH costs	(13,785)	43	9
10	Disallow rental house costs	(2,358)	43	10
11	Disallow seasonal mailer expense	(5,430)	43	11
12	Medicaid B write off	(75)	43	12
13	Disallow cable expense	(6,856)	43	13
14	Disallow volunteer appreciation expense	(35)	43	14
15	Patient Refund	(2,239)	43	15
16	Disallow Marketing Expense	(10,080)	43	16
17	Disallow CLU Benefit offset	(6,065)	22	17
18	Reclass Fixed assets to Repairs & Maintenance	2,580	6	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	(238,741)		49

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
N/A		N/A		N/A		

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				N/A				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V				N/A				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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									\$		1
2											2
3					N/A						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

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2010 Ending: 7/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		N/A				\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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				This page is not applicable			\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)		2010		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
This page is not applicable. Entity is not for-profit facility and does not pay real estate taxes.					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Illinois Knights Templar Home</u>	COUNTY	<u>Ford</u>
FACILITY IDPH LICENSE NUMBER	<u>0010058</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Kathy Swan</u>		
TELEPHONE	<u>(217) 379-2116</u>	FAX #:	<u>(217) 379-3000</u>

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

40,268

B. General Construction Type:

Exterior Brick

Frame Fire Resistant

Number of Stories

2

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).

Illinois Knights Templar Home-Townhouse Apartments; 2862 Sq Ft; 4 units

Illinois Knights Templar Home- Congregate Living Units (CLU's): 3330 sq Ft; 11 units

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:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	120,000		\$ 23,000	1
2	Garage	7,850		3,204	2
3	TOTALS	127,850		\$ 26,204	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	13			1963	\$ 155,247	\$	40	\$		\$ 155,247	4
5	37			1975	825,217	20,630	40	20,630		763,310	5
6	6			1987	587,238	14,681	40	14,681		367,025	6
7	4			1992	64,239	1,606	40	1,606		32,120	7
8	15			1996	1,292,665	32,317	40	32,317		274,115	8
	Improvement Type**										
9	Doors			1977	10,621		15			10,621	9
10	Parking Lights			1977	5,523		8			5,523	10
11	Improvements			1978	40,262	1,007	40	1,007		33,803	11
12	Generator			1979	12,921		20			12,921	12
13	Generator			1980	26,890		20			26,890	13
14	Roof			1980	32,948		20			32,948	14
15	Roof - Nurses Station			1981	22,000		20			22,000	15
16	Basement Renovation			1981	20,614		40			20,614	16
17	Air Conditioner Installation			1982	1,271		5			1,271	17
18	Carpeting - Administrators House			1982	365		5			365	18
19	Laundry Room - Plumbing & Heating			1982	9,799		25			9,847	19
20	Electrical Updates			1984	1,405		18			1,405	20
21	Water Heater			1984	1,430		10			1,430	21
22	Garage			1985	6,015	150	25	150		5,538	22
23	Furnace - Administrators House			1985	1,522		15			1,522	23
24	5 Room Renovation			1988	144,260	3,607	40	3,607		82,961	24
25	Resurface Parking Lots & Drives			1988	12,875		8			12,875	25
26	Patio			1989	9,000		15			9,000	26
27	Solarium			1989	21,547		15			21,547	27
28	Remodel Day Room			1989	3,558		15			3,558	28
29	Install Catch Basins			1989	790	20	20	20		780	29
30	New Sidewalk			1989	890		15			890	30
31	Sidewalk & Ramp			1990	1,090		15			1,090	31
32	Rewire Garage			1992	3,238	81	20	81		2,673	32
33	Install New Hot Water Supply			1992	3,039	76	20	76		2,356	33
34	Land Improvement - Cleared Site For Garage			1992	1,540		10			1,540	34
35	Garage			1992	39,976		15			39,976	35
36	Wall Replacement			1993	71,464	1,787	40	1,787		32,165	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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2010 Ending: 07/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Land Improvement -Removal Of Tank	1993	\$ 2,500	\$	10	\$	\$	\$ 2,500	37
38 Roof Insulation	1993	15,800	395	15	395		15,401	38
39 Roof Insulation and Replace Skylights	1993	6,672	167	15	167		6,359	39
40 Wallpaper, Lights, Sashes - Adm House	1993	3,531		5			3,531	40
41 Sump Pump & Pit -Adm House	1993	815		10			815	41
42 Repaired Generator	1994	5,156	129	20	129		4,561	42
43 Wallpaper, Blinds, Cabinets - Adm House	1994	2,338		5			2,338	43
44 Land Improvement - Repaired Water Main	1994	1,063	27	25	27		662	44
45 Land Improvement - Sidewalks	1994	1,721	43	15	43		1,566	45
46 Air Conditioner in Dining Room	1994	4,801		5			4,801	46
47 Rewired Cable	1995	875		5			875	47
48 Tile In Front Entrance, Intermediate Rooms & House	1995	7,408	185	20	185		4,995	48
49 Land Improvement - Transplanted Tree	1995	275	7	20	7		189	49
50 Replace Fire System	1995	2,915		10			2,915	50
51 Installed New Shower	1996	647		10			647	51
52 Installed Garage Door & Asbestos Analysis	1996	1,254	31	20	31		784	52
53 Land Improvement - Repaired Water Main	1996	1,002	25	25	25		535	53
54 Remodeled Dining Room - Wallpaper	1996	550		5			550	54
55 Replaced Tile In Bath #1	1996	685	17	20	17		415	55
56 Installed New Fire Door	1996	4,321	108	15	108		3,348	56
57 Wallpaper & Blinds In Dining Room - Adm House	1996	2,136		5			2,136	57
58 Repaired Generator	1996	2,217	55	18	55		1,492	58
59 Replace Piping From Hot Water Heater	1996	603	15	20	15		375	59
60 Wallpaper & Jacks In Master Bedroom - Adm House	1997	785		5			785	60
61 Run New Water Line In Mechanical Room	1997	2,643	66	15	66		1,870	61
62 Installed New Door Alarms In 1995 Addition	1997	1,752	44	10	44		1,708	62
63 Increased Value Of Land - Demolition Of Old House	1997	51,268						63
64 Maintenance Equipment	2003	937	23	10	23		349	64
65 Wallpaper And Tile In Solarium	1997	2,586		5			2,586	65
66 Installed Wallpaper	1997	392	10	20	10		382	66
67 Installed New Water Line	1997	3,336	83	20	83		2,151	67
68 Installed Mop Sink & Ductwork For Furnace	1997	2,508	63	20	63		1,441	68
69 Land Improvement - Removed Trees	1997	860	22	20	22		498	69
70 TOTAL (lines 4 thru 69)		\$ 3,567,811	\$ 77,477		\$ 77,477	\$	\$ 2,063,486	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2010 Ending: 07/31/2011

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		\$ 3,567,811	\$ 77,477		\$ 77,477	\$	\$ 2,063,486	1
2	Replaced Water & Sewer Lines, Sink, Faucet & Countertops	1998	3,511	88	20	88		1,774	2
3	Installed Mini-Blinds in Breakroom	1998	904		5			904	3
4	Land Improvement	1998	3,239		20	(90)	(90)	3,239	4
5	Land Improvement - Planted Trees	1998	699	17	20	17		341	5
6	Repaired Generator	1998	1,925	48	20	48		944	6
7	Installed Closet Dividers	1998	474	12	15	12		287	7
8	Repaired Roof	1998	633	16	10	16		506	8
9	Installed Oxygen Ventilation System	1998	2,980	75	20	75		1,431	9
10	Installed Carpet	1998	680		5			680	10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050	201	25	201		3,366	11
12	Landscaping	1998	300		5			300	12
13	Concrete Driveway	1999	8,000	200	10	200		5,800	13
14	Roof Improvements on 1975 Addition	1999	4,776	119	10	119		3,462	14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528	263	10	263		7,633	15
16	Pavillion	1999	14,214	355	25	355		5,045	16
17	Electric Improvements on the 1995 Addition	1999	4,762	119	20	119		1,904	17
18	Kitchen Fire System	1999	1,797	45	10	45		1,125	18
19	Pavillion Lights	2000	1,235	31	10	31		775	19
20	Building Improvement Original Memorial Monument	2000	746	19	40	19		240	20
21	Building Improvement Original BTU Heat Pump	2000	1,988	50	40	50		550	21
22	Building Improvements 1988 New Wander Guard System	2000	11,990	300	40	300		3,300	22
23	Land Improvement Sidewalk and Pad	2001	2,300	58	15	58		1,018	23
24	Building Improvement 1975 PTAC Chassis	2002	25,807	645	40	645		6,450	24
25	Garage Door	2002	675	17	10	17		323	25
26	Building Improvements - Handrails	2002	1,480	37	10	37		703	26
27	Water Heater	2002	2,378	59	10	59		1,127	27
28	Smoke Damper	2002	605	15	10	15		294	28
29	Transformer	2002	206	5	10	5		98	29
30	Building Improvements - Roofing	2003	140,166	3,504	40	3,504		31,536	30
31	Room Furnishings	2003	1,248	31	10	31		467	31
32	Building Improvements - Original Building	2004	17,366	434	40	434		3,472	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,843,473	\$ 84,240		\$ 84,150	\$ (90)	\$ 2,152,580	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2010 Ending: 07/31/2011

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 12B, Carried Forward		\$ 3,843,473	\$ 84,240		\$ 84,150	\$ (90)	\$ 2,152,580	1
2	<u>PTAC Unit</u>	2004	2,848	71	40	71		497	2
3	<u>Door</u>	2005	1,806	15	40	15		105	3
4	<u>Water supply & pipe</u>	2005	1,500	12	40	12		84	4
5	<u>PTAC Unit</u>	2005	586	18	40	18		99	5
6	<u>Handrail</u>	2006	1,156	20	40	20		110	6
7	<u>PTAC Unit</u>	2006	562	14	40	14		77	7
8	<u>PTAC Unit</u>	2006	570	14	40	14		77	8
9	<u>Door</u>	2006	4,780	20	40	20		110	9
10									10
11	<u>PTAC Units</u>	2006	7,470	187	40	187		841	11
12	<u>Wallpaper</u>	2007	2,557	64	40	64		230	12
13	<u>Carpeting</u>	2007	4,754	119	40	119		535	13
14	<u>Blinds</u>	2007	3,700	93	40	93		418	14
15	<u>Dishwasher Booster Heater</u>	2007	10,175	254	40	254		1,143	15
16	<u>Fire Rated Duct Enclosure</u>	2007	9,000	225	40	225		1,013	16
17	<u>Rebuild Water Softener</u>	2007	2,938	294	10	294		1,323	17
18	<u>Kitchen floor tile & installation</u>	2007	6,785	678	10	678		3,051	18
19	<u>Re-Roof Rent House & Garage</u>	2006	7,418	185	40	185		833	19
20									20
21	<u>Landscaping (new flower beds around facility)</u>	2008	3,275	82	40	82		286	21
22	<u>Paving of parking lot</u>	2007	42,750	1,068	40	1,068		3,738	22
23	<u>Replace concrete sidewalk and fire hydrant area</u>	2007	6,582	164	40	164		574	23
24	<u>Dining Room (new floor, cabinets, window coverings, painting)</u>	2008	13,960	350	40	350		1,225	24
25	<u>Water Heater</u>	2007	16,308	408	40	408		1,428	25
26	<u>Kitchen (blinds, entrance board, linoleum)</u>	2008	3,049	78	40	78		273	26
27	<u>Kitchen (cabinets, flooring)</u>	2007	17,068	894	40	894		3,129	27
28	<u>Shower/Tub</u>	2007	3,311	84	40	84		294	28
29	<u>Plumbing/electrical work</u>	2007	3,908	98	40	98		343	29
30	<u>Concrete repairs - new patio</u>	2008	5,448	136	40	136		476	30
31	<u>Carpeting/Tile</u>	2007	7,258	182	40	182		637	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,995	\$ 90,067		\$ 89,977	\$ (90)	\$ 2,175,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2010 Ending: 07/31/2011

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,034,995	\$ 90,067		\$ 89,977	\$ (90)	\$ 2,175,529	1
2	Asphalt work-new retaining wall, landscape beneath	2008	20,710	932	20	932		2,330	2
3	Gazebo	2008	27,889	1,046	25	1,046		2,615	3
4	South Tunnel Exit	2008	10,582	530	20	530		1,325	4
5	Plumbing & Heat pump	2008	10,147	306	35	306		765	5
6	Electrical work, exhaust fan	2009	6,854	172	40	172		430	6
7	Elevator Repair	2008	5,124	176	30	176		440	7
8	Gutter Helmets	2008	5,784	266	20	266		665	8
9	New Shelving	2008	4,682	176	25	176		440	9
10	Sewer line replacement & unit compressor	2008	10,075	296	35	296		740	10
11	Fire doors	2009	10,163	212	40	212		530	11
12	Smoke Detectors	2009	4,368	110	40	110		275	12
13	Handicap electrical door	2009	6,528	136	40	136		340	13
14	Electrical doors	2009	19,998	414	40	414		1,035	14
15	Generator charging system	2009	3,725	62	40	62		155	15
16	Security system	2009	5,430	22	40	22		55	16
17									17
18	Room Repair-plumbing	2009	2,995	75	40	75		112	18
19	Water Heater	2009	3,665	367	10	367		550	19
20	Bathroom Renovation-Plumbing,hardware	2010	52,122	1,303	40	1,303		1,955	20
21	Elevator Repair	2010	5,248	175	30	175		262	21
22	Roof Repair	2010	9,928	248	40	248		744	22
23	Air Conditioner	2010	6,690	669	10	669		1,004	23
24	Accordion Doors	2010	4,750	158	30	158		238	24
25									25
26	Heating/Ventilation	2010	9,455	118	40	118		118	26
27	Security Cameras	2010	16,650	208	40	208		208	27
28	Doors	2011	8,050	101	40	101		101	28
29									29
30	PTAC Unit	2011	6,165	77	40	77		77	30
31	Increased Value Of Land - Demolition Of Old House	2011	5,000	62	40	62		62	31
32									32
33	To tie book depreciation to book balance			(3,727)			3,727		33
34	TOTAL (lines 1 thru 33)		\$ 4,317,772	\$ 94,757		\$ 98,394	\$ 3,637	\$ 2,193,100	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 867,255	\$ 29,828	\$ 83,354	\$ 53,526	10	\$ 988,169	71
72	Current Year Purchases	15,439	772	772		10	772	72
73	Fully Depreciated Assets	144,110					144,110	73
74								74
75	TOTALS	\$ 1,026,804	\$ 30,600	\$ 84,126	\$ 53,526		\$ 1,133,051	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	Facility-Patient Care	Ford Aerotech, 1980	1980	\$ 35,800	\$	\$	\$		\$ 35,800
77	Facility-Maintenance	Chevy S-10, 1988	1988	10,077					10,077
78	Facility-Patient Care	Buick Century, 1993	1993	14,491					14,491
79									
80	TOTALS			\$ 60,368	\$	\$	\$		\$ 60,368

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)			\$ 5,431,148
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 125,357
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 182,520
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 57,163
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,386,519

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	Townhouse 1975	\$ 136,194	\$ 3,989	\$ 99,852	86
87	Congregate Living Units, 1998	419,680	13,259	352,302	87
88					88
89					89
90					90
91	TOTALS	\$ 555,874	\$ 17,248	\$ 452,154	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93	Call System	19,272	93
94			94
95		\$ 19,272	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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:				\$ N/A			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 . N/A
N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 8,442 Description: Nursing Eqpt - 7,430; Office Eqpt - 438; Mtce. Eqpt. - 574
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

It is the policy of this facility to only hire certified nurses aides.
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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	10(A) 3	hrs	\$	2,075	\$ 149,394	\$	2,075	\$ 149,394	1
2	Licensed Speech and Language Development Therapist	10(A) 3	hrs		365	26,261		365	26,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10(A) 2, 3	hrs		2,997	215,812	974	2,997	216,786	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				72,928		72,928	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,437	\$ 391,467	\$ 73,902	5,437	\$ 465,369	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,630	\$ 8,630	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	1,072,607	1,072,607	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	165,060	165,060	6
7	Other Prepaid Expenses	24,774	24,774	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,271,071	\$ 1,271,071	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	87,951	26,204	13
14	Buildings, at Historical Cost	3,878,228	2,924,606	14
15	Leasehold Improvements, at Historical Cost	487,071	1,393,166	15
16	Equipment, at Historical Cost	948,185	1,087,172	16
17	Accumulated Depreciation (book methods)	(3,064,796)	(3,386,519)	17
18	Deferred Charges			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): <u>Net Non-Care Assets</u>	128,287	103,720	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,464,926	\$ 2,148,349	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,735,997	\$ 3,419,420	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 150,259	\$ 150,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,862	153,862	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,565	17,565	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	10,269	10,269	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	68,390	68,390	36
37	<u>Other Current Liabilities</u>	192,562	192,562	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 592,907	\$ 592,907	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 592,907	\$ 592,907	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,143,090	\$ 2,826,513	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,735,997	\$ 3,419,420	48

Illinois Knights Templar Home
Provider # 0010058
8/1/10-7/31/11

Schedule 17A

XV. Balance Sheet
Line 36. Other Current Liabilities

Description	Operating	After Consolidation
RT Offset	1,636	1,636
Cash in Bank	21,973	21,973
Funds held by CIPS	228	228
Accounts Receivable - CLU	975	975
First National Employee Saving	175	175
Wage Garnishment Withheld	323	323
Employee Insurance-Health	2,230	2,230
Employee Insurance-Dental	679	679
Employee Ins-Opt Life	1,822	1,822
Uniform Deduction	100	100
Pension-Employee Portion	2,007	2,007
Employer's Share FICA Taxes	51	51
Accrued Expenses	17,529	17,529
Due to Third Party Payors	18,662	18,662
	<u>68,390</u>	<u>68,390</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,749,845	1
2	Restatements (describe):		2
3	Prior Period Adjustment	786,204	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,536,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(392,959)	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)	\$ (392,959)	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)	\$ 3,143,090	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,323,048	1
2	Discounts and Allowances for all Levels	(408,196)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,914,852	3
	B. Ancillary Revenue		
4	Day Care	80	4
5	Other Care for Outpatients		5
6	Therapy	938,844	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 938,924	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	18,098	13
14	Non-Patient Meals	5,958	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	60,809	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,274	19
20	Radiology and X-Ray		20
21	Other Medical Services	191,645	21
22	Laundry	16,948	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 298,732	23
	D. Non-Operating Revenue		
24	Contributions	8,097	24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,104	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	153,402	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 153,402	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,314,014	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	906,314	31
32	Health Care	1,934,717	32
33	General Administration	1,368,958	33
	B. Capital Expense		
34	Ownership	133,799	34
	C. Ancillary Expense		
35	Special Cost Centers	322,122	35
36	Provider Participation Fee	41,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,706,973	40
41	Income before Income Taxes (line 30 minus line 40)**	(392,959)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (392,959)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Illinois Knights Templar Home
Provider# 0010058
8/1/10-7/31/11

Schedule 19A

XVII. Income Statement
Line 27: Other Revenue

Description	Amount
Monthly Service CLU's Private	114,558
Monthly Service Fee Townhouses	24,400
Clearing Account	7,354
Banquet & Pilgrimage Income	4,361
Miscellaneous Income	572
Cookbook Income	776
Activity Miscellaneous Income	1,381
	<u>153,402</u>

See Accountants' Compilation 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	1,856	2,088	\$ 75,244	\$ 36.04	1
2	Assistant Director of Nursing	2,023	2,229	48,856	21.92	2
3	Registered Nurses	5,693	6,140	156,268	25.45	3
4	Licensed Practical Nurses	14,409	15,626	327,162	20.94	4
5	CNAs & Orderlies	49,988	52,653	603,597	11.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,787	2,027	24,727	12.20	9
10	Activity Assistants	1,838	1,974	19,368	9.81	10
11	Social Service Workers	3,016	3,280	55,960	17.06	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,092	31,950	15.27	13
14	Head Cook	6,737	7,628	79,610	10.44	14
15	Cook Helpers/Assistants	7,526	8,054	72,300	8.98	15
16	Dishwashers	5,044	5,316	53,235	10.01	16
17	Maintenance Workers	5,837	6,405	111,343	17.38	17
18	Housekeepers	12,699	14,022	146,812	10.47	18
19	Laundry	3,224	3,488	36,194	10.38	19
20	Administrator	1,856	2,088	85,091	40.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,887	9,847	167,778	17.04	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	1,859	1,987	18,760	9.44	31
32	Other Health C; See Sch 20A	5,169	5,473	90,332	16.51	32
33	Other(specify) See Sch 20A	1,803	1,982	23,274	11.74	33
34	TOTAL (lines 1 - 33)	143,119	154,399	\$ 2,227,861 *	\$ 14.43	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	111	\$ 5,121	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant	18	1,170	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,980	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	60	2,905	11(3)	44
45	Social Service Consultant	60	2,905	12(3)	45
46	Other(specify) Quality Assurance	Monthly	600	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	249	\$ 26,681		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	173	4,992	10(3)	52
53	TOTAL (lines 50 - 52)	173	\$ 4,992		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Illinois Knights Templar Home
Provider # 0010058
8/1/10-7/31/11

Schedule 20A

XVIII:A

Line 32 Other Healthcare (specify):

Description	# of Hrs Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Rate
MDS Coordinator	1,856	2,088	60,679	29.06
Unit Coordinator	3,313	3,385	29,653	8.76
	5,169	5,473	90,332	16.51

XVIII:A

Line 33 Other (specify):

Description	# of Hrs Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Rate
Barber and Beauty	482	498	5,633	11.31
Independent Living	1,321	1,484	17,641	11.89
	1,803	1,982	23,274	11.74

See Accountants' Compilation Report

Facility Name & ID Number		Illinois Knights Templar Home		STATE OF ILLINOIS		# 0010058		Report Period Beginning:		08/01/2010		Page 21		Ending: 07/31/2011	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount	
Katheryn Swan		Administrator		0%		\$ 85,091		Workers' Compensation Insurance		\$ 93,000		IDPH License Fee		\$	
								Unemployment Compensation Insurance		12,923		Advertising: Employee Recruitment		1,867	
								FICA Taxes		167,355		Health Care Worker Background Check			
								Employee Health Insurance		423,207		(Indicate # of checks performed 72)		868	
								Employee Meals				Patient Background Checks		104 1,250	
								Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous Licenses & Fees		884	
								Employee Retirement		65,218		Miscellaneous Dues & Subscriptions		1,585	
								Employee Relations		4,230		IHCA Dues		4,140	
												EE Recruitment (Hiring) Expense		10,646	
												Less: Public Relations Expense		(445)	
												Non-allowable advertising		()	
												Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)												TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,795	
(List each licensed administrator separately.)						\$ 85,091									
B. Administrative - Other								Offset CLU Benefits				(6,065)			
Description						Amount									
N/A						\$									
TOTAL (agree to Schedule V, line 17, col. 3)						\$									
(Attach a copy of any management service agreement)															
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount	
Duane Morris		Legal		\$ 79,702		N/A				\$		Out-of-State Travel		\$	
McGladrey & Pullen, LLP		Accounting		74,755											
Citi Business Card		Computer Service		214											
Conxxus		Computer Service		959								In-State Travel			
Accu-Med		Computer Service		8,520											
Ivans		Computer Service		787											
Reece Computer		Computer Service		180											
Ribbon Rail		Computer Service		620								Seminar Expense		6,111	
McKesson Medical		Data Processing		580											
WDM Computer Services		Data Processing		8,000											
AllScripts		Data Processing/Computer Serv		2,500											
												Entertainment Expense		()	
												(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				\$		TOTAL		\$ 6,111	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 176,817											
* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT															
**See instructions.															

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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.

IHCA - \$4,140

(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 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 34,082

Line 10

(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.

\$ 41,063

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?

Yes

(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?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 5,958

(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.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

Adequate records have been maintained.

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?

Yes

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.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

McGladrey & Pullen, LLP

(18)

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

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT