

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0010058

Facility Name: Illinois Knights Templar Home

Address: 450 Fulton Street, P.O. Box 49 Paxton 60957
Number City Zip Code

County: Ford

Telephone Number: (217) 379-2116 Fax # (217) 379-3000

HFS ID Number:

Date of Initial License for Current Owners: 8/1/1954

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/2011 to 07/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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: 08/01/2011 Ending: 07/31/2012

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 bedsN/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>27,450</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>27,450</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,088</u>	<u>11,169</u>	<u>2,071</u>	<u>22,328</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>9,088</u>	<u>11,169</u>	<u>2,071</u>	<u>22,328</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.34%

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?

YesG. 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 2,071Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 07/31/2012 Fiscal Year: 07/31/2012

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

	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	216,652	19,931	18,501	255,084		255,084		255,084			1
2	Food Purchase		147,726		147,726		147,726	(12,370)	135,356			2
3	Housekeeping	128,990	11,389		140,379		140,379		140,379			3
4	Laundry	32,762	10,377		43,139		43,139		43,139			4
5	Heat and Other Utilities			80,368	80,368		80,368		80,368			5
6	Maintenance	95,204	18,170	69,243	182,617		182,617		182,617			6
7	Other (specify):*											7
8	TOTAL General Services	473,608	207,593	168,112	849,313		849,313	(12,370)	836,943			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,305,155	96,286	41,287	1,442,728		1,442,728		1,442,728			10
10a	Therapy											10a
11	Activities	48,164	4,845	4,057	57,066		57,066	(772)	56,294			11
12	Social Services	61,796	368	3,274	65,438		65,438		65,438			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,415,115	101,499	60,618	1,577,232		1,577,232	(772)	1,576,460			16
	C. General Administration											
17	Administrative	91,163			91,163		91,163		91,163			17
18	Directors Fees											18
19	Professional Services			135,843	135,843		135,843		135,843			19
20	Dues, Fees, Subscriptions & Promotions			23,328	23,328		23,328	(630)	22,698			20
21	Clerical & General Office Expenses	175,011	14,760	20,740	210,511		210,511	(52)	210,459			21
22	Employee Benefits & Payroll Taxes			811,160	811,160		811,160	(10,719)	800,441			22
23	Inservice Training & Education			562	562		562		562			23
24	Travel and Seminar			5,921	5,921		5,921		5,921			24
25	Other Admin. Staff Transportation			2,806	2,806		2,806		2,806			25
26	Insurance-Prop.Liab.Malpractice			135,326	135,326		135,326		135,326			26
27	Other (specify):*											27
28	TOTAL General Administration	266,174	14,760	1,135,686	1,416,620		1,416,620	(11,401)	1,405,219			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,897	323,852	1,364,416	3,843,165		3,843,165	(24,543)	3,818,622			29

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

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			109,910	109,910		109,910	26,787	136,697			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			4,573	4,573		4,573		4,573			35
36	Other (specify):*											36
37	TOTAL Ownership			114,483	114,483		114,483	26,787	141,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,040	427,446	482,486		482,486		482,486			39
40	Barber and Beauty Shops		1,403	16,573	17,976		17,976		17,976			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,874	174,874		174,874		174,874			42
43	Other (specify):* Non-Allowable Co	26,446	51,461	145,580	223,487		223,487	(223,487)				43
44	TOTAL Special Cost Centers	26,446	107,904	764,473	898,823		898,823	(223,487)	675,336			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,181,343	431,756	2,243,372	4,856,471		4,856,471	(221,243)	4,635,228			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	26,787	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	(17,670)	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	(11,406)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(218,954)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (221,243)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (221,243)		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

Illinois Knights Templar Home

ID# 0010058

Report Period Beginning: 08/01/2011

Ending: 07/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Offset meal income	\$ (5,104)	2	1
2	Offset pilgrimage income	(7,266)	2	2
3	Offset Miscellaneous revenue	(52)	21	3
4	Offset miscellaneous activities revenue	(772)	11	4
5	Disallow chamber/rotary dues	(630)	20	5
6	Disallow Medicare ancillary expenses	(69,232)	43	6
7	Disallow banquet expenses	(339)	43	7
8	Disallow CLU cost	(73,717)	43	8
9	Disallow TH costs	(13,799)	43	9
10	Disallow rental house costs	(629)	43	10
11	Disallow seasonal mailer expense	(5,467)	43	11
12	Medicaid B write off	(2,595)	43	12
13	Disallow cable expense	(7,204)	43	13
14	Disallow volunteer appreciation expense	(64)	43	14
15	Patient Refund	(2,810)	43	15
16	Disallow Marketing Expense	(14,524)	43	16
17	Disallow CLU Benefit offset	(9,834)	22	17
18	Disallow Board Expense	(512)	43	18
19	Disallow Dentist Supplies	(3,474)	43	19
20	Disallow Fringe Benefit Med	(885)	22	20
21	Disallow Rental House Equipment	(45)	43	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	(218,954)		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

X NO

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

1		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.

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	See attached Sch 7A								\$		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

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2011 Ending: 7/31/2012

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 _____
Street Address N/A _____
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.)**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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.)		2011		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2012 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:	2007		8		
	2008		9		
	2009		10		
	2010		11		
	2011		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Illinois Knights Templar Home</u>	COUNTY	<u>Ford</u>
---------------	--------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0010058

CONTACT PERSON REGARDING THIS REPORT Kathy Swan

TELEPHONE (217) 379-2116 FAX #: (217) 379-3000

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. Entity is a not-for-profit facility and does not pay real estate taxes.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2011

Ending:

07/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	13			1963	\$ 155,247	\$	40	\$	\$	155,247	4
5	37			1975	825,217	20,630	40	20,630		783,940	5
6	6			1987	587,238	14,681	40	14,681		381,706	6
7	4			1992	64,239	1,606	40	1,606		33,726	7
8	15			1996	1,292,665	32,317	40	32,317		306,432	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		34,810	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			9,799	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		5,688	22
23	Furnace - Administrators House			1985	1,522		15			1,522	23
24	5 Room Renovation			1988	144,260	3,607	40	3,607		86,568	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	10	20	10		790	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		2,754	32
33	Install New Hot Water Supply			1992	3,039	76	20	76		2,432	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		33,952	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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2011

Ending:

07/31/2012

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	Land Improvement -Removal Of Tank	1993	\$ 2,500	\$	10	\$	\$	\$ 2,500	37
38	Roof Insulation	1993	15,800	395	15	395		15,796	38
39	Roof Insulation and Replace Skylights	1993	6,672	167	15	167		6,526	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		4,690	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		689	44
45	Land Improvement - Sidewalks	1994	1,721	43	15	43		1,609	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		5,180	48
49	Land Improvement - Transplanted Tree	1995	275	7	20	7		196	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		815	52
53	Land Improvement - Repaired Water Main	1996	1,002	25	25	25		560	53
54	Remodeled Dining Room - Wallpaper	1996	550		5			550	54
55	Replaced Tile In Bath #1	1996	685	17	20	17		432	55
56	Installed New Fire Door	1996	4,321	108	15	108		3,456	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		1,547	58
59	Replace Piping From Hot Water Heater	1996	603	15	20	15		390	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		1,936	61
62	Installed New Door Alarms In 1995 Addition	1997	1,752	44	10	44		1,752	62
63	Increased Value Of Land - Demolition Of Old House	1997	51,268						63
64	Maintemance Equipment	2003	937	23	10	23		372	64
65	Wallpaper And Tile In Solarium	1997	2,586		5			2,586	65
66	Installed Wallpaper	1997	392	10	20	10		392	66
67	Installed New Water Line	1997	3,336	83	20	83		2,234	67
68	Installed Mop Sink & Ductwork For Furnace	1997	2,508	63	20	63		1,504	68
69	Land Improvement - Removed Trees	1997	860	22	20	22		520	69
70	TOTAL (lines 4 thru 69)		\$ 3,567,811	\$ 77,467		\$ 77,467	\$	\$ 2,140,905	70

**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:

08/01/2011

Ending:

07/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,567,811	\$ 77,467		\$ 77,467	\$	\$ 2,140,905	1
2	Replaced Water & Sewer Lines, Sink, Faucet & Countertops	1998	3,511	88	20	88		1,862	2
3	Installed Mini-Blinds in Breakroom	1998	904		5			904	3
4	Land Improvement	1998	3,239		20			3,239	4
5	Land Improvement - Planted Trees	1998	699	17	20	17		358	5
6	Repaired Generator	1998	1,925	48	20	48		992	6
7	Installed Closet Dividers	1998	474	12	15	12		299	7
8	Repaired Roof	1998	633	16	10	16		522	8
9	Installed Oxygen Ventilation System	1998	2,980	75	20	75		1,506	9
10	Installed Carpet	1998	680		5			680	10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050	201	25	201		3,567	11
12	Landscaping	1998	300		5			300	12
13	Concrete Driveway	1999	8,000	200	10	200		6,000	13
14	Roof Improvements on 1975 Addition	1999	4,776	119	10	119		3,581	14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528	263	10	263		7,896	15
16	Pavillion	1999	14,214	355	25	355		5,400	16
17	Electric Improvements on the 1995 Addition	1999	4,762	119	20	119		2,023	17
18	Kitchen Fire System	1999	1,797	45	10	45		1,170	18
19	Pavillion Lights	2000	1,235	31	10	31		806	19
20	Building Improvement Original Memorial Monument	2000	746	19	40	19		259	20
21	Building Improvement Original BTU Heat Pump	2000	1,988	50	40	50		600	21
22	Building Improvements 1988 New Wander Guard System	2000	11,990	300	40	300		3,600	22
23	Land Improvement Sidewalk and Pad	2001	2,300	58	15	58		1,076	23
24	Building Improvement 1975 PTAC Chassis	2002	25,807	645	40	645		7,095	24
25	Garage Door	2002	675	17	10	17		340	25
26	Building Improvements - Handrails	2002	1,480	37	10	37		740	26
27	Water Heater	2002	2,378	59	10	59		1,186	27
28	Smoke Damper	2002	605	15	10	15		309	28
29	Transformer	2002	206	5	10	5		103	29
30	Building Improvements - Roofing	2003	140,166	3,504	40	3,504		35,040	30
31	Room Furnishings	2003	1,248	31	10	31		498	31
32	Building Improvements - Original Building	2004	17,366	434	40	434		3,906	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,843,473	\$ 84,230		\$ 84,230	\$	\$ 2,236,762	34

**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:

08/01/2011

Ending:

07/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,843,473	\$ 84,230		\$ 84,230	\$	\$ 2,236,762	1
2	PTAC Unit	2004	2,848	71	40	71		568	2
3	Door	2005	1,806	15	40	15		120	3
4	Water supply & pipe	2005	1,500	12	40	12		96	4
5	PTAC Unit	2005	586	18	40	18		117	5
6	Handrail	2006	1,156	20	40	20		130	6
7	PTAC Unit	2006	562	14	40	14		91	7
8	PTAC Unit	2006	570	14	40	14		91	8
9	Door	2006	4,780	20	40	20		130	9
10									10
11	PTAC Units	2006	7,470	187	40	187		1,028	11
12	Wallpaper	2007	2,557	64	40	64		294	12
13	Carpeting	2007	4,754	119	40	119		654	13
14	Blinds	2007	3,700	93	40	93		511	14
15	Dishwasher Booster Heater	2007	10,175	254	40	254		1,397	15
16	Fire Rated Duct Enclosure	2007	9,000	225	40	225		1,238	16
17	Rebuild Water Softener	2007	2,938	294	10	294		1,617	17
18	Kitchen floor tile & installation	2007	6,785	678	10	678		3,729	18
19	Re-Roof Rent House & Garage	2006	7,418	185	40	185		1,018	19
20									20
21	Landscaping (new flower beds around facility)	2008	3,275	82	40	82		368	21
22	Paving of parking lot	2007	42,750	1,068	40	1,068		4,806	22
23	Replace concrete sidewalk and fire hydrant area	2007	6,582	164	40	164		738	23
24	Dining Room (new floor, cabinets, window coverings, painting)	2008	13,960	350	40	350		1,575	24
25	Water Heater	2007	16,308	408	40	408		1,836	25
26	Kitchen (blinds, entrance board, linoleum)	2008	3,049	78	40	78		351	26
27	Kitchen (cabinets, flooring)	2007	17,068	894	40	894		4,023	27
28	Shower/Tub	2007	3,311	84	40	84		378	28
29	Plumbing/electrical work	2007	3,908	98	40	98		441	29
30	Concrete repairs - new patio	2008	5,448	136	40	136		612	30
31	Carpeting/Tile	2007	7,258	182	40	182		819	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,995	\$ 90,057		\$ 90,057	\$	\$ 2,265,538	34

**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:

08/01/2011

Ending:

07/31/2012

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	\$ 90,057		\$ 90,057	\$	\$ 2,265,538	1
2	Asphalt work-new retaining wall, landscape beneath	2008	20,710	932	20	932		3,262	2
3	Gazebo	2008	27,889	1,046	25	1,046		3,661	3
4	South Tunnel Exit	2008	10,582	530	20	530		1,855	4
5	Plumbing & Heat pump	2008	10,147	306	35	306		1,071	5
6	Electrical work, exhaust fan	2009	6,854	172	40	172		602	6
7	Elevator Repair	2008	5,124	176	30	176		616	7
8	Gutter Helmets	2008	5,784	266	20	266		931	8
9	New Shelving	2008	4,682	176	25	176		616	9
10	Sewer line replacement & unit compressor	2008	10,075	296	35	296		1,036	10
11	Fire doors	2009	10,163	212	40	212		742	11
12	Smoke Detectors	2009	4,368	110	40	110		385	12
13	Handicap electrical door	2009	6,528	136	40	136		476	13
14	Electrical doors	2009	19,998	414	40	414		1,449	14
15	Generator charging system	2009	3,725	62	40	62		217	15
16	Security system	2009	5,430	22	40	22		77	16
17	Room Repair-plumbing	2009	2,995	75	40	75		187	17
18	Water Heater	2009	3,665	367	10	367		917	18
19	Bathroom Renovation-Plumbing,hardware	2010	52,122	1,303	40	1,303		3,258	19
20	Elevator Repair	2010	5,248	175	30	175		437	20
21	Roof Repair	2010	9,928	248	40	248		992	21
22	Air Conditioner	2010	6,690	669	10	669		1,673	22
23	Accordion Doors	2010	4,750	158	30	158		396	23
24	Heating/Ventilation	2010	9,455	236	40	236		354	24
25	Security Cameras	2010	16,650	416	40	416		624	25
26	Doors	2011	8,050	202	40	202		303	26
27	PTAC Unit	2011	6,165	154	40	154		231	27
28	Increased Value Of Land - Demolition Of Old House	2011	5,000	124	40	124		186	28
29	Call Light System	2012	41,607	520	40	520		520	29
30	PTAC Unit	2012	8,028	100	40	100		100	30
31	Fire Alarm	2012	17,000	213	40	213		213	31
32									32
33	To tie book depreciation to book balance			(22,035)			22,035		33
34	TOTAL (lines 1 thru 33)		\$ 4,384,407	\$ 77,839		\$ 99,873	\$ 22,035	\$ 2,292,925	34

**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	\$ 885,793	\$ 31,372	\$ 36,125	\$ 4,753	10	\$ 704,602	71
72	Current Year Purchases	13,977	699	699		10	699	72
73	Fully Depreciated Assets	156,672					156,672	73
74								74
75	TOTALS	\$ 1,056,442	\$ 32,071	\$ 36,824	\$ 4,753		\$ 861,973	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	76
77	Facility-Maintenance	Chevy S-10, 1988	1988	10,077					10,077	77
78	Facility-Patient Care	Buick Century, 1993	1993	14,491					14,491	78
79										79
80	TOTALS			\$ 60,368	\$	\$	\$		\$ 60,368	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,527,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 109,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,697	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,788	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,215,266	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Townhouse 1975	\$ 136,194	\$ 3,989	\$ 103,841	86
87	Congregate Living Units, 1998	419,680	13,259	365,561	87
88					88
89					89
90					90
91	TOTALS	\$ 555,874	\$ 17,248	\$ 469,402	91

G. Construction-in-Progress

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

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

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

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

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. /2013 \$
13. /2014 \$
14. /2015 \$

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: \$ 4,573 Description: Nursing Eqpt - 3,155; Office Eqpt - 658; Mtce. Eqpt. - 760
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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	39 (3)	hrs	\$	1,832	\$ 131,911	\$	1,832	\$ 131,911	1
2	Licensed Speech and Language Development Therapist	39 (3)	hrs		1,076	77,493		1,076	77,493	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 (2), (3)	hrs		3,028	218,042	1,931	3,028	219,973	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				53,109		53,109	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,936	\$ 427,446	\$ 55,040	5,936	\$ 482,486	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 246,745	\$ 246,745	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	724,771	724,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,842	55,842	6
7	Other Prepaid Expenses	27,366	27,366	7
8	Accounts Receivable (owners or related parties)	550	550	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,055,274	\$ 1,055,274	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	564,763	1,459,801	15
16	Equipment, at Historical Cost	962,162	1,116,810	16
17	Accumulated Depreciation (book methods)	(3,101,268)	(3,215,266)	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>	122,906	86,427	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,514,742	\$ 2,398,582	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,570,016	\$ 3,453,856	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,437	\$ 254,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,915	162,915	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	10,619	10,619	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch 17A</u>	2,227	2,227	36
37	<u>Other Current Liabilities</u>	191,055	191,055	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 621,253	\$ 621,253	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)	\$ 621,253	\$ 621,253	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,948,763	\$ 2,832,603	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,570,016	\$ 3,453,856	48

*(See instructions.)

Schedule 17A

XV. Balance Sheet
Line 36: Other Current Liabilities

Description	Operating	After Consolidation
Funds held by CIPS	228	228
Accounts Receivable - CLU	1,999	1,999
	2,227	2,227

XV. Balance Sheet
Line 37: Other Current Liabilities

Description	Operating	After Consolidation
Other Current Liabilities	175,302	175,302
Clearing Account	15,753	15,753
	191,055	191,055

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,143,090	1
2	Restatements (describe):		2
3	Prior Period Adjustment	492,077	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,635,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(686,404)	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)	\$ (686,404)	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)	\$ 2,948,763	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illinois Knights Templar Home# 0010058Report Period Beginning: 08/01/2011Ending: 07/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,315,378	1
2	Discounts and Allowances for all Levels	(711,213)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,604,165	3
	B. Ancillary Revenue		
4	Day Care	715	4
5	Other Care for Outpatients		5
6	Therapy	1,118,536	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,119,251	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	24,577	13
14	Non-Patient Meals	5,104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,223	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,249	19
20	Radiology and X-Ray		20
21	Other Medical Services	199,758	21
22	Laundry	15,334	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 293,245	23
	D. Non-Operating Revenue		
24	Contributions	5,747	24
25	Interest and Other Investment Income***	69	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,816	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19A</u>	147,590	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 147,590	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,170,067	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	849,313	31
32	Health Care	1,577,232	32
33	General Administration	1,416,620	33
	B. Capital Expense		
34	Ownership	114,483	34
	C. Ancillary Expense		
35	Special Cost Centers	723,949	35
36	Provider Participation Fee	174,874	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,856,471	40
41	Income before Income Taxes (line 30 minus line 40)**	(686,404)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (686,404)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,163,211	44
45	Private Pay - Net Inpatient Revenue	1,762,075	45
46	Medicare - Net Inpatient Revenue	390,092	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,315,378	49

* 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.

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

Illinois Knights Templar Home
Provider# 0010058
8/1/11-7/31/12

Schedule 19A

XVII. Income Statement
Line 27: Other Revenue

Description	Amount
Monthly Service CLU's Private	110,983
Monthly Service Fee Townhouses	26,600
Monthly Service Fee Rental Hous	1,725
Banquet & Pilgrimage Income	7,266
Miscellaneous Income	52
Cookbook Income	192
Activity Miscellaneous Income	772
	<u>147,590</u>

Facility Name & ID Number Illinois Knights Templar Home# 0010058Report Period Beginning: 08/01/2011Ending: 07/31/2012

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	1,288	1,512	\$ 53,114	\$ 35.13	1
2	Assistant Director of Nursing	2,108	2,183	79,886	36.59	2
3	Registered Nurses	7,196	7,605	190,301	25.02	3
4	Licensed Practical Nurses	12,988	14,217	250,606	17.63	4
5	CNAs & Orderlies	47,349	49,783	585,844	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,128	27,830	13.08	9
10	Activity Assistants	1,878	2,006	20,334	10.14	10
11	Social Service Workers	3,343	3,671	61,796	16.83	11
12	Dietician					12
13	Food Service Supervisor	1,936	1,992	27,826	13.97	13
14	Head Cook	5,637	6,413	63,917	9.97	14
15	Cook Helpers/Assistants	5,560	6,256	53,617	8.57	15
16	Dishwashers	6,936	7,360	71,292	9.69	16
17	Maintenance Workers	5,542	6,046	95,204	15.75	17
18	Housekeepers	11,804	13,104	128,990	9.84	18
19	Laundry	2,914	3,122	32,762	10.49	19
20	Administrator	1,800	2,088	91,163	43.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,717	9,489	175,011	18.44	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	1,728	1,940	18,483	9.53	31
32	Other Health C; See Sch 20A	4,835	5,243	126,921	24.21	32
33	Other(specify) See Sch 20A	1,980	2,224	26,446	11.89	33
34	TOTAL (lines 1 - 33)	137,499	148,382	\$ 2,181,343 *	\$ 14.70	34

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

** See instructions.

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	282	\$ 11,978	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant	30	1,989	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	48	2,757	11(3)	44
45	Social Service Consultant	48	3,274	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	408	\$ 33,978		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	1,397	37,318	10(3)	52
53	TOTAL (lines 50 - 52)	1,397	\$ 37,318		53

Illinois Knights Templar Home
Provider # 0010058
8/1/11-7/31/12

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	1,824	2,088	99,013	47.42
Unit Coordinator	3,011	3,155	27,908	8.85
	4,835	5,243	126,921	24.21

XVIII:A

Line 33 Other (specify):

Description	# of Hrs Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Rate
Independent Living	1,980	2,224	26,446	11.89
	1,980	2,224	26,446	11.89

STATE OF ILLINOIS

0010058

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Facility Name & ID Number

Illinois Knights Templar Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katheryn Swan	Administrator	0	\$ 91,163
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,163

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	\$ 55,148
McGladrey & Pullen, LLP	Accounting	56,180
Citi Business Card	Computer Service	213
Conxxus	Computer Service	1,039
Accu-Med	Computer Service	8,580
Ivans	Computer Service	1,940
Reece Computer	Computer Service	150
Ribbon Rail	Computer Service	260
Computrition	Computer Service	433
McKesson Medical	Data Processing	560
WDM Computer Services	Data Processing	7,460
See Sch 21 A		3,880
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 135,843

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 111,263
Unemployment Compensation Insurance	21,821
FICA Taxes	169,916
Employee Health Insurance	437,053
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	65,454
Employee Relations	4,768
Offset CLU Benefits	(9,834)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 800,441

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

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	862
Health Care Worker Background Check (Indicate # of checks performed 28)	588
Patient Background Checks 21	250
Miscellaneous Licenses & Fees	805
Miscellaneous Dues & Subscriptions	3,136
IHCA Dues	5,313
EE Recruitment (Hiring) Expense	8,394
Less: Public Relations Expense	(630)
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,698

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	5,921
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 5,921

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Illinois Knights Templar Home
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Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Allscripts	Data Processing/Computer Services	2,750
Reece Computer	Data Processing/Consultant	1,020
MCS Office Tech	Data Processing/Consultant	110
		<u>3,880</u>

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$5,313
- (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.

\$ 33,487

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.

\$ 174,874

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. \$ 5,104
- (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 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.