

Facility Name & ID Number Illinois Knights Templar Home

0010058 Report Period Beginning: 08/01/2012 Ending: 07/31/2013

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,930	9,559	2,552	20,041	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,930	9,559	2,552	20,041	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.21%

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 8/1/54

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 1,901

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: 07/31/2013 Fiscal Year: 07/31/2013

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

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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	208,430	18,217	9,813	236,460		236,460	(10,959)	225,501		1
2	Food Purchase		128,798		128,798		128,798	(1,207)	127,591		2
3	Housekeeping	125,975	10,635		136,610		136,610		136,610		3
4	Laundry	15,126	7,732	150	23,008		23,008		23,008		4
5	Heat and Other Utilities			76,088	76,088		76,088		76,088		5
6	Maintenance	105,176	20,652	81,049	206,877		206,877	(3,000)	203,877		6
7	Other (specify):*										7
8	TOTAL General Services	454,707	186,034	167,100	807,841		807,841	(15,166)	792,675		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,395,360	89,187	46,110	1,530,657		1,530,657		1,530,657		10
10a	Therapy										10a
11	Activities	48,456	4,647	4,353	57,456		57,456	(699)	56,757		11
12	Social Services	65,301	48	2,953	68,302		68,302		68,302		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,509,117	93,882	65,416	1,668,415		1,668,415	(699)	1,667,716		16
	C. General Administration										
17	Administrative	96,263			96,263		96,263		96,263		17
18	Directors Fees										18
19	Professional Services			257,230	257,230		257,230		257,230		19
20	Dues, Fees, Subscriptions & Promotions			29,791	29,791		29,791	(590)	29,201		20
21	Clerical & General Office Expenses	201,302	25,091	25,976	252,369		252,369	(4,745)	247,624		21
22	Employee Benefits & Payroll Taxes			800,266	800,266		800,266	(9,298)	790,968		22
23	Inservice Training & Education			4,440	4,440		4,440		4,440		23
24	Travel and Seminar			1,818	1,818		1,818		1,818		24
25	Other Admin. Staff Transportation			460	460		460		460		25
26	Insurance-Prop.Liab.Malpractice			124,449	124,449		124,449		124,449		26
27	Other (specify):*										27
28	TOTAL General Administration	297,565	25,091	1,244,430	1,567,086		1,567,086	(14,633)	1,552,453		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,261,389	305,007	1,476,946	4,043,342		4,043,342	(30,498)	4,012,844		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.

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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			114,598	114,598		114,598	54,732	169,330			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			1,416	1,416		1,416		1,416			35
36	Other (specify):*											36
37	TOTAL Ownership			116,014	116,014		116,014	54,732	170,746			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,776	443,279	499,055		499,055		499,055			39
40	Barber and Beauty Shops		900	13,547	14,447		14,447		14,447			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,192	201,192		201,192		201,192			42
43	Other (specify):* Non-Allowable Cos	30,079	38,685	119,546	188,310		188,310	(188,310)				43
44	TOTAL Special Cost Centers	30,079	95,361	777,564	903,004		903,004	(188,310)	714,694			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,291,468	400,368	2,370,524	5,062,360		5,062,360	(164,076)	4,898,284			45

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

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	54,732	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	(12,373)	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	(6,578)	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	(199,857)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (164,076)		\$	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))	\$ (164,076)		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	

Illinois Knights Templar Home

ID# 0010058

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset meal income	\$ (4,816)	2	1
2	Offset pilgrimage income	(6,143)	2	2
3	Offset Miscellaneous revenue	(4,745)	21	3
4	Offset miscellaneous activities revenue	(699)	11	4
5	Disallow chamber/rotary dues	(590)	20	5
6	Disallow Medicare ancillary expenses	(40,066)	43	6
7	Disallow banquet expenses	(259)	43	7
8	Disallow CLU cost	(77,537)	43	8
9	Disallow TH costs	(13,549)	43	9
10	Disallow rental house costs	(621)	43	10
11	Disallow seasonal mailer expense	(2,500)	43	11
12	Disallow cable expense	(7,638)	43	12
13	Disallow volunteer appreciation expense	(295)	43	13
14	Patient Refund	(16,557)	43	14
15	Disallow Marketing Expense	(10,221)	43	15
16	Disallow CLU Benefit offset	(10,505)	22	16
17	Disallow Board Expense	(93)	43	17
18	Disallow Rental House Cleaning	(23)	43	18
19	Reclass Building Improvements	(3,000)	6	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	(199,857)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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.

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08/01/2012

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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				N/A	N/A	N/A	N/A	\$ N/A	N/A	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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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	<u>N/A</u>				\$	\$		\$	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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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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 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.)		2012		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2013 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:	2008	_____	8		
	2009	_____	9		
	2010	_____	10		
	2011	_____	11		
	2012	_____	12		
This page is not applicable. Entity is not for-profit facility and does not pay real estate taxes.					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illinois Knights Templar Home COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0010058

CONTACT PERSON REGARDING THIS REPORT Kathy Laube

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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>Entity is a not-for-profit facility and does not pay real estate taxes.</u>		\$ _____	\$ _____
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

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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? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Rows include Facility (120,000 sq ft, \$23,000 cost), Garage (7,850 sq ft, \$3,204 cost), and TOTALS (127,850 sq ft, \$26,204 cost).

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	13			1963	\$ 155,247	\$	40	\$	\$	\$ 155,247	4
5	37			1975	825,217	20,630	40	20,630		804,570	5
6	6			1987	587,238	14,681	40	14,681		396,387	6
7	4			1992	64,239	1,606	40	1,606		35,332	7
8	15			1996	1,292,665	32,317	40	32,317		338,749	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		35,817	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		5,838	22
23	Furnace - Administrators House			1985	1,522		15			1,522	23
24	5 Room Renovation			1988	144,260	3,607	40	3,607		90,175	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			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		2,835	32
33	Install New Hot Water Supply			1992	3,039	76	20	76		2,508	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		35,739	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:

08/01/2012 Ending: 07/31/2013**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	4	15	4		15,800	38
39	Roof Insulation and Replace Skylights	1993	6,672	146	15	146		6,672	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		4,819	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		716	44
45	Land Improvement - Sidewalks	1994	1,721	43	15	43		1,652	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		5,365	48
49	Land Improvement - Transplanted Tree	1995	275	7	20	7		203	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		846	52
53	Land Improvement - Repaired Water Main	1996	1,002	25	25	25		585	53
54	Remodeled Dining Room - Wallpaper	1996	550		5			550	54
55	Replaced Tile In Bath #1	1996	685	17	20	17		449	55
56	Installed New Fire Door	1996	4,321	108	15	108		3,564	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		1,602	58
59	Replace Piping From Hot Water Heater	1996	603	15	20	15		405	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		2,002	61
62	Installed New Door Alarms In 1995 Addition	1997	1,752		10			1,752	62
63	Increased Value Of Land - Demolition Of Old House	1997	51,268						63
64	Maintemance Equipment	2003	937	23	10	23		395	64
65	Wallpaper And Tile In Solarium	1997	2,586		5			2,586	65
66	Installed Wallpaper	1997	392		20			392	66
67	Installed New Water Line	1997	3,336	83	20	83		2,317	67
68	Installed Mop Sink & Ductwork For Furnace	1997	2,508	63	20	63		1,567	68
69	Land Improvement - Removed Trees	1997	860	22	20	22		542	69
70	TOTAL (lines 4 thru 69)		\$ 3,567,811	\$ 76,991		\$ 76,991	\$	\$ 2,217,896	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:

08/01/2012 Ending: 07/31/2013**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,567,811	\$ 76,991		\$ 76,991	\$	\$ 2,217,896	1
2	Replaced Water & Sewer Lines, Sink, Faucet & Countertops	1998	3,511	88	20	88		1,950	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		375	5
6	Repaired Generator	1998	1,925	48	20	48		1,040	6
7	Installed Closet Dividers	1998	474	12	15	12		311	7
8	Repaired Roof	1998	633	16	10	16		538	8
9	Installed Oxygen Ventilation System	1998	2,980	75	20	75		1,581	9
10	Installed Carpet	1998	680		5			680	10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050	201	25	201		3,768	11
12	Landscaping	1998	300		5			300	12
13	Concrete Driveway	1999	8,000	200	10	200		6,200	13
14	Roof Improvements on 1975 Addition	1999	4,776	119	10	119		3,700	14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528	263	10	263		8,159	15
16	Pavillion	1999	14,214	355	25	355		5,755	16
17	Electric Improvements on the 1995 Addition	1999	4,762	119	20	119		2,142	17
18	Kitchen Fire System	1999	1,797	45	10	45		1,215	18
19	Pavillion Lights	2000	1,235	31	10	31		837	19
20	Building Improvement Original Memorial Monument	2000	746	19	40	19		278	20
21	Building Improvement Original BTU Heat Pump	2000	1,988	50	40	50		650	21
22	Building Improvements 1988 New Wander Guard System	2000	11,990	300	40	300		3,900	22
23	Land Improvement Sidewalk and Pad	2001	2,300	58	15	58		1,134	23
24	Building Improvement 1975 PTAC Chassis	2002	25,807	645	40	645		7,740	24
25	Garage Door	2002	675	17	10	17		357	25
26	Building Improvements - Handrails	2002	1,480	37	10	37		777	26
27	Water Heater	2002	2,378	59	10	59		1,245	27
28	Smoke Damper	2002	605	15	10	15		324	28
29	Transformer	2002	206	5	10	5		108	29
30	Building Improvements - Roofing	2003	140,166	3,504	40	3,504		38,544	30
31	Room Furnishings	2003	1,248	31	10	31		529	31
32	Building Improvements - Original Building	2004	17,366	434	40	434		4,340	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,843,473	\$ 83,754		\$ 83,754	\$	\$ 2,320,516	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:

08/01/2012 Ending: 07/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,843,473	\$ 83,754		\$ 83,754	\$	\$ 2,320,516	1
2	PTAC Unit	2004	2,848	71	40	71		639	2
3	Door	2005	1,806	15	40	15		135	3
4	Water supply & pipe	2005	1,500	12	40	12		108	4
5	PTAC Unit	2005	586	18	40	18		135	5
6	Handrail	2006	1,156	20	40	20		150	6
7	PTAC Unit	2006	562	14	40	14		105	7
8	PTAC Unit	2006	570	14	40	14		105	8
9	Door	2006	4,780	20	40	20		150	9
10									10
11	PTAC Units	2006	7,470	187	40	187		1,215	11
12	Wallpaper	2007	2,557	64	40	64		358	12
13	Carpeting	2007	4,754	119	40	119		773	13
14	Blinds	2007	3,700	93	40	93		604	14
15	Dishwasher Booster Heater	2007	10,175	254	40	254		1,651	15
16	Fire Rated Duct Enclosure	2007	9,000	225	40	225		1,463	16
17	Rebuild Water Softener	2007	2,938	294	10	294		1,911	17
18	Kitchen floor tile & installation	2007	6,785	678	10	678		4,407	18
19	Re-Roof Rent House & Garage	2006	7,418	185	40	185		1,203	19
20									20
21	Landscaping (new flower beds around facility)	2008	3,275	82	40	82		450	21
22	Paving of parking lot	2007	42,750	1,068	40	1,068		5,874	22
23	Replace concrete sidewalk and fire hydrant area	2007	6,582	164	40	164		902	23
24	Dining Room (new floor, cabinets, window coverings, painting)	2008	13,960	350	40	350		1,925	24
25	Water Heater	2007	16,308	408	40	408		2,244	25
26	Kitchen (blinds, entrance board, linoleum)	2008	3,049	78	40	78		429	26
27	Kitchen (cabinets, flooring)	2007	17,068	894	40	894		4,917	27
28	Shower/Tub	2007	3,311	84	40	84		462	28
29	Plumbing/electrical work	2007	3,908	98	40	98		539	29
30	Concrete repairs - new patio	2008	5,448	136	40	136		748	30
31	Carpeting/Tile	2007	7,258	182	40	182		1,001	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,995	\$ 89,581		\$ 89,581	\$	\$ 2,355,119	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:

08/01/2012 Ending: 07/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,034,995	\$ 89,581		\$ 89,581	\$	\$ 2,355,119	1
2	Asphalt work-new retaining wall, landscape beneath	2008	20,710	932	20	932		4,194	2
3	Gazebo	2008	27,889	1,046	25	1,046		4,707	3
4	South Tunnel Exit	2008	10,582	530	20	530		2,385	4
5	Plumbing & Heat pump	2008	10,147	306	35	306		1,377	5
6	Electrical work, exhaust fan	2009	6,854	172	40	172		774	6
7	Elevator Repair	2008	5,124	176	30	176		792	7
8	Gutter Helmets	2008	5,784	266	20	266		1,197	8
9	New Shelving	2008	4,682	176	25	176		792	9
10	Sewer line replacement & unit compressor	2008	10,075	296	35	296		1,332	10
11	Fire doors	2009	10,163	212	40	212		954	11
12	Smoke Detectors	2009	4,368	110	40	110		495	12
13	Handicap electrical door	2009	6,528	136	40	136		612	13
14	Electrical doors	2009	19,998	414	40	414		1,863	14
15	Generator charging system	2009	3,725	62	40	62		279	15
16	Security system	2009	5,430	22	40	22		99	16
17	Room Repair-plumbing	2009	2,995	75	40	75		262	17
18	Water Heater	2009	3,665	367	10	367		1,284	18
19	Bathroom Renovation-Plumbing,hardware	2010	52,122	1,303	40	1,303		4,561	19
20	Elevator Repair	2010	5,248	175	30	175		612	20
21	Roof Repair	2010	9,928	248	40	248		1,240	21
22	Air Conditioner	2010	6,690	669	10	669		2,342	22
23	Accordion Doors	2010	4,750	158	30	158		554	23
24	Heating/Ventilation	2010	9,455	236	40	236		590	24
25	Security Cameras	2010	16,650	416	40	416		1,040	25
26	Doors	2011	8,050	202	40	202		505	26
27	PTAC Unit	2011	6,165	154	40	154		385	27
28	Increased Value Of Land - Demolition Of Old House	2011	5,000	124	40	124		310	28
29	Call Light System	2012	41,607	1,040	40	1,040		1,040	29
30	PTAC Unit	2012	8,028	201	40	201		200	30
31	Fire Alarm	2012	17,000	425	40	425		426	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,384,407	\$ 100,230		\$ 100,230	\$	\$ 2,392,322	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,384,407	\$ 100,230		\$ 100,230	\$	\$ 2,392,322	1
2	New Fire Alarm System	2013	81,944	1,024	40	1,024		1,024	2
3	Renovation - Windows	2012	2,400	30	40	30		30	3
4	Renovation - Floors	2012	7,660	96	40	96		96	4
5	Sewer Repair	2012	8,064	101	40	101		101	5
6	Door Replacement	2013	6,125	77	40	77		77	6
7	Call Light System	2013	5,872	73	40	73		73	7
8	Reclass R&M - Painting	2013	3,000			38	38	38	8
9	To reconcile to F/S			(54,695)			54,695		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,499,472	\$ 46,936		\$ 101,669	\$ 54,733	\$ 2,393,761	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:

08/01/2012

Ending:

07/31/2013

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	\$ 922,569	\$ 65,557	\$ 65,557	\$	10	\$ 766,196	71
72	Current Year Purchases	34,904	1,745	1,745		10	1,745	72
73	Fully Depreciated Assets	156,672					156,672	73
74								74
75	TOTALS	\$ 1,114,145	\$ 67,302	\$ 67,302	\$		\$ 924,613	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	\$	\$	\$	5	\$ 35,800	76
77	Facility-Maintenance	Chevy S-10, 1988	1988	10,077				5	10,077	77
78	Facility-Patient Care	Buick Century, 1993	1993	14,491				5	14,491	78
79	Truck		2003	3,596	360	360		5	360	79
80	TOTALS			\$ 63,964	\$ 360	\$ 360	\$		\$ 60,728	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)	\$ 5,703,785	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 114,598	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,331	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,733	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,379,102	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	\$ 107,830	86
87	Congregate Living Units, 1998	419,680	13,259	378,820	87
88					88
89					89
90					90
91	TOTALS	\$ 555,874	\$ 17,248	\$ 486,650	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:				\$ <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 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: \$ 1,416 Description: Nursing Eqpt - \$342, Office Eqpt - \$439, Mtce. Eqpt. - \$635

(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. /2014 \$ _____

13. /2015 \$ _____

14. /2016 \$ _____

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	39 (3)	hrs	\$	1,684	\$ 136,364	\$	1,684	\$ 136,364	1
2	Licensed Speech and Language Development Therapist	39 (3)	hrs		827	77,271		827	77,271	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 (2), (3)	hrs		2,926	229,644	6,691	2,926	236,335	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				49,085		49,085	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			\$	5,437	\$ 443,279	\$ 55,776	5,437	\$ 499,055	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	\$ 98,028	\$ 98,028	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	457,595	457,595	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,507	39,507	6
7	Other Prepaid Expenses	31,821	31,821	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 626,951	\$ 626,951	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	3,884,878	2,924,606	14
15	Leasehold Improvements, at Historical Cost	668,162	1,574,866	15
16	Equipment, at Historical Cost	994,905	1,178,109	16
17	Accumulated Depreciation (book methods)	(3,216,739)	(3,379,102)	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>	122,519	69,224	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,541,676	\$ 2,393,907	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,168,627	\$ 3,020,858	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 357,403	\$ 357,403	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,030	171,030	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	10,694	10,694	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	57,198	57,198	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 596,325	\$ 596,325	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)	\$ 596,325	\$ 596,325	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,572,302	\$ 2,424,533	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,168,627	\$ 3,020,858	48

*(See instructions.)

Illinois Knights Templar Home
Provider # 0010058
8/1/12-7/31/13

Schedule 17A

XV. Balance Sheet
Line 36: Other Current Liabilities

Description	Operating	After Consolidation
Funds held by CIPS	288	288
Accounts Receivable - CLU	1,437	1,437
Accounts Receivable - TH	25	25
Accrued Expenses	55,508	55,508
	<u>57,258</u>	<u>57,258</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,948,763	1
2	Restatements (describe):		2
3	Prior Period Adjustment	588,368	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,537,131	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(964,829)	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)	\$ (964,829)	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)	\$ 2,572,302	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning: 08/01/2012

Ending: 07/31/2013

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,144,771	1
2	Discounts and Allowances for all Levels	(523,328)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,621,443	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,033,149	6
7	Oxygen	9	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,033,158	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	16,798	13
14	Non-Patient Meals	4,816	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	42,239	17
18	Sale of Supplies to Non-Patients	5,943	18
19	Laboratory	3,573	19
20	Radiology and X-Ray		20
21	Other Medical Services	160,313	21
22	Laundry	12,926	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 246,608	23
D. Non-Operating Revenue			
24	Contributions	2,690	24
25	Interest and Other Investment Income***	609	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	193,023	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 193,023	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,097,531	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	807,841	31
32	Health Care	1,668,415	32
33	General Administration	1,567,086	33
B. Capital Expense			
34	Ownership	116,014	34
C. Ancillary Expense			
35	Special Cost Centers	701,812	35
36	Provider Participation Fee	201,192	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,062,360	40
41	Income before Income Taxes (line 30 minus line 40)**	(964,829)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (964,829)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 748,210	44
45	Private Pay - Net Inpatient Revenue	1,709,192	45
46	Medicare - Net Inpatient Revenue	162,690	46
47	Other-(specify) <u>Hospice</u>	1,351	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,621,443	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
8/1/12-7/31/13

Schedule 19A

XVII. Income Statement
Line 28: Other Revenue

<u>Description</u>	<u>Amount</u>
Monthly Service CLU's Private	113,796
Monthly Service Fee Townhouses	27,800
Monthly Service Fee Rental House	6,950
Recovered Write-Offs	32,620
Wheelchair charges Private	260
Banquet & Pilgrimage Income	6,143
Miscellaneous Income	4,745
Cookbook Income	10
Activity Miscellaneous Income	699
	<u>193,023</u>

Facility Name & ID Number Illinois Knights Templar Home

0010058

Report Period Beginning:

08/01/2012

Ending:

07/31/2013

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	1,616	1,860	\$ 67,285	\$ 36.17	1
2	Assistant Director of Nursing	3,527	3,703	108,060	29.18	2
3	Registered Nurses	11,333	11,741	305,009	25.98	3
4	Licensed Practical Nurses	7,576	8,131	150,537	18.51	4
5	CNAs & Orderlies	49,250	51,947	613,271	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,012	2,228	30,398	13.64	9
10	Activity Assistants	1,627	1,915	18,058	9.43	10
11	Social Service Workers	3,495	3,799	65,301	17.19	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,088	23,749	11.37	13
14	Head Cook	6,002	6,828	66,294	9.71	14
15	Cook Helpers/Assistants	4,264	4,927	49,594	10.07	15
16	Dishwashers	7,502	7,814	68,793	8.80	16
17	Maintenance Workers	6,354	6,759	105,176	15.56	17
18	Housekeepers	12,519	13,736	125,975	9.17	18
19	Laundry	1,818	1,830	15,126	8.27	19
20	Administrator	1,840	2,088	96,263	46.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,804	10,660	201,302	18.88	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	1,994	2,098	29,589	14.10	31
32	Other Health C: See Sch 20A	5,111	5,463	121,609	22.26	32
33	Other(specify) See Sch 20A	2,252	2,530	30,079	11.89	33
34	TOTAL (lines 1 - 33)	141,776	152,145	\$ 2,291,468 *	\$ 15	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	125	\$ 5,660	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant	24	1,560	10(3)	37
38	Nurse Consultant	311	42,585	10(3)	38
39	Pharmacist Consultant	Monthly	1,815	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	2,953	11(3)	44
45	Social Service Consultant	48	2,953	12(3)	45
46	Other(specify) Administration	51	3,448	21(3)	46
47	Quality Assurance	Monthly	150	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	607	\$ 73,124		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Illinois Knights Templar Home
 Provider # 0010058
 8/1/12-7/31/13

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	1,912	2,088	89,393	42.81
Unit Coordinator	3,011	3,155	32,216	10.21
	<u>4,923</u>	<u>5,243</u>	<u>121,609</u>	<u>23.19</u>

XVIII:A

Line 33 Other (specify):

Description	# of Hrs Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Rate
Independent Living	2,252	2,530	30,079	11.89
	<u>2,252</u>	<u>2,530</u>	<u>30,079</u>	<u>11.89</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Katheryn Laube	Administrator	0	\$ 96,263	Workers' Compensation Insurance	\$ 107,326	IDPH License Fee	\$ 0		
				Unemployment Compensation Insurance	27,917	Advertising: Employee Recruitment	5,691		
				FICA Taxes	163,985	Health Care Worker Background Check (Indicate # of checks performed <u>21</u>)	588		
				Employee Health Insurance	429,873	Patient Background Checks <u>63</u>	750		
				Employee Meals	1,207	Miscellaneous Licenses & Fees	704		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	2,050		
				Employee Retirement	66,039	IHCA Dues	3,933		
				Employee Relations	5,126	EE Recruitment (Hiring) Expense	16,075		
				Offset CLU Benefits	(10,505)				
						Less: Public Relations Expense	(590)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,263	TOTAL (agree to Schedule V, line 22, col.8)		\$ 790,968	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,201
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,818	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,818
C. Professional Services									
Vendor/Payee	Type	Amount							
Duane Morris	Legal	\$ 163,878							
McGladrey LLP	Accounting	63,992							
Citi Business Card	Computer Service	125							
Conxxus	Computer Service	883							
Accu-Med	Computer Service	6,885							
Wesom	Computer Service	1,406							
Ability Net	Computer Service	1,525							
Ribbon Rail	Computer Service	170							
Design	Computer Service	1,615							
Roth, Tim	Computer Service	760							
WDM Computer Services	Data Processing	7,516							
See Sch 21 A		8,475							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 257,230						

* Attach copy of IMRF notifications

**See instructions.

Illinois Knights Templar Home
Provider # 0010058
8/1/12-7/31/13

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Allscripts	Data Processing/Computer Services	3,000
Mckesson Medical	Data Processing	600
E Health Data	Data Processing/Consultant	3,717
MCS Office Tech	Data Processing/Consultant	1,158
		<u>8,475</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	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3										N/A										
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name & ID Number Illinois Knights Templar Home# 0010058Report Period Beginning: 08/01/2012Ending: 07/31/2013**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 - \$3,933
- (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. \$ 27,093 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 201,192
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. \$ 1,207 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,816
- (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 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