FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0010223

Facility Name: Odd Fellow Rebekah Home

Address: 201 Lafayette Ave E (Number) Mattoon (City) 61938 (Zip Code)

County: Coles

Telephone Number: 217 235-5449 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 C 3

In the event there are further questions about this report, please contact:
Name: David Underwood **Telephone Number:** 309823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/15 to 06/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	162	Skilled (SNF)	162	59,292	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	162	TOTALS	162	59,292	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,198	14,645	4,828	43,671	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,198	14,645	4,828	43,671	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.65%

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)
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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 162 and days of care provided 4,828

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	356,336	34,906		391,242		391,242		391,242			1
2	Food Purchase		385,301		385,301		385,301		385,301			2
3	Housekeeping	191,802	25,428		217,230		217,230		217,230			3
4	Laundry	65,008	10,989		75,997		75,997		75,997			4
5	Heat and Other Utilities			217,643	217,643		217,643		217,643			5
6	Maintenance	174,678	90,032	76,136	340,846		340,846		340,846			6
7	Other (specify):*											7
8	TOTAL General Services	787,824	546,656	293,779	1,628,259		1,628,259		1,628,259			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,530,253	171,249	10,637	2,712,139		2,712,139		2,712,139			10
10a	Therapy		341,714	764,716	1,106,430	(384,815)	721,615		721,615			10a
11	Activities	111,633	11,990		123,623		123,623		123,623			11
12	Social Services	87,318		6,044	93,362		93,362		93,362			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,729,204	524,953	793,397	4,047,554	(384,815)	3,662,739		3,662,739			16
	C. General Administration											
17	Administrative	103,291			103,291		103,291		103,291			17
18	Directors Fees											18
19	Professional Services			471,711	471,711		471,711	(6,003)	465,708			19
20	Dues, Fees, Subscriptions & Promotions			136,442	136,442	(88,938)	47,504	(36,047)	11,457			20
21	Clerical & General Office Expenses	330,003	26,364	28,999	385,366		385,366		385,366			21
22	Employee Benefits & Payroll Taxes			1,234,485	1,234,485		1,234,485		1,234,485			22
23	Inservice Training & Education			8,849	8,849		8,849		8,849			23
24	Travel and Seminar			14,369	14,369		14,369	(9,370)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			161,543	161,543		161,543		161,543			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	TOTAL General Administration	433,294	26,364	2,074,398	2,534,056	(88,938)	2,445,118	(69,420)	2,375,698			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,950,322	1,097,973	3,161,574	8,209,869	(473,753)	7,736,116	(69,420)	7,666,696			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.

Facility Name & ID Number Odd Fellow Rebekah Home #0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			281,862	281,862		281,862		281,862			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(5,002)	(5,002)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,113	26,113		26,113		26,113			35
36	Other (specify):*											36
37	**TOTAL Ownership**			307,975	307,975		307,975	(5,002)	302,973			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					384,815	384,815		384,815			39
40	Barber and Beauty Shops							(1,595)	(1,595)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,938	88,938		88,938			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					473,753	473,753	(1,595)	472,158			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,950,322	1,097,973	3,469,549	8,517,844		8,517,844	(76,017)	8,441,827			45

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,002)			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	(9,370)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,003)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(36,047)			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 Plan of Correction	(1,595)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,017)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (76,017)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

Odd Fellow Rebekah Home

ID# 0010223

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(6,003)	19	22
23				23
24		(18,000)	27	24
25		(36,047)	20	25
26				26
27		(1,595)	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	(61,645)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(6,003)	0	0	0	0	0	0	0	0	0	0	(6,003)	19
20	Fees, Subscriptions & Promotions	(36,047)	0	0	0	0	0	0	0	0	0	0	(36,047)	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	(9,370)	0	0	0	0	0	0	0	0	0	0	(9,370)	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):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	**TOTAL General Administration**	(69,420)	0	0	0	0	0	0	0	0	0	0	(69,420)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,420)	0	0	0	0	0	0	0	0	0	0	(69,420)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,002)	0	0	0	0	0	0	0	0	0	0	(5,002)	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**	(5,002)	0	0	0	0	0	0	0	0	0	0	(5,002)	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	(1,595)	0	0	0	0	0	0	0	0	0	0	(1,595)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,595)	0	0	0	0	0	0	0	0	0	0	(1,595)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(76,017)	0	0	0	0	0	0	0	0	0	0	(76,017)	45

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 [x] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Interest Income										(5,002)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,002)	14
15	TOTALS (line 9+line14)						$	$			$ (5,002)	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.)**

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow Rebekah Home COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0010223

CONTACT PERSON REGARDING THIS REPORT David M Underwood

TELEPHONE 3098237135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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. [ ] (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).

None

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: 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				$ 437,500	1
2					2
3	TOTALS			$ 437,500	3

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	162				$ 1,774,077	$		$	$	$	4
5					151,724						5
6					1,867,245						6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	28,527						9
10	1980 Improvements			1980	19,254						10
11	1981 Improvements			1981	45,037						11
12	1982 Improvements			1982	4,295						12
13	1983 Improvements			1983	106,089						13
14	1984 Improvements			1984	6,600						14
15	1985 Improvements			1985	34,689						15
16	1986 Improvements			1986	135,963						16
17	1987 Improvements			1987	1,732						17
18	1988 Improvements			1988	20,341						18
19	1989 Improvements			1989	322,810						19
20	1990 Improvements			1990	56,795						20
21	1991 Improvements			1991	25,089						21
22	1991 Improvements			1992	36,953						22
23	1993 Improvements			1993	16,174						23
24	1994 Improvements			1994	30,400						24
25	1995 Improvements			1995	48,815						25
26	1996 Improvements			1996	1,082,895						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34						204,659		204,659			34
35											35
36											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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1997	$ 349,692	$		$	$	$	37
38	Architect Fees	1997	3,203						38
39	Wallpaper	1997	2,692						39
40	Water Hydrant	1997	5,430						40
41	Sinks, Cabinets	1997	496						41
42	Baseboards	1997	350						42
43	Woodframe Shed	1997	7,704						43
44									44
45	Water Heater	1998	14,664						45
46	Painting & Wallcovering	1998	4,567						46
47	Double drive gate & locks	1998	982						47
48									48
49	Carpet cleaning	1999	919						49
50	Exterior doors	1999	1,481						50
51	Water Heater	1999	7,660						51
52	Room renovations (wall coverings, tile, electrical)	1999	5,494						52
53	Decorating	1999	1,052						53
54	Window parts	1999	541						54
55									55
56	Baseboards, wallpaper	2000	1,120						56
57	Power panels	2000	2,722						57
58	Electrical outlets	2000	561						58
59									59
60									60
61	Booster Installation	2000	2,032						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,228,866	$ 204,659		$ 204,659	$	$	70

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,228,866	$ 204,659		$ 204,659	$	$	1
2									2
3	Heat Exchanger	2002	4,724						3
4	LAN	2002	3,142						4
5	Water Heater	2002	7,397						5
6	Interior Renovations -- Entry Way	2002	7,493						6
7									7
8	Boiler	2003	1,941						8
9	Compressor	2003	6,361						9
10	Temperature control	2003	1,941						10
11	A/C Unit	2003	1,000						11
12	Smoke Detectors	2003	1,882						12
13	Lobby renovations: Wall paper, paint, floor coverings	2003	41,598						13
14	Kitchen Hood	2003	1,840						14
15	Firewall / Roof safty improvments	2003	32,502						15
16	Water Heater	2003	7,300						16
17									17
18	Lobby renovations: Wall paper, paint, floor coverings	2004	4,694						18
19	Water Heater	2004	2,516						19
20	Alzheimer Unit renovations: Wall paper, paint, floor coverings	2004	47,811						20
21	Alarm System	2004	2,863						21
22	Nurse Station	2004	29,661						22
23	Wallcoverings	2004	19,247						23
24	Wall Guards	2004	9,409						24
25	Corrodor Renovations	2004	15,153						25
26	Emergency Systems	2004	1,535						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,480,876	$ 204,659		$ 204,659	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,480,876	$ 204,659		$ 204,659	$	$	1
2									2
3	Wire Access Doors	2005	3,568						3
4	Resident Room Remodel-- paint	2005	9,616						4
5	Compressor	2005	868						5
6	Grease Trap	2005	9,545						6
7	Garbage Disposal	2005	1,049						7
8	Fire Protection System	2005	3,332						8
9	2 Heat/ Cool Unit	2005	1,943						9
10	Heat Exchanger	2005	924						10
11	Security System	2005	1,095						11
12	Dinning room Remodel--Paint/Wallpaper/carpet	2005	7,114						12
13	Insurance Proceeds--roof repair	2005	(16,568)						13
14									14
15	Dinning room Remodel--Paint/Wallpaper/carpet	2006	20,984						15
16	Roof/Fence Replacement	2006	21,748						16
17	Sidewalk	2006	1,637						17
18	Remodel Therapeutic Rehab Unit	2006	28,486						18
19									19
20	Remodel Therapeutic Rehab Unit (paint, carpet, fixtures)	2007	4,343						20
21	Rooftop compressor	2007	1,362						21
22	Wiring for IT	2007	4,200						22
23	Heat Exchanger	2007	988						23
24	West Wing Remodel--Paint/Wallpaper/carpet	2007	5,534						24
25	Water Heater	2007	12,335						25
26	Roof repair	2007	1,157						26
27	Compressor	2007	1,237						27
28	HVAC unit	2007	967						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,608,340	$ 204,659		$ 204,659	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,608,340	$ 204,659		$ 204,659	$	$	1
2									2
3	Compressor	2008	1,446						3
4	Bather	2008	1,673						4
5	Heat Exchanger	2008	5,760						5
6	Light Fixture	2008	812						6
7	Doors	2008	6,986						7
8	Boiler	2008	1,114						8
9	Wander Guard	2008	2,968						9
10	Floor Tile	2008	2,283						10
11	PTAC Unit	2008	971						11
12	Roof -- Harmony Corridor	2008	7,630						12
13	Vent Sleeves	2008	1,275						13
14	Blinds	2008	1,143						14
15	Fire System	2008	3,424						15
16	Compressor	2008	1,295						16
17	Ridge Vent	2008	4,330						17
18	Employee Entrance Door	2008	1,343						18
19									19
20	Hallway Floor Replacement	2009	104,987						20
21	Heat Exchanger	2009	5,714						21
22									22
23	New Roof	2010	125,051						23
24	Water Meter valve	2010	3,113						24
25	Awning Front Entrance	2010	3,630						25
26	Water Heater	2010	11,977						26
27	Paint, Floor Tiles (Rehab to Home Rooms)	2010	3,158						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,910,423	$ 204,659		$ 204,659	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,910,423	$ 204,659		$ 204,659	$	$	1
2									2
3	Compressor	2011	7,961						3
4	Dryer Enclosure	2011	11,862						4
5	Water Heater	2011	12,800						5
6	Concrete Patio Floor	2011	2,675						6
7									7
8	Pavillion Roof	2012	3,975						8
9	Compressor	2012	2,986						9
10	Parking Lot Patch & Seal	2012	6,923						10
11	Rooftop A/C	2012	6,305						11
12	Water Heater	2012	10,173						12
13									13
14	Therapy Room Remodel-Cabinets	2013	1,431						14
15	Therapy Room Remodel-Countertops	2013	1,062						15
16	Therapy Room Remodel-Electrical	2013	1,667						16
17	Therapy Room Remodel-Materials	2013	982						17
18	Lobby A/C	2013	3,511						18
19	Lighting Retrofit	2013	5,781						19
20	Furnaces	2013	6,998						20
21	Yale doors (8)	2013	2,942						21
22									22
23	Facility cabling for new Nurse Call System	2014	259,332						23
24	Rooftop HVAC Purchase and Installation-Main Living Area	2014	6,580						24
25	Bather acquisition and installation	2014	12,679						25
26	Air conditioner for computer room	2014	4,178						26
27	Rooftop HVAC Purchase and Installation-Kitchen	2014	8,534						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,291,760	$ 204,659		$ 204,659	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,291,760	$ 204,659		$ 204,659	$	$	1
2									2
3	Carrier Rooftop Unit - Laundry	2015	6,690						3
4	Replaced Water Heater	2015	12,860						4
5	Replacement of Exterior Signage	2015	3,899						5
6	Security System Installation - Door Controls & Tag Readers	2015	6,878						6
7	Replaced Sidewalk Entrance to Front Door	2015	3,450						7
8	Installation of and Rewiring of Kitchen Receptacles	2015	3,141						8
9	Acquisition and Installation of Walk-In Freezer/Cooler	2015	48,547						9
10	Replace Compressor - Harmony Unit - Southeast Corner	2015	6,965						10
11	Dining Hall Air Conditioner Replacements with Coils	2015	11,455						11
12									12
13									13
14	Carrier Rooftop Unit - Northwest Hallway	2016	7,980						14
15	New Fence and Enclosure for Trash Bin Area	2016	4,200						15
16	(3) Progressive Flow Water Softeners	2016	23,289						16
17	Replace Sidewalk - Building Front	2016	3,075						17
18	Boiler Replacement - Harmony Area North	2016	19,706						18
19	Carrier Rooftop Unit - Main	2016	7,716						19
20	(2) 120 Gallon Hot Water Heaters	2016	24,554						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)		$ 7,486,165	$ 204,659		$ 204,659	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 1,998,157	$ 77,203	$ 77,203	$		$	71
72	Current Year Purchases	57,119						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,055,276	$ 77,203	$ 77,203	$		$	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 9,978,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 281,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 281,862	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	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.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 26,113 Description: Televisons and copiers
    (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.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 263,414	$		$ 263,414	1
2	Licensed Speech and Language Development Therapist		hrs			119,945			119,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			338,256	0		338,256	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				341,714		341,714	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					43,101			43,101	13
14	TOTAL			$		$ 764,716	$ 341,714		$ 1,106,430	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.

STATE OF ILLINOIS

Facility Name & ID Number Odd Fellow Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/16 **(last day of reporting year)**

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	$ 1,034,761	$	1
2	Cash-Patient Deposits	17,235		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,004,719		3
4	Supply Inventory (priced at FIFO)	35,843		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,279		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,631,508		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,777,345	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,128,776		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,925,294		16
17	Accumulated Depreciation (book methods)	(7,557,397)		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)**	$ 2,496,673	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,274,018	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 289,407	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,236		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	378,247		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,803		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	Bed Tax	40,335		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 733,028	$	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)**	$ 733,028	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,540,990	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,274,018	$	48

***(See instructions.)**

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,579,216	1
2	Restatements (describe):		2
3	**Audit Adjustments**	16,009	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,595,225	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(54,235)	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)**	$ (54,235)	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)**	$ 8,540,990	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,940,727	1
2	Discounts and Allowances for all Levels	(2,889,444)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,051,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,769,556	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,769,556	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
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	610,303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26,617	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 636,920	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,850	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,850	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)**	$ 8,463,609	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,628,259	31
32	Health Care	4,047,554	32
33	General Administration	2,534,056	33
	B. Capital Expense		
34	Ownership	307,975	34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 8,517,844	40
41	**Income before Income Taxes (line 30 minus line 40)****	(54,235)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (54,235)	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 Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,741	1,852	$ 65,505	$ 35.37	1
2	Assistant Director of Nursing	1,801	1,916	55,750	29.10	2
3	Registered Nurses	18,402	19,577	538,963	27.53	3
4	Licensed Practical Nurses	24,150	25,692	586,265	22.82	4
5	CNAs & Orderlies	88,566	94,219	1,251,352	13.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,811	1,927	32,418	16.82	8
9	Activity Director					9
10	Activity Assistants	8,295	8,824	111,633	12.65	10
11	Social Service Workers	5,459	5,807	87,318	15.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,092	27,757	356,336	12.84	15
16	Dishwashers					16
17	Maintenance Workers	10,580	11,255	174,678	15.52	17
18	Housekeepers	15,708	16,711	191,802	11.48	18
19	Laundry	5,905	6,282	65,008	10.35	19
20	Administrator	1,955	2,080	103,291	49.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,030	14,926	330,003	22.11	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)	224,495	238,825	$ 3,950,322 *	$ 16.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,600		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,949		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		6,044		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,593		49

C. CONTRACT NURSES

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

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Standefer			$ 103,291
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,291

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 421,959
Pehlman & Dold	Audit	18,895
Grand Lodge	Consulting	10,000
ADP	PR Tax Processing	1,339
Principal Financial	403 B Plan Admin	2,315
Sulaski & Webb	403 B Audits (2014-2015)	11,200
Legal adj to Zero		6,003
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 471,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 218,019
Unemployment Compensation Insurance	16,774
FICA Taxes	302,200
Employee Health Insurance	677,982
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	19,510
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,234,485

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,847
Health Care Worker Background Check	
(Indicate # of checks performed)	3,084
Patient Background Checks	
PR	18,324
Dues & Subscriptions	10,469
License & Fees	1,024
Less: Public Relations Expense	(18,324)
Non-allowable advertising	(5,967)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,457

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	13,408
	27
Seminar Expense	934
	(9,370)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/15 Ending: 06/30/16

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. **HCCI**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **88,938**
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. $ **12,566**

(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: **Pehlman & Dold**

(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

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009			PETTY CASH	1,034,761							
1010			CASH IN BANK								
1040			CASH IN BANK-PAYROLL								
1100			ACCOUNTS RECEIVABLE	1,004,719							
1110			MEDICARE RECEIVABLES								
1125			IPA INCOME RECEIVABLE								
1130			MEDICARE COST REPORT								
1135			ACCOUNTS RECEIVABLE-IC								
1140			UNAPPLIED CASH RECEIPTS								
1145			A/R SUSPENSE-REFUNDS								
1190			ACCRUED INTEREST REC								
1200			PREPAID INSURANCE	53,279							
1220			OTHER PREPAID EXPENSES								
1300			FOOD INVENTORY	35,843							
1310			SUPPLIES INVENTORY								
1409			LAND	0							
1450			FURNITURE & EQUIPMENT	1,925,294							
1460			ACCUM DEPR-FURN & EQUIP	-1,669,600							
1475			BUILDING & IMPROVEMENTS	8,128,776							
1490			ACCUM DEPR-BUILDING	-5,887,797							
1530			RESIDENT FUNDS	17,235							
1550			LOAN FEES	0							
1560			REAL ESTATE TAX ESCROW								
1575			REIMBURSABLE PURCHASES								
1850			INTRACOMPANY	4,631,508							
2010			ACCOUNTS PAYABLE	-289,407							
2095			BONUSES PAYABLE								
2100			ACCRUED PAYROLL	-128,580							
2110			ACCRUED VACATION PAY	-249,667							
2120			UC TAXES PAYABLE								
2125			FICA TAX PAYABLE	-7,803	-7,803						
2130			FIT PAYABLE								
2140			STATE W/H PAYABLE		0						
2145			EARNED INCOME CREDIT								
2150			UC FED CREDIT REDUCTION								
2230			PAYROLL SAVINGS								
2235			IRA W/HOLDINGS								
2240			UNITED WAY								
2245			GROUP INSURANCE PAYABLE								
2246			GROUP INSURANCE PAYABLE-CAFETERIA								
2260			WAGE GARNISHMENTS								
2280			MISC PAYROLL DEDUCTIONS								
2300			ACCRUED INTEREST PAYABLE	0							
2310			SALES TAX PAYABLE								
2320			IPA PAYMENTS PAYABLE	-40,335							
2350			REAL ESTATE TAX PAYABLE	0							
2385			ACTIVITY FUND	0							
2390			SECURITY DEPOSITS	0							
2391			VOLUNTEER FUND								
2393			HEART FUND/BAZAAR								
2395			DEFERRED INC EMP & MEM								
2400			CURRENT PORTION LT DEBT								
2460			INCOME TAXES PAYABLE								
2512			DUE TO RESIDENTS	-17,236							
2600			MORTGAGE PAYABLE	0							
2650			EQUIPMENT LOAN PAYABLE								
2695			CURRENT PORTION LT DEBT								
2696			DEFERRED INCOME TAXES								
2710			COMMON STOCK								
2720			RETAINED EARNINGS	-8,595,225							
2970			PROFIT/LOSS FOR PERIOD	54,235							
3007.1			PATIENT DAYS-PRIVATE	14,645							
3007.2			PATIENT DAYS-IPA	24,198							
3007.3			PATIENT DAYS-MEDICARE	4,828							
3007.4			PATIENT DAYS-CONVERSION								
3007.5			PATIENT DAYS-LICENSED								
3007.6			PATIENT DAYS-TOTAL								
3010		1	BASIC CHARGE-PRIVATE & VA	-7,901,514		0	0	0	0		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		
3035		4	DAY CARE/HOME CARE			0	0	0	0		
3040		1	LIGHT NURSING CARE	0		0	0	0	0		
3050		1	MEDIUM NURSING CARE			0	0	0	0		
3060		1	HEAVY NURSING CARE			0	0	0	0		
3061		1	SKILLED NURSING CARE								
3080		1	NURSING SUPPLIES-PRIVATE	-48,118		0	0	0	0		
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		
3083		1	NURSING SUPPLIES MED PT B								
3100		17	DRUGS	-610,303		0	0	0	0		
3101		17	DRUGS-OTHER								
3110		6	PT-PRIVATE	-2,769,556		0	0	0	0		
3111		6	PT-IPA			0	0	0	0		
3112		6	PT-MEDICARE PART A			0	0	0	0		
3113		6	PT-MEDICARE PART B			0	0	0	0		
3130		1	PUBLIC AID ASSESSMENT INC								
3140		19	LABORATORY INCOME			0	0	0	0		
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		
3151		6	SPEECH/OT-IPA			0	0	0	0		
3152		6	SPEECH/OT-MED PART A			0	0	0	0		
3153		6	SPEECH/OT MED PART B								
3410		2	IPA DISCOUNTS	2,889,444		0	0	0	0		
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		
3420		2	MEDICARE DISCOUNTS			0	0	0	0		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		
3520		16	RENT INCOME	0		6	0	6	0		
3530		13	BEAUTY SHOP	0		0	0	0	0		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0		
3580		12	MANAGEMENT FEES			0	0	0	0		
3590		1	EQUIPMENT RENTAL	8,905		0	0	0	0		
3595		21	RESIDENT TRANSPORTATION	-21,023		0	0	0	0		
3600		21	MISC INCOME	-5,594		0	0	0	0		
4110			GENERAL & ADMINIST WAGES	298,253	330,003	21	1	17	0		
4111			ADMINISTRATOR WAGES	103,291	103,291	17	1	0	0		
4115			VACATION & SICK - G&A	31,750		21	1	0	0		
4120	4475		EMPLOYEE BENEFITS	12,282	1,234,485	22	3	0	0		
4125			EMPLOYEE HEPETITIS VACCIN	6,250		22	3	0	0		
4130			EMPLOYEE SCHOLORSHIP WA	794		21	1	0	0		
4135			EMPLOYEE SCHOLORSHIP CO	184		23	3	0	0		
4220			DIRECTORS FEES	0	0	18	3	0	0		
4250	4255		OFFICE SUPPLIES	26,364	26,364	21	2	0	0		
4260			TELEPHONE	28,999	28,999	21	3	0	0		
4275			TRAINING & EMPLOYEE DEVL	8,849	8,849	23	3	16	0	**	
4280			GENERAL TRAVEL	13,408	14,369	24	3	16	0		
4281			MEAL EXPENSE FOR TRAVEL	27		24	3	19	0		
4285			EDUCATION & SEMINAR	934		24	3	19	-9,370	***	
4290			HELP WANTED ADVERTISING	2,847	136,442	20	3	0	0		-88,938
4291			PROMOTIONAL ADVERTISING	11,756		20	3	25	-11,756		
4292			PUBLIC RELATIONS	18,324		20	3	25	-18,324		
4300			LICENSES & FEES	89,962		20	3	17	0		
4310			DUES & SUBSCRIPTIONS	10,469		20	3	17	-5,967		
4320			CONTRIBUTIONS	0		27	3	20	0		
4350			PROFESSIONAL FEES	39,670	471,711	19	3	22	-6,003		
4355			MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		
4360			UTILIZATION REVIEW	0		10	3	0	0		
4361			OTHER PHYSICIAN FEES			39	3	0	0		
4362			MEDICAL RECORDS CONSULT	2,600		10	3	0	0		
4363			PHARMACIST FEES	7,949		10	3	0	0		
4364			SOC SERV/ACT CONSULT	6,044	6,044	12	3	0	0		
4370			TV RENTAL	9,901		35	3	5	0		
4380			INCOME TAXES		18,000	27	3	26	0		
4383			BACKGROUND CHECKS	3,084		20	3	26	0		
4400			PAYROLL TAXES	308,252		22	3	0	0		
4401			PAYROLL TAXES ADMINIST	10,722		22	3	0	0		
4410			GROUP INSURANCE	677,982		22	3	0	0		
4420			LIABILITY INSURANCE	161,543	161,543	26	3	0	0		
4425			INSURANCE-OWNERS			22	3	21	0		
4430			WORKMENS COMP INSURANCE	218,019		22	3	0	0		
4450			CENTRAL OFFICE FEES	432,041		19	3	34	0	**	
4460			BAD DEBTS	18,000		27	3	24	-18,000		
4470			LOST ITEMS-RESIDENTS	0		27	3	0			
4490			MISCELLANEOUS	0		27	3	0	0		
4510			REAL ESTATE TAXES	0	0	33	3	0	0		
4600			LEASED EQUIPMENT	16,212	26,113	35	3	16	0		
5110			MAINTENANCE SALARIES	159,556	174,678	6	1	0	0		
5120			MAINTENANCE SICK & VAC	15,122		6	1	0	0		
5130			ELECTRIC	124,005	217,643	5	3	0	0		
5131			NATURAL GAS	21,173		5	3	0	0		
5132			HEATING & DEISEL OIL			5	3	0	0		
5133			WATER & SEWER	72,465		5	3	0	0		
5134			TRASH COLLECTION	15,984	76,136	6	3	0	-1,595		
5140			PROPERTY PLANT REPLACEM	8,048	90,032	6	2	0	0		
5160			GENERAL REPAIR & MAINT	81,984		6	2	0	0		
5165			MAINTENANCE CONTRACTS	60,152		6	3	0	0		
5210			DIETARY WAGES	323,865	356,336	1	1	0	0		
5220			DIETARY SICK & VAC	32,471		1	1	0	0		
5240			SALES TAX			2	3	13	0		
5248			FOOD PURCHASES	397,867	385,301	2	2	0	0		
5250			SUPPLIES-DISHWASHING	6,985	34,906	1	2	0	0		
5260			DIETARY REPLACEMENT	6,345		1	2	0	0		
5270			KITCHEN SUPPLIES-PAPER	21,576		1	2	0	0		
5295			MEAL CREDIT	-12,566		2	2	0	0		
5310			LAUNDRY WAGES	60,678	65,008	4	1	0	0		
5340			LAUNDRY SICK & VAC	4,330		4	1	0	0		
5370			LAUNDRY REPLACEMENT	3,585	10,989	4	2	0	0		
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		
5390			LAUNDRY SUPPLIES	7,404		4	2	0	0		
5410			HOUSEKEEPING WAGES	177,492	191,802	3	1	0	0		
5440			HOUSEKEEPING SICK & VAC	14,310		3	1	0	0		
5480			HOUSEKEEPING SUPPLIES	25,333	25,428	3	2	0	0		
5490			HOUSEKEEPING SUPPLIES-PP	95		3	2	0	0		
6010			RN WAGES-MEDICARE		2,530,253	10	1	0	0		
6020			RN WAGES-NON MEDICARE	495,973		10	1	0	0		
6030			DON WAGES	65,505		10	1	0	0		
6035			ADON	55,750		10	1	0	0		
6040			RN SICK & VACATION	42,990		10	1	0	0		
6110			LPN WAGES-MEDICARE	544,011		10	1	0	0		
6120			LPN WAGES-NON MEDICARE	0		10	1	0	0		
6130			LPN WAGES OTHER			10	1	0	0		
6140			LPN SICK & VACATION	42,254		10	1	0	0		
6210			AIDE WAGES-MEDICARE			10	1	0	0		
6220			AIDE WAGES-NON MEDICARE	1,175,971		10	1	0	0		
6230			WARD CLERKS			10	1	0	0		
6240			AIDE VACATION & SICK	75,381		10	1	0	0		
6245			CONTRACT NURSES-RN	0		10	3	0	0		
6246			CONTRACT NURSES-LPN	0		10	3	0	0		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0		
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0		
6270			REHAB WAGES	29,958		10	1	0	0		
6275			REHAB SICK & VAC	2,460		10	1	0	0		
6280			NURSING DEPT EDUCATION			23	3	0	0		
6290			NURSING SUPPLIES	145,278	171,249	10	2	0	0		
6295			NURSING SUPPLIES	25,311		10	2	0	0		
6390			REPLACEMENT-NURSING	660		10	2	0	0		
6490			NURSING OTHER	88	10,637	10	3	0	0		
7280			DRUG PURCHASES	325,527	341,714	39	2	0	0	***	
7281			DRUG PURCHASES-OTHER	16,187		39	2				
7380			LABORATORY SERVICES	43,101	764,716	39	3	0	0		
7410			HOME HEALTH SALARY			39	1	0	0		
7440			HOME HEALTH SICK & VAC			39	1	0	0		
7450			HOME HEALTH EXPENSES			39	3	0	0		
7510			ACTIVITES WAGES	99,484	111,633	11	1	0	0		
7540			ACTIVITIES SICK & VAC	12,149		11	1	0	0		
7590			ACTIVITIES SUPPLIES	11,990	11,990	11	2	0	0		
7595			ACTIVITIES FEES	0	0	11	3	0	0		
7610			PT WAGES			39	1	0	0		
7611			PT SICK & VACATION			39	1	0	0		
7620			PT FEES	338,256		39	3	0	0	***	
7660			PT SUPPLIES	0		39	2	0	0		
7710			SOCIAL SERVICE WAGES	81,597	87,318	12	1	0	0		
7720			SOCIAL SERVICE SICK & VAC	5,721		12	1	0	0		
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740			OT FEE	263,414		39	3	0	0	***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770			SPEECH THERAPY FEE	119,945		39	3	0	0	***	
7800			BEAUTICIAN WAGES		0	40	1	0	0		
7810			BEAUTICIAN SICK & VAC			40	1	0	0		
7820			BEAUTICIAN FEES	0	0	40	3	0	0		
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910			VOLUNTEER COORDINATOR			21	1	0	0		
7940			VOL COORD SICK & VAC			21	1	0	0		
7960			VOL COORD SUPPLIES	0		21	2	0	0		
8100			RENT	0	0	34	3	0	0		
8120			INTEREST EXPENSE	0	0	32	3	14	-5,002		
8130			DEPRECIATION	281,862	281,862	30	3	9	0		
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510			INTEREST INCOME	-5,002		32	0	10	0		
9520			MISC NON-OPERATING INCOM	-848		0	0	0	0		
9700			INCOME TAXES	0		0	0	0	0		
				8,511,994	8,517,844						
					5,850						
GRAND TOTALS				54,235					-76,017		
				(NET INCOME)							
				0							
			FACILITY NAME:								
			FACILITY ID:	0							
			FACILITY UNITS:	89							
			BALANCE SHEET TOTAL	0							

1,009	1,009	CASH	1,034,761
1,100	1,100	ACCTS RE	1,004,719
1,101	1,101	ALLOW. FOR UNCOLLECTIBLES	
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID I	53,279
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY I	35,843
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITUF	1,925,294
1,460			(1,669,600)
1,475	1,475	BUILDING:	8,128,776
1,490	1,490	ACCUM DI	(5,887,797)
1,530	1,530	RESIDENT	17,235
1,550	1,550	LOAN FEE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOI	4,631,508
2,010	2,010	ACCOUNT	(289,407)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED	(128,580)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED	(249,667)
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	(7,803)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	
2,300	2,300	ACCRUED	0
2,320	2,320	IPA PAYM	(40,335)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO R	(17,236)
2,600	2,600	LASALLE I	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINEI	(8,595,225)
		net income	54,235
		balance	0

3,007	3,007	PATIENT I	14,645
3,007	3,007	PATIENT I	24,198
3,007	3,007	PATIENT I	4,828
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH	(7,901,514)
3,020	3,020	BASIC CH	0
3,030	3,030	BASIC CH	0
3,040			0
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	(48,118)
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(610,303)
3,101			0
3,110	3,110	PHYSICAL	(2,769,556)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THE	0
3,153	3,153	ST/OT THE	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHEI	0
3,411	3,411	MEDICARI	0
3,420	3,420	MEDICARI	2,837,714
3,500			
3,520	3,520	RENT INC	0
3,530	3,530	BEAUTY S	0
3,560			0
3,570	3,570	VENDING	0
3,590	3,590	EQUIPMEI	8,905
3,595	3,595	RESIDENT	(21,023)
3,600	3,600	MISC INC	(5,594)
4,110	4,110	G&A WAG	298,253
4,111	4,111	ADMINIST	103,291
4,115	4,115	G&A PTO &	31,750
4,120	4,120	EMPLOYE	14,544
4,121			6,250
4,130	4,130	EMPLOYE	794
4,135	4,135	EMPLOYE	184
4,250	4,250	OFFICE SI	13,889
4,255	4,255	POSTAGE	3,799
4,260	4,260	TELEPHOI	28,999
4,275	4,275	TRAINING	8,849
4,276			587
4,280	4,280	GENERAL	13,408
4,281	4,281	MEAL EXP	27
4,285	4,285	EDUCATIC	584
4,289	4,289	MEETINGS	350
4,290	4,290	HELP WAN	2,847
4,291	4,291	PROMOTI	11,756
4,292	4,292	PUBLIC RI	18,324
4,300	4,300	LICENSE &	89,962
4,310	4,310	DUES & SI	10,469
4,320	4,320	CONTRIBU	0
4,350	4,350	PROFESS	39,670
4,355	4,355	MEDICAL	12,000
4,362			2,600
4,363			7,949
4,364	4,364	SOCIAL SI	6,044
4,370	4,370	TV RENTA	9,901
4,383	4,383	BACKGRC	3,084
4,390	4,390	OTHER TA	0
4,400	4,400	PAYROLL	308,252
4,401	4,401	PAYROLL	10,722
4,410	4,410	GROUP IN	677,982
4,420	4,420	LIABILITY	161,543
4,430	4,430	WORKMAI	215,798
4,435	4,435	W/C-FIRST	88
4,436	4,436	DRUG TES	1,546
4,450	4,450	MANAGEN	432,041
4,460	4,460	BAD DEBT	18,000
4,461	4,461	BAD DEBT	51,730
4,470	4,470	LOST ITEM	0
4,475	4,475	UNIFORM	(2,262)
4,486	4,486	SERVICE (	38,511
4,490	4,490	MISC EXP	8,687
4,496	4,496	MISC. M.I.:	8,676
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	16,212
5,110	5,110	MAINTEN/	159,556
5,120	5,120	MAINTEN/	15,122
5,130	5,130	ELECTRIC	124,005
5,131	5,131	NATURAL	21,173
5,133	5,133	WATER &	72,465
5,134	5,134	TRASH CC	15,984
5,140	5,140	PROP/PLA	8,048
5,160	5,160	GENERAL	81,984
5,165	5,165	MAINTEN/	21,641
5,210	5,210	DIETARY \	323,865
5,220	5,220	DIETARY I	32,471
5,248	5,248	FOOD PUI	389,180
5,250	5,250	SUPPLIES	6,985
5,260	5,260	REPLACEI	6,345
5,270	5,270	KITCHEN :	21,576
5,295	5,295	MEAL INC	(12,566)
5,310	5,310	LAUNDRY	60,678
5,340	5,340	LAUNDRY	4,330
5,370	5,370	REPLACEI	3,585
5,380			0
5,390	5,390	SUPPLIES	7,404
5,410	5,410	HOUSEKE	177,492
5,440	5,440	HOUSEKE	14,310
5,480	5,480	SUPPLIES	25,333
5,490	5,490	SUPPLIES	95
6,020	6,020	RN WAGE	495,973
6,030	6,030	DON WAG	65,505
6,035	6,035	ADON WA	55,750
6,040	6,040	RN PTO &	42,990
6,120	6,120	LPN WAGI	544,011
6,140	6,140	LPN PTO &	42,254
6,220	6,220	AIDES WA	1,175,971
6,240	6,240	AIDES PT(	75,381
6,245			
6,246			
6,247			
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB W/	29,958
6,275	6,275	REHAB PT	2,460
6,290	6,290	NURSING	145,278
6,295	6,295	NURSING	25,311
6,390	6,390	REPLACEI	660
6,490	6,490	OTHER	88
7,280	7,280	DRUG PUI	325,527
7,281	7,281	DRUG PUI	16,187
7,380	7,380	LABORAT(	14,274
7,391	7,390	X-RAY SEI	7,793
7,393			21,034
7,510	7,510	ACTIVITIE	99,484
7,540	7,540	ACTIVITIE	12,149
7,590	7,590	ACTIVITIE	11,990
7,620	7,620	PHYSICAL	338,256
7,660	7,660	P.T. SUPP	0
7,710	7,710	SOCIAL SI	81,597
7,720	7,720	SOCIAL SI	5,721
7,730	7,730	SOCIAL SI	0
7,740	7,740	OCCUPAT	263,414
7,750			
7,770	7,770	SPEECH T	119,945
7,820	7,820	BEAUTICI/	0
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			0
8,130	8,130	DEPRECI/	281,862
8,150			0
9,510	9,510	INTEREST	(5,002)
9,520	9,520	MISC NON	(848)
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			54,235

Expenses Fixed Assets 0

	G/L	RECAP CENSUS
PP	14,645	14,645

Odd Fellow Rebekah Home
2016 Cost Report
Supplemental Schedules

1. Schedule V Line 23 - Inservice Training & Education

Vendor	Purpose		Amount
Relias	Health care mandatory training software modules	$	5,841
Providigm	Quality management tools and training modules		1,920
American Red Cross	CPR Sessions		1,028
Green Tree Pharmacy	In-Service		60
Total - Line 23 - Inservice Training & Education		$	8,849

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

Line Item		
Purchased Drugs and Medications	$	341,714
Purchased Hospital Services		21,034
Purchased Laboratory Services		14,274
Purchased Radiology Services		7,793
Amount Reclassified to Line 39	$	384,815

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

Line Item		
Provider Participation Fee	$	88,938