

Facility Name & ID Number Illinois Knights Templar Hme

0010058 Report Period Beginning: 8/1/2016 Ending: 7/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,459	7,012	1,862	16,333	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,459	7,012	1,862	16,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.66%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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 8/1/1954

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 1,862

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: _____ Fiscal Year: _____

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

Facility Name & ID Number Illinois Knights Templar Hme # 0010058 Report Period Beginning: 8/1/2016 Ending: 7/31/2017

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	217,939	13,913		231,852		231,852		231,852		1
2	Food Purchase		108,577		108,577		108,577		108,577		2
3	Housekeeping	82,054	6,661		88,715		88,715		88,715		3
4	Laundry	32,045	6,344		38,389		38,389		38,389		4
5	Heat and Other Utilities			101,733	101,733		101,733		101,733		5
6	Maintenance	107,510	40,302	82,938	230,750		230,750		230,750		6
7	Other (specify):*										7
8	TOTAL General Services	439,548	175,797	184,671	800,016		800,016		800,016		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	785,486	89,494	363,931	1,238,911		1,238,911		1,238,911		10
10a	Therapy		72,584	12,379	84,963	(84,689)	274		274		10a
11	Activities	57,262	4,845		62,107		62,107		62,107		11
12	Social Services	42,958		7,968	50,926		50,926		50,926		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	885,706	166,923	396,278	1,448,907	(84,689)	1,364,218		1,364,218		16
	C. General Administration										
17	Administrative	90,788			90,788		90,788		90,788		17
18	Directors Fees										18
19	Professional Services			269,449	269,449		269,449	(2,336)	267,113		19
20	Dues, Fees, Subscriptions & Promotions			154,357	154,357	(127,299)	27,058	(13,728)	13,330		20
21	Clerical & General Office Expenses	228,525	17,406	5,540	251,471		251,471		251,471		21
22	Employee Benefits & Payroll Taxes			498,359	498,359		498,359		498,359		22
23	Inservice Training & Education			793	793		793		793		23
24	Travel and Seminar			6,869	6,869		6,869	(1,870)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			92,524	92,524		92,524		92,524		26
27	Other (specify):* Bad Debts			9,996	9,996		9,996	(9,996)			27
28	TOTAL General Administration	319,313	17,406	1,037,887	1,374,606	(127,299)	1,247,307	(27,930)	1,219,377		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,644,567	360,126	1,618,836	3,623,529	(211,988)	3,411,541	(27,930)	3,383,611		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			153,651	153,651		153,651	(10,645)	143,006		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			464	464		464	(1,715)	(1,251)		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			21,559	21,559		21,559		21,559		35
36	Other (specify):*										36
37	TOTAL Ownership			175,674	175,674		175,674	(12,360)	163,314		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			362,767	362,767	84,689	447,456		447,456		39
40	Barber and Beauty Shops		452	8,733	9,185		9,185		9,185		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					127,299	127,299		127,299		42
43	Other (specify):* Non-Allowable		73,094	2,678	75,772		75,772	(75,772)			43
44	TOTAL Special Cost Centers		73,546	374,178	447,724	211,988	659,712	(75,772)	583,940		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,644,567	433,672	2,168,688	4,246,927		4,246,927	(116,062)	4,130,865		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				9
10	Interest and Other Investment Income	(1,715)			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				18
19	Entertainment	(1,870)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,336)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,996)			24
25	Fund Raising, Advertising and Promotional	(13,728)			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 Attached	(86,417)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,062)		\$	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))	\$ (116,062)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Illinois Knights Templar Hme

ID# 0010058

Report Period Beginning: 8/1/2016

Ending: 7/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallow ILC Expenses	\$ (73,094)	43	1
2	Disallow Townhome Expenses	(2,594)	43	2
3	Disallow Rental House Expenses	(84)	43	3
4	Disallow Townhome Depreciation	(10,645)	30	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		(2,336)	19	22
23				23
24		(9,996)	27	24
25		(13,728)	20	25
26				26
27		(86,417)	29	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	(198,894)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illinois Knights Templar Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,336)	0	0	0	0	0	0	0	0	0	0	(2,336)	19
20	Fees, Subscriptions & Promotions	(13,728)	0	0	0	0	0	0	0	0	0	0	(13,728)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,870)	0	0	0	0	0	0	0	0	0	0	(1,870)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(9,996)	0	0	0	0	0	0	0	0	0	0	(9,996)	27
28	TOTAL General Administration	(27,930)	0	(27,930)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,930)	0	(27,930)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,645)	0	0	0	0	0	0	0	0	0	0	(10,645)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,715)	0	0	0	0	0	0	0	0	0	0	(1,715)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,360)	0	(12,360)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(75,772)	0	0	0	0	0	0	0	0	0	0	(75,772)	43
44	TOTAL Special Cost Centers	(75,772)	0	(75,772)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,062)	0	(116,062)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors List Attached						
(Not for profit Board-No individual ownership)						

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							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 Hme # 0010058 Report Period Beginning: 8/1/2016 Ending: 7/31/2017

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	Board Members are not compensated								\$	1
2	for their services									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending: 1/31/2017

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 _____

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					\$	\$		\$	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

Facility Name & ID Number

Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

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											2							
3											3							
4											4							
5											5							
Working Capital																		
6										464	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 464	9							
B. Non-Facility Related*																		
10	Interest Income									(1,715)	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ (1,715)	14							
15	TOTALS (line 9+line14)					\$	\$			\$ (1,251)	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.)

** 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 2016 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.)

\$ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2017 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:

2012	<u> </u>	8
2013	<u> </u>	9
2014	<u> </u>	10
2015	<u> </u>	11
2016	<u> </u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illinois Knights Templar Hme COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0010058

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u> </u>	\$ <u> </u>

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 _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.**

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

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 Use	2 Square Feet	3 Year Acquired	4 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

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

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	\$		\$		\$
5	37		1975		825,217					
6	6		1987		587,238					
7	4		1992		64,239					
8	15		1996		1,292,665					
	Improvement Type**									
9	Doors		1977		10,621					
10	Parking Lights		1977		5,523					
11	Improvements		1978		40,262					
12	Generator		1979		12,921					
13	Generator		1980		26,890					
14	Roof		1980		32,948					
15	Roof - Nurses Station		1981		22,000					
16	Basement Renovation		1981		20,614					
17	Air Conditioner Installation		1982		1,271					
18	Carpeting - Administrators House		1982		365					
19	Laundry Room - Plumbing & Heating		1982		9,799					
20	Electrical Updates		1984		1,405					
21	Water Heater		1984		1,430					
22	Garage		1985		6,015					
23	Furnace - Administrators House		1985		1,522					
24	5 Room Renovation		1988		144,260					
25	Resurface Parking Lots & Drives		1988		12,875					
26	Patio		1989		9,000					
27	Solarium		1989		21,547					
28	Remodel Day Room		1989		3,558					
29	Install Catch Basins		1989		790					
30	New Sidewalk		1989		890					
31	Sidewalk & Ramp		1990		1,090					
32	Rewire Garage		1992		3,238					
33	Install New Hot Water Supply		1992		3,039					
34	Land Improvement -Cleared Site for Garage		1992		1,540					
35	Garage		1992		39,976					
36	Wall Replacement		1993		71,464					

*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 Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017**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 Improvenet - Removal of Tank	1993	\$ 2,500	\$		\$	\$	\$	37
38	Roof Insulation	1993	15,800						38
39	Roof Insulation and Replace Skylights	1993	6,672						39
40	Wallpaper, Lights, Sashes - Adm House	1993	3,531						40
41	Sump Pump & Pit-Adm House	1993	815						41
42	Repaired Generator	1994	5,156						42
43	Wallpaper, Blinds, Cabinets - Adm House	1994	2,338						43
44	Land Improvement - Repaired Water Main	1994	1,063						44
45	Land Improvement - Sidewalks	1994	1,721						45
46	Air Conditioner in Dining Room	1994	4,801						46
47	Rewired Cable	1995	875						47
48	Tile In Front Entrance, Intermediate Rooms & House	1995	7,408						48
49	Land Imporvement - Transplanted Tree	1995	275						49
50	Replace Fire System	1995	2,915						50
51	Installed New Shower	1996	647						51
52	Instaalled Garage Door & Asbestos Analysis	1996	1,254						52
53	Land Improvement - Repaired Water Main	1996	1,002						53
54	Remodeled Dining Room - Wallpaper	1996	550						54
55	Replace Tile in Bath #1	1996	685						55
56	Installed New Fire Door	1996	4,321						56
57	Wallpaper & Blinds In Dining Room - Adm House	1996	2,136						57
58	Reparied Generator	1996	2,217						58
59	Replace Piping From hot water heater	1996	603						59
60	Wallpaer & Jacks In Master Bedrood - Adm House	1997	785						60
61	Run New Water Line In Mechanical Room	1997	2,643						61
62	Install New Door Alarms In 1995 Addition	1997	1,752						62
63	Increased Value of Land - demolition of Old House	1997	51,268						63
64	Maintenance Equipment	2003	937						64
65	Wallpaper and Tile in Solarium	1997	2,586						65
66	Installed Wallpaper	1997	392						66
67	Installed New Water Line	1997	3,336						67
68	Installed Mop Sink & Ductwork for Furnace	1997	2,508						68
69				116,221		116,221			69
70	TOTAL (lines 4 thru 69)		\$ 3,566,951	\$ 116,221		\$ 116,221	\$	\$	70

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

Facility Name & ID Number Illinois Knights Templar Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017**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		\$ 3,566,951	\$ 116,221		\$ 116,221	\$	\$	1
2	Replaced Water & Sewer Lines, Sink, Facet & Countertops	1998	3,511						2
3	Installed Mini-Blinds in Breakroom	1998	904						3
4	Land Improvement	1998	3,239						4
5	Land Improvement - Plant Trees	1998	699						5
6	Repaired Generator	1998	1,925						6
7	Installed Closet Dividers	1998	474						7
8	Repaired Roof	1998	633						8
9	Installed Oxygen Ventilation System	1998	2,980						9
10	Installed Carpet	1998	680						10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050						11
12	Landscaping	1998	300						12
13	Concrete Driveway	1999	8,000						13
14	Roof Improvements on 1975 Addition	1999	4,776						14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528						15
16	Pravillion	1999	14,214						16
17	Electric Improvements on the 1995 Addition	1999	4,762						17
18	Kitchen Fire System	1999	1,797						18
19	Pavillion Lights	2000	1,235						19
20	Building Improvement Original Memorial Monument	2000	746						20
21	Building Improvement Original BTU Heat Pump	2000	1,988						21
22	Building Improvements 1988 New Wander Guard System	2000	11,990						22
23	Land Improvement Sidewalk and Pad	2001	2,300						23
24	Building Improvement 1975 PTAC Chassis	2002	25,807						24
25	Garage Door	2002	675						25
26	Building Improvements - Handrails	2002	1,480						26
27	Water Heater	2002	2,378						27
28	Smoke Damper	2002	605						28
29	Transformer	2002	206						29
30	Building Improvements - Roofing	2003	140,166						30
31	Room Furnishings	2003	1,248						31
32	Building Improvements - Original Building	2004	17,366						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,842,613	\$ 116,221		\$ 116,221	\$	\$	34

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

Facility Name & ID Number Illinois Knights Templar Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017**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		\$ 3,842,613	\$ 116,221		\$ 116,221	\$	\$	1
2	PTAC Unit	2004	2,848						2
3	Door	2005	1,806						3
4	Water supply & pipe	2005	1,500						4
5	PTAC Unit	2005	586						5
6	Handrail	2006	1,156						6
7	PTAC Unit	2006	562						7
8	PTAC Unit	2006	570						8
9	Door	2006	4,780						9
10									10
11	PTAC Unit	2006	7,470						11
12	Wallpaper	2007	2,557						12
13	CARPETING/TILE	2007	4,754						13
14	Blinds	2007	3,700						14
15	Dishwasher Booster Heater	2007	10,175						15
16	Fire Rated Duct Enclosure	2007	9,000						16
17	Rebuild Water Softener	2007	2,938						17
18	Kitchen floor tile & installation	2007	6,785						18
19	Re-Roof Rent House & Garage	2006	7,418						19
20									20
21	Landscaping (new flower beds areound facility	2008	3,275						21
22	Paving of parking lot	2007	42,750						22
23	Replace concrete sidewalk and fire hydrant area	2007	6,582						23
24	Dining Room (new floor,cabinets,window coverings,painting)	2008	13,960						24
25	Water Heater	2007	16,308						25
26	Kitchen (blinds, entrance board, linoleum)	2008	3,049						26
27	Kitchen (cabinets, Flooring)	2007	17,068						27
28	Shower/Tub	2007	3,311						28
29	Plumbing/electrical work	2007	3,908						29
30	Concrete repairs - new patio	2008	5,448						30
31	Carpeting/Tile	2007	7,258						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,034,135	\$ 116,221		\$ 116,221	\$	\$	34

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

Facility Name & ID Number Illinois Knights Templar Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017**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		\$ 4,034,135	\$ 116,221		\$ 116,221	\$	\$	1
2	Asphalt work-new retaining wall, landscape beneath	2008	20,710						2
3	Gazebo	2008	27,889						3
4	South Tunnel Exit	2008	10,582						4
5	Plumbing & Heat pump	2008	10,147						5
6	Electrical work, exhaust fan	2009	6,854						6
7	Elevator Repair	2008	5,124						7
8	Gutter Helmets	2008	5,784						8
9	New Shelving	2008	4,682						9
10	Sewer line replacement & unit compressor	2008	10,075						10
11	Fire doors	2009	10,163						11
12	Smoke Detectors	2009	4,368						12
13	Handicap electrical door	2009	6,528						13
14	Electrical doors	2009	19,998						14
15	Generator charging system	2009	3,725						15
16	Security systems	2009	5,430						16
17	Room Repair-plumbing	2009	2,995						17
18	Water Heater	2009	3,665						18
19	Bathroom Renovation-Plumbing, hardware	2010	52,122						19
20	Elevator Repair	2010	5,248						20
21	Roof Repair	2010	9,928						21
22	Air Conditioner	2010	6,690						22
23	Accordion Doors	2010	4,750						23
24	Heating/Ventilation	2010	9,455						24
25	Security Cameras	2010	16,650						25
26	Doors	2011	8,050						26
27	PTAC Unit	2011	6,165						27
28	Increased Value of Land - Denolition of Old House	2011	5,000						28
29	Call Light System	2012	41,607						29
30	PTAC Unit	2012	8,028						30
31	Fire Alarm	2012	17,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,383,547	\$ 116,221		\$ 116,221	\$	\$	34

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

Facility Name & ID Number Illinois Knights Templar Hme# 0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017**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		\$ 4,383,547	\$ 116,221		\$ 116,221	\$	\$	1
2	New Fire Alarm System	2013	81,944						2
3	Renovation - Windows	2012	2,400						3
4	Renovation- Floors	2012	7,660						4
5	Sewer Repair	2012	8,064						5
6	Door Replacement	2013	6,125						6
7	Call Light System	2013	5,872						7
8	Reclass R&M - Painting	2013	3,000						8
9									9
10									10
11									11
12	Fire alarm system	2013	29,749						12
13	IT Network	2013	39,579						13
14	Furnace Part Replacement	2014	2,070						14
15	Patio Replacement	2014	15,072						15
16	Retaining Wall Construction	2014	7,275						16
17	New Rooftop AC Unit	2014	6,496						17
18	Installation of 4 PTAC Units	2014	2,600						18
19	Painting and Installation of New Blinds-Rehab Unit	2014	7,146						19
20									20
21	Completion of Rehab Unit Remodeling - Installation of	2015	5,847						21
22	cabinetry, millwork and new signage								22
23	Replace Hot Water Storage Tank - 175 gallons	2015	7,132						23
24									24
25	Sidewalk Replacement	2016	4,000						25
26	Replace Life Safety Panel	2016	9,950						26
27									27
28	Roof Replacement - West Wing	2017	65,430						28
29	Roof Replacement - Dining Hall	2017	11,700						29
30	Rebuild Generator Engine	2017	21,977						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,734,635	\$ 116,221		\$ 116,221	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,229,066	\$ 26,066	\$ 26,066	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,229,066	\$ 26,066	\$ 26,066	\$		\$	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	Truck		2013	\$ 3,596	\$ 719	\$ 719	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 3,596	\$ 719	\$ 719	\$		\$	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)	\$ 5,993,501	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,006	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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	\$ 177,120	\$	\$ 177,120	86
87	Congregate Living Units, 1998	434,381	10,645	198,707	87
88					88
89					89
90					90
91	TOTALS	\$ 611,501	\$ 10,645	\$ 375,827	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. 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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 21,559 Description: Office equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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			
		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		hrs	\$		\$ 167,742	\$		\$ 167,742	1
2	Licensed Speech and Language Development Therapist		hrs			12,702			12,702	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			182,323	274		182,597	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				72,310		72,310	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					12,379			12,379	13
14	TOTAL			\$		\$ 375,146	\$ 72,584		\$ 447,730	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.

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning: 8/1/2016

Ending:

7/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/2017

(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	\$ 136,513	\$	1
2	Cash-Patient Deposits	5,342		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	629,359		3
4	Supply Inventory (priced at FIFO)	27,698		4
5	Short-Term Investments			5
6	Prepaid Insurance	51,150		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 850,062	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	235,273		13
14	Buildings, at Historical Cost	5,245,038		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,052,002		16
17	Accumulated Depreciation (book methods)	(4,385,676)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,146,637	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,996,699	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 357,535	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,342		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,442		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,883)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	44,909		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 497,345	\$	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)	\$ 497,345	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,499,354	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,996,699	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,463,012	1
2	Restatements (describe):		2
3	Audit Adjustments		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,463,012	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(366,114)	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)	\$ (366,114)	17
	B. Transfers (Itemize):		
18	Administrative Transfers	402,456	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 402,456	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,499,354	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning: 8/1/2016

Ending: 7/31/2017

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	\$ 3,542,783	1
2	Discounts and Allowances for all Levels	(1,274,643)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,268,140	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,313,721	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,313,721	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	13,781	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	157,273	16
17	Sale of Drugs	120,379	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	849	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 292,282	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,670	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,670	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,880,813	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	800,016	31
32	Health Care	1,448,907	32
33	General Administration	1,374,606	33
B. Capital Expense			
34	Ownership	175,674	34
C. Ancillary Expense			
35	Special Cost Centers	447,724	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,246,927	40
41	Income before Income Taxes (line 30 minus line 40)**	(366,114)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (366,114)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending:

7/31/2017

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	444	472	\$ 16,808	\$ 35.61	1
2	Assistant Director of Nursing	1,053	1,120	32,737	29.23	2
3	Registered Nurses	6,126	6,517	194,661	29.87	3
4	Licensed Practical Nurses	7,199	7,658	186,800	24.39	4
5	CNAs & Orderlies	24,213	25,759	354,216	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			264		8
9	Activity Director					9
10	Activity Assistants	4,548	4,838	57,262	11.84	10
11	Social Service Workers	1,745	1,856	42,958	23.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,628	19,817	217,939	11.00	15
16	Dishwashers					16
17	Maintenance Workers	5,415	5,761	107,510	18.66	17
18	Housekeepers	8,215	8,739	82,054	9.39	18
19	Laundry	2,526	2,687	32,045	11.93	19
20	Administrator	1,955	2,080	90,788	43.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,602	12,343	228,525	18.51	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	93,669	99,647	\$ 1,644,567 *	\$ 16.50	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	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,699		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,151		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	7,968		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,818		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 114,726		50
51	Licensed Practical Nurses	30,750		51
52	Certified Nurse Assistants/Aides	213,492		52
53	TOTAL (lines 50 - 52)	\$ 358,968		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Traci Harris			\$ 90,788	Workers' Compensation Insurance	\$ 96,385	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,853	Advertising: Employee Recruitment	5,929	
				FICA Taxes	125,809	Health Care Worker Background Check (Indicate # of checks performed _____)	1,292	
				Employee Health Insurance	219,206	Patient Background Checks		
				Employee Meals		PR	5,364	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,578	
				Other Benefits	53,106	License & Fees	3,012	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,788			Less: Public Relations Expense	(5,364)	
B. Administrative - Other						Non-allowable advertising	(481)	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,330	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 498,359			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$		
Heritage Operations Group	Mgmt		\$ 180,946				Out-of-State Travel	\$
RSM US LLP	Accounting & Tax		66,901					
ADP	Payroll Tax Processing		566				In-State Travel	
Benefit Plan Consultants	Retirement Plan		200					6,194
Bank Champaign	Consulting		750					0
Govig	Recruiting		17,750				Seminar Expense	675
								(1,870)
							Entertainment Expense	()
Legal adj to Zero			2,336				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 269,449	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illinois Knights Templar Hme

0010058

Report Period Beginning:

8/1/2016

Ending: 7/31/2017

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? No
If YES, give association name and amount. NA
- (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? NA
- (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? _____
- (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? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 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. _____
- (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. \$ _____
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 15,900
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: RSM US LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Illinois Knights Templar Home
 2017 Cost Report
 Supplemental Schedules

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>		
Purchased Drugs and Medications	\$	72,310
Purchased Hospital Services		3,715
Purchased Laboratory Services		3,094
Purchased Radiology Services		5,570
Amount Reclassified to Line 39	\$	<u>84,689</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	(41,063)
Provider Assessment Fee - \$6.07		(86,236)
		<u>(127,299)</u>
Provider Participation Fee		<u>127,299</u>

3. Schedule V - Line 43 - Non-Allowable Costs

<u>Line Item</u>		
Independent Living Center - Supplies	\$	73,094
Independent Living Center - Other		0
Townhome - Supplies		0
Townhome - Other		<u>2,678</u>
Total Non-Allowable Costs	\$	<u>75,772</u>

4. Schedule VI - Line 29 - Other Adjustments

<u>Item</u>		
Independent Living Center - Supplies	\$	73,094
Townhome - Other		2,678
Independent Living Center - Depreciation		<u>10,645</u>
Total Other Adjustments	\$	<u>86,417</u>