

Facility Name & ID Number Illinois Knights Templar Home

0010058 Report Period Beginning: 8/1/08 Ending: 7/31/09

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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	12,759	10,374	1,692	24,825	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,759	10,374	1,692	24,825	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.68%

#REF!

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

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 1,692

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 7/31/09 Fiscal Year: 7/31/09

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

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 8/1/08 Ending: 7/31/09

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	280,234	19,184	13,512	312,930		312,930		312,930		1
2	Food Purchase		149,538		149,538		149,538	(7,723)	141,815		2
3	Housekeeping	158,300	13,286		171,586		171,586		171,586		3
4	Laundry	43,292	9,126	11,925	64,343		64,343		64,343		4
5	Heat and Other Utilities			109,965	109,965		109,965		109,965		5
6	Maintenance	112,853	17,463	87,336	217,652		217,652		217,652		6
7	Other (specify):*										7
8	TOTAL General Services	594,679	208,597	222,738	1,026,014		1,026,014	(7,723)	1,018,291		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,256,641	85,109	65,640	1,407,390		1,407,390		1,407,390		10
10a	Therapy		918	212,465	213,383		213,383		213,383		10a
11	Activities	48,222	3,839	5,374	57,435		57,435		57,435		11
12	Social Services	52,485	22	2,871	55,378		55,378		55,378		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,357,348	89,888	298,350	1,745,586		1,745,586		1,745,586		16
	C. General Administration										
17	Administrative	76,416			76,416		76,416		76,416		17
18	Directors Fees										18
19	Professional Services			246,058	246,058		246,058		246,058		19
20	Dues, Fees, Subscriptions & Promotions			17,052	17,052		17,052	(432)	16,620		20
21	Clerical & General Office Expenses	167,156	18,906	37,605	223,667		223,667	(304)	223,363		21
22	Employee Benefits & Payroll Taxes			741,787	741,787		741,787	(5,834)	735,953		22
23	Inservice Training & Education			853	853		853		853		23
24	Travel and Seminar			6,091	6,091		6,091		6,091		24
25	Other Admin. Staff Transportation			3,412	3,412		3,412		3,412		25
26	Insurance-Prop.Liab.Malpractice			100,686	100,686		100,686		100,686		26
27	Other (specify):*										27
28	TOTAL General Administration	243,572	18,906	1,153,544	1,416,022		1,416,022	(6,570)	1,409,452		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,195,599	317,391	1,674,632	4,187,622		4,187,622	(14,293)	4,173,329		29

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

#REF!

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

Facility Name & ID Number Illinois Knights Templar Home

#0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			110,776	110,776		110,776	53,767	164,543			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			1,796	1,796		1,796		1,796			35
36	Other (specify):*											36
37	TOTAL Ownership			112,572	112,572		112,572	53,767	166,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,668		57,668		57,668		57,668			39
40	Barber and Beauty Shops	20,938	1,526	576	23,040		23,040		23,040			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):* Non-allowable cost	17,570	28,210	108,574	154,354		154,354	(154,354)				43
44	TOTAL Special Cost Centers	38,508	87,404	150,213	276,125		276,125	(154,354)	121,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,234,107	404,795	1,937,417	4,576,319		4,576,319	(114,880)	4,461,439			45

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

** See schedule of adjustments attached at end of cost report.

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

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.)

		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	53,767	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	(225)	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	(13,967)	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 PG5A	(154,455)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,880)		\$	30

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

		1	2	
		Amount	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))	\$ (114,880)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

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Illinois Knights Templar Home

ID# 0010058

Report Period Beginning: 8/1/08

Ending: 7/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset meal revenue	\$ (2,195)	2	1
2	Offset pilgrimage revenue	(5,528)	2	2
3	Offset miscellaneous revenue	(304)	21	3
4	Disallow chamber/rotary dues	(432)	20	4
5	Disallow Medicare ancillary expenses	(48,747)	43	5
6	Disallow banquet expenses	(391)	43	6
7	Disallow CLU Costs	(52,936)	43	7
8	Disallow TH Costs	(5,391)	43	8
9	Disallow rental house costs	(1,949)	43	9
10	Disallow seasonal mailer expense	(4,411)	43	10
11	Medicaid B Write off	(380)	43	11
12	Disallow cable expense	(6,067)	43	12
13	Disallow volunteer appreciation expense	(684)	43	13
14	Patient Refund	(280)	43	14
15	Plant Operations	(18,926)	43	15
16	Benefiti offset CLU	(5,834)	22	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(154,455)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 8/1/08 Ending: 7/31/09

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

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending: 7/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

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Facility Name & ID Number

Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

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		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						\$	\$			\$	1							
2			This page not applicable								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. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.) #REF!

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

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	13			1963	\$ 155,247	\$	40	\$	\$	\$ 155,247	4
5	37			1975	825,217	20,630	40	20,630		722,050	5
6	6			1987	587,238	14,681	40	14,681		337,663	6
7	4			1992	64,239	1,606	40	1,606		28,908	7
8	15			1996	1,292,665	32,317	40	32,317		209,481	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		31,789	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	48	25	48		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		5,238	22
23	Furnace - Administrators House			1985	1,522		15			1,522	23
24	5 Room Renovation			1988	144,260	3,607	40	3,607		75,747	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		740	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		2,511	32
33	Install New Hot Water Supply			1992	3,039	76	20	76		2,204	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		28,591	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

#REF!

Facility Name & ID Number Illinois Knights Templar Home# 0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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		14,611	38
39	Roof Insulation and Replace Skylights	1993	6,672	167	15	167		6,025	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		4,303	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		608	44
45	Land Improvement - Sidewalks	1994	1,721	43	15	43		1,480	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		4,625	48
49	Land Improvement - Transplanted Tree	1995	275	7	20	7		175	49
50	Replace Fire System	1995	2,915		10			2,915	50
51	Installed New Shower	1996	647	16	10	16		633	51
52	Installed Garage Door & Asbestos Analysis	1996	1,254	31	20	31		722	52
53	Land Improvement - Repaired Water Main	1996	1,002	25	25	25		485	53
54	Remodeled Dining Room - Wallpaper	1996	550		5			550	54
55	Replaced Tile In Bath #1	1996	685	17	20	17		381	55
56	Installed New Fire Door	1996	4,321	108	15	108		3,132	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		1,382	58
59	Replace Piping From Hot Water Heater	1996	603	15	20	15		345	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		1,738	61
62	Installed New Door Alarms In 1995 Addition	1997	1,752	44	10	44		1,620	62
63	Increased Value Of Land - Demolition Of Old House	1997	51,268						63
64	Maintenance Equipment	2003	937	23	10	23		303	64
65	Wallpaper And Tile In Solarium	1997	2,586		5			2,586	65
66	Installed Wallpaper	1997	392	10	20	10		362	66
67	Installed New Water Line	1997	3,336	83	20	83		1,985	67
68	Installed Mop Sink & Ductwork For Furnace	1997	2,508	63	20	63		1,315	68
69	Land Improvement - Removed Trees	1997	860	22	20	22		454	69
70	TOTAL (lines 4 thru 69)		\$ 3,567,811	\$ 77,541		\$ 77,541	\$	\$ 1,908,518	70

#REF!

**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:

8/1/08

Ending:

7/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	\$ 77,541		\$ 77,541	\$	\$ 1,908,518	1
2	Replaced Water & Sewer Lines, Sink, Faucet & Countertops	1998	3,511	88	20	88		1,598	2
3	Installed Mini-Blinds in Breakroom	1998	904		5			904	3
4	Land Improvement	1998	3,239		20			3,329	4
5	Land Improvement - Planted Trees	1998	699	17	20	17		307	5
6	Repaired Generator	1998	1,925	48	20	48		848	6
7	Installed Closet Dividers	1998	474	12	15	12		263	7
8	Repaired Roof	1998	633	16	10	16		474	8
9	Installed Oxygen Ventilation System	1998	2,980	75	20	75		1,281	9
10	Installed Carpet	1998	680		5			680	10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050	201	25	201		2,964	11
12	Landscaping	1998	300		5			300	12
13	Concrete Driveway	1999	8,000	200	10	200		5,400	13
14	Roof Improvements on 1975 Addition	1999	4,776	119	10	119		3,224	14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528	263	10	263		7,107	15
16	Pavillion	1999	14,214	355	25	355		4,335	16
17	Electric Improvements on the 1995 Addition	1999	4,762	119	20	119		1,666	17
18	Kitchen Fire System	1999	1,797	45	10	45		1,035	18
19	Pavillion Lights	2000	1,235	31	10	31		713	19
20	Building Improvement Original Memorial Monument	2000	746	19	40	19		202	20
21	Building Improvement Original BTU Heat Pump	2000	1,988	50	40	50		450	21
22	Building Improvements 1988 New Wander Guard System	2000	11,990	300	40	300		2,700	22
23	Land Improvement Sidewalk and Pad	2001	2,300	58	15	58		902	23
24	Building Improvement 1975 PTAC Chassis	2002	25,807	645	40	645		5,160	24
25	Garage Door	2002	675	17	10	17		289	25
26	Building Improvements - Handrails	2002	1,480	37	10	37		629	26
27	Water Heater	2002	2,378	59	10	59		1,009	27
28	Smoke Damper	2002	605	15	10	15		264	28
29	Transformer	2002	206	5	10	5		88	29
30	Building Improvements - Roofing	2003	140,166	3,504	40	3,504		24,528	30
31	Room Furnishings	2003	1,248	31	10	31		405	31
32	Building Improvements - Original Building	2004	17,366	434	40	434		2,604	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,843,473	\$ 84,304		\$ 84,304	\$	\$ 1,984,176	34

#REF!

**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:

8/1/08

Ending:

7/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	\$ 84,304		\$ 84,304	\$	\$ 1,984,176	1
2	PTAC Unit	2004	2,848	71	40	71		355	2
3	Door	2005	1,806	15	40	15		75	3
4	Water supply & pipe	2005	1,500	12	40	12		60	4
5	PTAC Unit	2005	586	18	40	18		63	5
6	Handrail	2006	1,156	20	40	20		70	6
7	PTAC Unit	2006	562	14	40	14		49	7
8	PTAC Unit	2006	570	14	40	14		49	8
9	Door	2006	4,780	20	40	20		70	9
10									10
11	PTAC Units	2006	7,470	187	40	187		467	11
12	Wallpaper	2007	2,557	64	40	64		102	12
13	Carpeting	2007	4,754	119	40	119		297	13
14	Blinds	2007	3,700	93	40	93		232	14
15	Dishwasher Booster Heater	2007	10,175	254	40	254		635	15
16	Fire Rated Duct Enclosure	2007	9,000	225	40	225		563	16
17	Rebuild Water Softener	2007	2,938	294	10	294		735	17
18	Kitchen floor tile & installation	2007	6,785	678	10	678		1,695	18
19	Re-Roof Rent House & Garage	2006	7,418	185	40	185		463	19
20									20
21	Landscaping (new flower beds around facility)	2008	3,275	82	40	82		122	21
22	Paving of parking lot	2007	42,750	1,068	40	1,068		1,602	22
23	Replace concrete sidewalk and fire hydrant area	2007	6,582	164	40	164		246	23
24	Dining Room (new floor, cabinets, window coverings, painting)	2008	13,960	350	40	350		525	24
25	Water Heater	2007	16,308	408	40	408		612	25
26	Kitchen (blinds, entrance board, linoleum)	2008	3,049	78	40	78		117	26
27	Kitchen (cabinets, flooring)	2007	17,068	894	40	894		1,341	27
28	Shower/Tub	2007	3,311	84	40	84		126	28
29	Plumbing/electrical work	2007	3,908	98	40	98		147	29
30	Concrete repairs - new patio	2008	5,448	136	40	136		204	30
31	Carpeting/Tile	2007	7,258	182	40	182		273	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,995	\$ 90,131		\$ 90,131	\$	\$ 1,995,471	34

#REF!

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12C, Carried Forward		\$ 4,034,995	\$ 90,131		\$ 90,131	\$	\$ 1,995,471	1
2	Asphalt work-new retaining wall, landscape beneath	2008	20,710	466		466		466	2
3	Gazebo	2008	27,889	523		523		523	3
4	South Tunnel Exit	2008	10,582	265		265		265	4
5	Plumbing & Heat pump	2008	10,147	153		153		153	5
6	Electrical work, exhaust fan	2009	6,854	86		86		86	6
7	Elevator Repair	2008	5,124	88		88		88	7
8	Gutter Helmets	2008	5,784	133		133		133	8
9	New Shelving	2008	4,682	88		88		88	9
10	Sewer line replacement & unit compressor	2008	10,075	148		148		148	10
11	Fire doors	2009	10,163	106		106		106	11
12	Smoke Detectors	2009	4,368	55		55		55	12
13	Handicap electrical door	2009	6,528	68		68		68	13
14	Electrical doors	2009	19,998	207		207		207	14
15	Generator charging system	2009	3,725	31		31		31	15
16	Security system	2009	5,430	11		11		11	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,187,054	\$ 92,559		\$ 92,559	\$	\$ 1,997,899	34

#REF!

**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:

8/1/08

Ending:

7/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 797,799	\$ 15,001	\$ 68,768	\$ 53,767		\$ 820,714	71
72	Current Year Purchases	34,890	3,216	3,216			3,216	72
73	Fully Depreciated Assets	144,110					144,110	73
74								74
75	TOTALS	\$ 976,799	\$ 18,217	\$ 71,984	\$ 53,767		\$ 968,040	75

D. Vehicle Depreciation (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 Car	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 Car	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)	\$ 5,250,425	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,776	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,543	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 53,767	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,026,307	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	\$ 4,468	\$ 91,395	86
87	Congregate Living Units, 1998	419,680	13,259	325,784	87
88					88
89					89
90					90
91	TOTALS	\$ 555,874	\$ 17,727	\$ 417,179	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

#REF!

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:				\$ <u>N/A</u>			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 N/A
by the length of the lease 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: \$ 1,796 Description: Nursing Equipment- \$426; Postal Equipment- \$449; Maintenance/Welding- \$921

(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			\$ <u>N/A</u>	\$	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. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

###

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

	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	\$	1,572	\$ 94,296	\$	1,572	\$ 94,296	1
2	Licensed Speech and Language Development Therapist	10 (A) 3	hrs		187	11,237		187	11,237	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10 (A) 3	hrs		1,778	106,656	918	1,778	107,574	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 prescripts				57,668		57,668	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			\$	3,536	\$ 212,189	\$ 58,586	3,536	\$ 270,775	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.

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning: 8/1/08

Ending: 7/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/09 (last day of reporting year)

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	\$ 340,047	\$ 340,047	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (9,504))	632,161	632,161	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,604	58,604	6
7	Other Prepaid Expenses	26,099	26,099	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,056,911	\$ 1,056,911	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	82,951	26,204	13
14	Buildings, at Historical Cost	3,878,228	2,924,606	14
15	Leasehold Improvements, at Historical Cost	332,984	1,262,448	15
16	Equipment, at Historical Cost	898,681	1,037,167	16
17	Accumulated Depreciation (book methods)	(2,818,480)	(3,026,307)	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>	159,600	138,695	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,533,964	\$ 2,362,813	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,590,875	\$ 3,419,724	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 92,285	\$ 92,285	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	165,464	165,464	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,916	17,916	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	7,450	7,450	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	46,664	46,664	36
37	<u>Other Current Liabilities</u>	151,327	151,327	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 481,106	\$ 481,106	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)	\$ 481,106	\$ 481,106	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,109,769	\$ 2,938,618	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,590,875	\$ 3,419,724	48

#REF!

*(See instructions.)

Illinois Knights Templar Home
Provider #: 0010058
8/1/2008 to 07/31/2009

Schedule 17A

XV. Balance Sheet
Line 36: Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Funds held by CIPS	176	176
Employee Benefit Liabilities	5,029	5,029
Accrued Expenses	30,995	30,995
Due to Third Party Payors	10,464	10,464
	<u>46,664</u>	<u>46,664</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,099,268	1
2	Restatements (describe):		2
3	Prior period adjustment	(910,014)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,189,254	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(842,217)	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)	\$ (842,217)	17
	B. Transfers (Itemize):		
18	Administrative Transfer	1,762,732	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,762,732	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,109,769	24 *

* This must agree with page 17, line 47.

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning: 8/1/08

Ending:

7/31/09

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	\$ 3,305,948	1
2	Discounts and Allowances for all Levels	(533,884)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,772,064	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	566,536	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 566,536	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	18,090	13
14	Non-Patient Meals	2,195	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	51,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,751	19
20	Radiology and X-Ray		20
21	Other Medical Services	172,241	21
22	Laundry	11,586	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 265,562	23
D. Non-Operating Revenue			
24	Contributions	11,646	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,646	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	118,294	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 118,294	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,734,102	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,026,014	31
32	Health Care	1,745,586	32
33	General Administration	1,416,022	33
B. Capital Expense			
34	Ownership	112,572	34
C. Ancillary Expense			
35	Special Cost Centers	235,062	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)*	\$ 4,576,319	40
41	Income before Income Taxes (line 30 minus line 40)**	(842,217)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (842,217)	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. #REF!

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

Illinois Knights Templar Home
Provider #: 0010058
8/1/2008 to 7/31/2009

Schedule 19A

XVII. Income Statement
Line 27: Other Revenue

Monthly service fees-townhomes & CLU's	110,173
Interest Income	477
Clearing account	1,812
Banquet and pilgrimage	5,528
Miscellaneous income	304
	<hr/>
	<u>118,294</u>

See Accountants' Compilation Report

Facility Name & ID Number **Illinois Knights Templar Home**

0010058

Report Period Beginning:

8/1/08

Ending:

7/31/09

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	1,997	2,276	\$ 65,581	\$ 28.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,843	11,830	222,747	18.83	3
4	Licensed Practical Nurses	9,446	10,576	210,672	19.92	4
5	CNAs & Orderlies	50,378	54,337	598,846	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,886	4,129	48,222	11.68	10
11	Social Service Workers	4,399	4,996	52,485	10.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,142	22,863	280,234	12.26	15
16	Dishwashers					16
17	Maintenance Workers	6,373	6,788	112,853	16.63	17
18	Housekeepers	14,306	15,446	158,300	10.25	18
19	Laundry	3,515	3,639	43,292	11.90	19
20	Administrator	2,320	2,413	76,416	31.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,835	9,386	167,156	17.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,072	2,285	20,926	9.16	31
32	Other Health C: See Sch 20A	9,960	10,245	137,869	13.46	32
33	Other(specify) See Sch 20A	3,054	3,380	38,508	11.39	33
34	TOTAL (lines 1 - 33)	148,526	164,589	\$ 2,234,107 *	\$ 13.57	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	272	\$ 11,828	1(3)	35
36	Medical Director	24	12,000	9(3)	36
37	Medical Records Consultant	56	2,974	10(3)	37
38	Nurse Consultant	6	512	10(3)	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	5	276	10A(3)	43
44	Activity Consultant	Monthly	2,871	11(3)	44
45	Social Service Consultant	Monthly	2,871	12(3)	45
46	Other(specify) Quality Assurance	Monthly	1,275	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	\$ 36,587		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	24	\$ 1,147	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,334	57,752	10(3)	52
53	TOTAL (lines 50 - 52)	2,358	\$ 58,899		53

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Illinois Knights Templar Home
 Provider #: 0010058
 8/1/2008 to 7/31/2009

Schedule 20A

XVIII: A
 Line 32 Other Healthcare (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Rate
MDS Coordinator	2,061	2,232	55,084	24.68
Unit Coordinator	3,441	3,555	30,019	8.44
Nurse Manager	4,458	4,458	52,766	11.84
	<u>9,960</u>	<u>10,245</u>	<u>137,869</u>	<u>13.46</u>

XVIII: A
 Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Rate
Barber and Beauty	1,725	1,887	20,938.00	11.10
Independent Living	1,329	1,493	17,570.00	11.77
	<u>3,054.00</u>	<u>3,380.00</u>	<u>38,508.00</u>	<u>11.39</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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

#REF!

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

8/1/08

Ending: 7/31/09

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. LSN \$4,198
- (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. \$ 32,867 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. \$ 2,195
- (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
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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.

#REF!