		FOR BHF USE					

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 10223

Facility Name: Odd Fellow Rebekah Home

Address: 201 Lafayette Ave (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
IRS Exemption Code 501 C 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David M 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 7/1/2017 to 6/30/2018 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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	59,130	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	59,130	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	24,282	13,479	4,598	42,359	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,282	13,479	4,598	42,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.64%

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 [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 4,598

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	345,344	27,659		373,003		373,003		373,003			1
2	Food Purchase		362,902		362,902		362,902		362,902			2
3	Housekeeping	176,968	26,742		203,710		203,710		203,710			3
4	Laundry	62,702	13,988		76,690		76,690		76,690			4
5	Heat and Other Utilities			192,424	192,424		192,424		192,424			5
6	Maintenance	190,856	105,192	96,914	392,962		392,962	(21,879)	371,083			6
7	Other (specify):*											7
8	TOTAL General Services	775,870	536,483	289,338	1,601,691		1,601,691	(21,879)	1,579,812			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,409,031	154,387	184,549	2,747,967		2,747,967		2,747,967			10
10a	Therapy		335,344	17,157	352,501	(352,417)	84		84			10a
11	Activities	123,903	9,058		132,961		132,961		132,961			11
12	Social Services	77,424		5,206	82,630		82,630		82,630			12
13	CNA Training	16,022	871		16,893		16,893		16,893			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,626,380	499,660	218,912	3,344,952	(352,417)	2,992,535		2,992,535			16
	C. General Administration											
17	Administrative	109,646			109,646		109,646		109,646			17
18	Directors Fees											18
19	Professional Services			426,828	426,828		426,828	(1,822)	425,006			19
20	Dues, Fees, Subscriptions & Promotions			374,777	374,777	(307,482)	67,295	(44,950)	22,345			20
21	Clerical & General Office Expenses	378,247	22,364	30,695	431,306		431,306		431,306			21
22	Employee Benefits & Payroll Taxes			1,125,995	1,125,995		1,125,995		1,125,995			22
23	Inservice Training & Education			4,335	4,335		4,335		4,335			23
24	Travel and Seminar			13,208	13,208		13,208	(8,209)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			163,050	163,050		163,050		163,050			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	TOTAL General Administration	487,893	22,364	2,156,888	2,667,145	(307,482)	2,359,663	(72,981)	2,286,682			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,890,143	1,058,507	2,665,138	7,613,788	(659,899)	6,953,889	(94,860)	6,859,029			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 #10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			216,810	216,810		216,810	(4,456)	212,354			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(9,767)	(9,767)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,247	35,247		35,247		35,247			35
36	Other (specify):*											36
37	**TOTAL Ownership**			252,057	252,057		252,057	(14,223)	237,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			735,683	735,683	352,417	1,088,100		1,088,100			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					307,482	307,482		307,482			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			735,683	735,683	659,899	1,395,582		1,395,582			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,890,143	1,058,507	3,652,878	8,601,528		8,601,528	(109,083)	8,492,445			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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	(21,879)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,456)			9
10	Interest and Other Investment Income	(9,767)			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	(8,209)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,822)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(44,950)			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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (109,083)		$	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))**	$ (109,083)		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# 10223

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

	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				15
16				16
17				17
18				18
19				19
20				20
21				21
22		(4,456)	30	22
23		(1,822)	19	23
24		(18,000)	27	24
25		(44,950)	20	25
26		(8,209)	24	26
27		(21,879)	6	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	(99,316)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	(21,879)	0	0	0	0	0	0	0	0	0	0	(21,879)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,879)	0	0	0	0	0	0	0	0	0	0	(21,879)	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	(1,822)	0	0	0	0	0	0	0	0	0	0	(1,822)	19
20	Fees, Subscriptions & Promotions	(44,950)	0	0	0	0	0	0	0	0	0	0	(44,950)	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	(8,209)	0	0	0	0	0	0	0	0	0	0	(8,209)	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**	(72,981)	0	0	0	0	0	0	0	0	0	0	(72,981)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(94,860)	0	0	0	0	0	0	0	0	0	0	(94,860)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(4,456)	0	0	0	0	0	0	0	0	0	0	(4,456)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,767)	0	0	0	0	0	0	0	0	0	0	(9,767)	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**	(14,223)	0	0	0	0	0	0	0	0	0	0	(14,223)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(109,083)	0	0	0	0	0	0	0	0	0	0	(109,083)	45

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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										(9,767)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,767)	14
15	TOTALS (line 9+line14)						$	$			$ (9,767)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

No Real Estate Taxes

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow Rebekah Home COUNTY Coles

FACILITY IDPH LICENSE NUMBER 10223

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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			1977	$ 437,500	1
2					2
3	TOTALS			$ 437,500	3

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	1997 Improvements			1997	369,567						27
28	1998 Improvements			1998	20,213						28
29	1999 Improvements			1999	17,147						29
30	2000 Improvements			2000	4,403						30
31	2001 Improvements			2001	2,032						31
32	2002 Improvements			2002	22,756						32
33	2003 Improvements			2003	96,365						33
34	2004 Improvements			2004	132,889						34
35	2005 Improvements			2005	22,486						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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	2006 Improvements	2006	$ 72,855	$		$	$	$	37
38	2007 Improvements	2007	32,123						38
39	2008 Improvements	2008	44,453						39
40	2009 Improvements	2009	110,701						40
41	2010 Improvements	2010	146,929						41
42	2011 Improvements	2011	35,298						42
43									43
44	Pavillion Roof	2012	3,975						44
45	Compressor	2012	2,986						45
46	Parking Lot Patch & Seal	2012	6,923						46
47	Rooftop A/C	2012	6,305						47
48	Water Heater	2012	10,173						48
49									49
50	Therapy Room Remodel-Cabinets	2013	1,431						50
51	Therapy Room Remodel-Countertops	2013	1,062						51
52	Therapy Room Remodel-Electrical	2013	1,667						52
53	Therapy Room Remodel-Materials	2013	982						53
54	Lobby A/C	2013	3,511						54
55	Lighting Retrofit	2013	5,781						55
56	Furnaces	2013	6,998						56
57	Yale doors (8)	2013	2,942						57
58									58
59	Facility cabling for new Nurse Call System	2014	259,332						59
60	Rooftop HVAC Purchase and Installation-Main Living Area	2014	6,580						60
61	Bather acquisition and installation	2014	12,679						61
62	Air conditioner for computer room	2014	4,178						62
63	Rooftop HVAC Purchase and Installation-Kitchen	2014	8,534						63
64									64
65									65
66									66
67	Depreciation			155,058		155,058			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,291,760	$ 155,058		$ 155,058	$	$	70

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

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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		$ 7,291,760	$ 155,058		$ 155,058	$	$	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	(2) Generators	2017	112,159						22
23	Install Carrier roof top ac unit	2017	7,716						23
24	Parking lot overlay	2017	40,001						24
25	Replace valve- sprinkler system	2017	4,900						25
26									26
27	Install Carrier Rooftop HVAC unit	2018	7,757						27
28	Replace Control Panel	2018	11,075						28
29	Roof Replacement - Partial	2018	18,105						29
30	Install Compressor - Harmony wing	2018	9,872						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,697,750	$ 155,058		$ 155,058	$	$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$ 2,069,846	$ 49,323	$ 49,323	$		$	71
72	Current Year Purchases	46,782						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,116,628	$ 49,323	$ 49,323	$		$	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	Transport	2016 Ford Turtle Top	2016	$ 55,810	$ 7,973	$ 7,973	$		$	76
77	Transport	2011 Ford Sport Top Van	2011	37,262	3,992		(3,992)			77
78	Maintenance	2001 Chevy Silverado	2010	7,800	464		(464)			78
79										79
80	TOTALS			$ 100,872	$ 12,429	$ 7,973	$ (4,456)		$	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)	$ 10,352,750	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,810	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,354	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,456)	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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 35,247 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.

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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? [x] 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 [x]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		871		871
3	Classroom Wages (a)				
4	Clinical Wages (b)		16,022		16,022
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 16,893	$	$ 16,893
10	SUM OF line 9, col. 1 and 2 (e)	$ 16,893			

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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	$		$ 258,569	$		$ 258,569	1
2	Licensed Speech and Language Development Therapist		hrs			139,027			139,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			338,087	84		338,171	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				335,260		335,260	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,157			17,157	13
14	TOTAL			$		$ 752,840	$ 335,344		$ 1,088,184	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 Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2018 (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	$ 893,269	$	1
2	Cash-Patient Deposits	19,184		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	880,203		3
4	Supply Inventory (priced at FIFO)	30,251		4
5	Short-Term Investments			5
6	Prepaid Insurance	70,554		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,499,075		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,392,536	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,442,179		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,993,438		16
17	Accumulated Depreciation (book methods)	(8,049,146)		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)**	$ 2,386,471	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,779,007	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 542,505	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,184		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	378,369		30
31	Accrued Taxes Payable (excluding real estate taxes)	86,432		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	32,918		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,059,408	$	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)**	$ 1,059,408	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,719,599	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,779,007	$	48

***(See instructions.)**

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,429,413	1
2	Restatements (describe):		2
3	Adjust Funds Held by Grand Lodge	747,664	3
4	Audit Adjustment	(14,293)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,162,784	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(443,185)	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)**	$ (443,185)	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)**	$ 8,719,599	24 *

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

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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	$ 7,736,326	1
2	Discounts and Allowances for all Levels	(2,860,092)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,876,234	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,639,640	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,639,640	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	21,879	16
17	Sale of Drugs	598,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,016	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 642,702	23
	D. Non-Operating Revenue		
24	Contributions	(10,000)	24
25	Interest and Other Investment Income***	9,767	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (233)	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)**	$ 8,158,343	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,601,691	31
32	Health Care	3,344,952	32
33	General Administration	2,667,145	33
	B. Capital Expense		
34	Ownership	252,057	34
	C. Ancillary Expense		
35	Special Cost Centers	735,683	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)***	$ 8,601,528	40
41	**Income before Income Taxes (line 30 minus line 40)****	(443,185)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (443,185)	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 # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	1,726	1,837	$ 66,133	$ 36.00	1
2	Assistant Director of Nursing	1,752	1,864	56,425	30.27	2
3	Registered Nurses	21,811	23,203	707,553	30.49	3
4	Licensed Practical Nurses	17,075	18,165	434,219	23.90	4
5	CNAs & Orderlies	75,161	79,958	1,111,645	13.90	5
6	CNA Trainees	1,855	1,855	16,022	8.64	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,759	1,871	33,056	17.67	8
9	Activity Director					9
10	Activity Assistants	9,308	9,903	123,903	12.51	10
11	Social Service Workers	5,211	5,544	77,424	13.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,894	26,483	345,344	13.04	15
16	Dishwashers					16
17	Maintenance Workers	11,465	12,197	190,856	15.65	17
18	Housekeepers	14,009	14,903	176,968	11.87	18
19	Laundry	5,617	5,976	62,702	10.49	19
20	Administrator	1,955	2,080	109,646	52.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,120	17,149	378,247	22.06	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)	209,718	222,988	$ 3,890,143 *	$ 17.45	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		2,080		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,386		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		5,206		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,672		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		174,898		52
53	TOTAL (lines 50 - 52)		$ 174,898		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Standefer			$ 109,646
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,646

B. Administrative - Other

Description	Amount
	$ 0
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	Management	$ 396,089
Pehlman and Dold	Audit	19,426
Sulaski & Webb	Audit - 401(k)	5,500
Principal Financial	Plan consulting	2,896
ADP	Payroll tax filing	294
Navex Global/Provider Trust	Compliance	801
Legal adj to Zero		1,822
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 426,828

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,933
Unemployment Compensation Insurance	25,016
FICA Taxes	297,596
Employee Health Insurance	565,678
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	62,772
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,125,995

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,737
Health Care Worker Background Check	
(Indicate # of checks performed)	2,696
Patient Background Checks	
PR	20,750
Dues & Subscriptions	17,785
License & Fees	581
Less: Public Relations Expense	(20,750)
Non-allowable advertising	(6,454)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	10,584
	10
Seminar Expense	2,614
	(8,209)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Odd Fellow Rebekah Home # 10223 Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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. **Health Care Council of Illinois**

(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. $ **307,482**
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? Indicate the amount. $ **11,012**

(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? **Y**
Firm Name: **Pehlman & Dold PC**

(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 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009	PETTY CASH	893,269						
1010	CASH IN BANK							
1040	CASH IN BANK-PAYROLL							
1100	ACCOUNTS RECEIVABLE	880,203						
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	70,554						
1220	OTHER PREPAID EXPENSES							
1300	FOOD INVENTORY	30,251						
1310	SUPPLIES INVENTORY							
1409	LAND	0						
1450	FURNITURE & EQUIPMENT	1,993,438						
1460	ACCUM DEPR-FURN & EQUIP	-1,805,782						
1475	BUILDING & IMPROVEMENTS	8,442,179						
1490	ACCUM DEPR-BUILDING	-6,243,364						
1530	RESIDENT FUNDS	19,184						
1550	LOAN FEES	0						
1560	REAL ESTATE TAX ESCROW							
1575	REIMBURSABLE PURCHASES							
1850	INTRACOMPANY	5,499,075						
2010	ACCOUNTS PAYABLE	-542,505						
2095	BONUSES PAYABLE							
2100	ACCRUED PAYROLL	-149,681						
2110	ACCRUED VACATION PAY	-228,688						
2120	UC TAXES PAYABLE							
2125	FICA TAX PAYABLE	-86,432	-86,432					
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	-32,918						
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	-19,184						
2600	MORTGAGE PAYABLE	0						
2650	EQUIPMENT LOAN PAYABLE							
2695	CURRENT PORTION LT DEBT							
2696	DEFERRED INCOME TAXES							
2710	COMMON STOCK							
2720	RETAINED EARNINGS	-9,162,784						
2970	PROFIT/LOSS FOR PERIOD	443,185						
3007.1	PATIENT DAYS-PRIVATE	13,206						
3007.2	PATIENT DAYS-IPA	22,250						
3007.3	PATIENT DAYS-MEDICARE	4,508						
3007.4	PATIENT DAYS-CONVERSION							
3007.5	PATIENT DAYS-LICENSED							
3007.6	PATIENT DAYS-TOTAL							
3010	1 BASIC CHARGE-PRIVATE & VA	-7,718,349		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	-30,879		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	-598,807		0	0	0	0	
3101	17 DRUGS-OTHER							
3110	6 PT-PRIVATE	-2,639,640		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	218,787						
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	2,860,092		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	-21,879		6	0	6	-21,879	
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	12,902		0	0	0	0	
3595	21 RESIDENT TRANSPORTATION	-20,345		0	0	0	0	
3600	21 MISC INCOME	-1,671		0	0	0	0	
4110	GENERAL & ADMINIST WAGES	350,990	378,247	21	1	17	0	
4111	ADMINISTRATOR WAGES	109,646	109,646	17	1	0	0	
4115	VACATION & SICK - G&A	27,257		21	1	0	0	
4120 4475	EMPLOYEE BENEFITS	19,423	1,125,995	22	3	0	0	
4125	EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130	EMPLOYEE SCHOLORSHIP WA	24,036	218,787	21	1	0	0	
4135	EMPLOYEE SCHOLORSHIP CO:	19,313		23	3	0	0	
4220	DIRECTORS FEES	0	0	18	3	0	0	
4250 4255	OFFICE SUPPLIES	22,364	22,364	21	2	0	0	
4260	TELEPHONE	30,695	30,695	21	3	0	0	
4275	TRAINING & EMPLOYEE DEVL	4,335	4,335	23	3	16	0 **	
4280	GENERAL TRAVEL	10,584	13,208	24	3	16	0	
4281	MEAL EXPENSE FOR TRAVEL	10		24	3	19	0	
4285	EDUCATION & SEMINAR	2,614		24	3	19	-8,209 ***	
4290	HELP WANTED ADVERTISING	7,737	155,990	20	3	0	0	-88,695
4291	PROMOTIONAL ADVERTISING	17,746		20	3	25	-17,746	
4292	PUBLIC RELATIONS	20,750		20	3	25	-20,750	
4300	LICENSES & FEES	89,276		20	3	17	0	
4310	DUES & SUBSCRIPTIONS	17,785		20	3	17	-6,454	
4320	CONTRIBUTIONS	0		27	3	20	0	
4350	PROFESSIONAL FEES	30,738	426,828	19	3	22	-1,822	
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	2,080		10	3	0	0	
4363	PHARMACIST FEES	7,386		10	3	0	0	
4364	SOC SERV/ACT CONSULT	5,206	5,206	12	3	0	0	
4370	TV RENTAL	3,595		35	3	5	0	
4380	INCOME TAXES		18,000	27	3	26	0	
4383	BACKGROUND CHECKS	2,696		20	3	26	0	
4400	PAYROLL TAXES	311,231		22	3	0	0	
4401	PAYROLL TAXES ADMINIST	11,381		22	3	0	0	
4410	GROUP INSURANCE	565,678		22	3	0	0	
4420	LIABILITY INSURANCE	163,050	163,050	26	3	0	0	
4425	INSURANCE-OWNERS			22	3	21	0	
4430	WORKMENS COMP INSURANCE	174,933		22	3	0	0	
4450	CENTRAL OFFICE FEES	396,090		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	31,652	35,247	35	3	16	0	
5110	MAINTENANCE SALARIES	172,946	190,856	6	1	0	0	
5120	MAINTENANCE SICK & VAC	17,910		6	1	0	0	
5130	ELECTRIC	104,460	192,424	5	3	0	0	
5131	NATURAL GAS	25,689		5	3	0	0	
5132	HEATING & DEISEL OIL			5	3	0	0	
5133	WATER & SEWER	62,275		5	3	0	0	
5134	TRASH COLLECTION	12,312	96,914	6	3	0	0	
5140	PROPERTY PLANT REPLACEMI	14,676	105,192	6	2	0	0	
5160	GENERAL REPAIR & MAINT	90,516		6	2	0	0	
5165	MAINTENANCE CONTRACTS	84,602		6	3	0	0	
5210	DIETARY WAGES	314,680	345,344	1	1	0	0	
5220	DIETARY SICK & VAC	30,664		1	1	0	0	
5240	SALES TAX			2	3	13	0	
5248	FOOD PURCHASES	373,914	362,902	2	2	0	0	
5250	SUPPLIES-DISHWASHING	8,393	27,659	1	2	0	0	
5260	DIETARY REPLACEMENT	3,882		1	2	0	0	
5270	KITCHEN SUPPLIES-PAPER	15,384		1	2	0	0	
5295	MEAL CREDIT	-11,012		2	2	0	0	
5310	LAUNDRY WAGES	58,375	62,702	4	1	0	0	
5340	LAUNDRY SICK & VAC	4,327		4	1	0	0	
5370	LAUNDRY REPLACEMENT	4,942	13,988	4	2	0	0	
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	
5390	LAUNDRY SUPPLIES	9,046		4	2	0	0	
5410	HOUSEKEEPING WAGES	162,245	176,968	3	1	0	0	
5440	HOUSEKEEPING SICK & VAC	14,723		3	1	0	0	
5480	HOUSEKEEPING SUPPLIES	27,725	26,742	3	2	0	0	
5490	HOUSEKEEPING SUPPLIES-PPR	-983		3	2	0	0	
6010	RN WAGES-MEDICARE		2,409,031	10	1	0	0	
6020	RN WAGES-NON MEDICARE	659,583		10	1	0	0	
6030	DON WAGES	66,133		10	1	0	0	
6035	ADON	56,425		10	1	0	0	
6040	RN SICK & VACATION	47,970		10	1	0	0	
6110	LPN WAGES-MEDICARE	388,892		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	45,327		10	1	0	0	
6210	AIDE WAGES-MEDICARE			10	1	0	0	
6220	AIDE WAGES-NON MEDICARE	1,038,348		10	1	0	0	
6230	WARD CLERKS			10	1	0	0	
6240	AIDE VACATION & SICK	73,297		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	174,898		10	3	0	0	
6250	NURSE AIDE TRAINING WAGES	16,022	16,022	13	1	0	0	
6255	NURSE AID TRAINING EXP	871	871	13	2	0	0	
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270	REHAB WAGES	30,378		10	1	0	0	
6275	REHAB SICK & VAC	2,678		10	1	0	0	
6280	NURSING DEPT EDUCATION			23	3	0	0	
6290	NURSING SUPPLIES	138,112	154,387	10	2	0	0	
6295	NURSING SUPPLIES	15,637		10	2	0	0	
6390	REPLACEMENT-NURSING	638		10	2	0	0	
6490	NURSING OTHER	185	184,549	10	3	0	0	
7280	DRUG PURCHASES	316,146	335,344	39	2	0	0 ***	
7281	DRUG PURCHASES-OTHER	19,114		39	2			
7380	LABORATORY SERVICES	17,157	17,157	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	113,934	123,903	11	1	0	0	
7540	ACTIVITIES SICK & VAC	9,969		11	1	0	0	
7590	ACTIVITIES SUPPLIES	9,058	9,058	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	338,087	735,683	39	3	0	0 ***	
7660	PT SUPPLIES	84		39	2	0	0	
7710	SOCIAL SERVICE WAGES	72,774	77,424	12	1	0	0	
7720	SOCIAL SERVICE SICK & VAC	4,650		12	1	0	0	
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740	OT FEE	258,569		39	3	0	0 ***	
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770	SPEECH THERAPY FEE	139,027		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	-9,767	
8130	DEPRECIATION	216,810	216,810	30	3	9	-4,456	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-9,767		32	0	10	0	
9520	MISC NON-OPERATING INCOME	10,000		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		8,382,974	8,601,528					
			218,554					
GRAND TOTALS		443,185 (NET INCOME)					-109,083	
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009	CASH	893,269
1,100	1,100	ACCTS RECEI	880,203
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 INSU	70,554
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVE	30,251
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITURE &	1,993,438
1,460			(1,805,782)
1,475	1,475	BUILDINGS	8,442,179
1,490	1,490	ACCUM DEPR	(6,243,364)
1,530	1,530	RESIDENT FU	19,184
1,550	1,550	LOAN FEES	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOMPA	5,499,075
2,010	2,010	ACCOUNTS P/	(542,505)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED PA'	(149,681)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED PT(	(228,688)
2,120	2,120	U.C. TAXES P/	0
2,125	2,125	FICA TAXES P	(86,432)
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 GARNI:	
2,300	2,300	ACCRUED INT	0
2,320	2,320	IPA PAYMENT	(32,918)
2,350	2,350	REAL ESTATE	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO RESII	(19,184)
2,600	2,600	LOC	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	RETAINED EA	(9,162,784)
		net income	443,185
		balance	0

3,007	3,007	PATIENT DAYS-PI	13,206
3,007	3,007	PATIENT DAYS-IP	22,250
3,007	3,007	PATIENT DAYS-M	4,508
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHARGE-P	(7,718,349)
3,020	3,020	BASIC CHARGE-II	0
3,030	3,030	BASIC CHARGE-N	0
3,040		ASSESSMENT	218,787
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SUPPL-	(30,879)
3,081	3,081	NURSING SUPPLI	0
3,082	3,082	NURSING SUPPLI	0
3,083	3,083	NURSING SUPPLI	0
3,100	3,100	DRUGS-MEDICAR	(598,807)
3,101			0
3,110	3,110	PHYSICAL THERA	(2,639,640)
3,111			0
3,112	3,112	PHYSICAL THERA	0
3,113	3,113	PHYSICAL THERA	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THERAPY-I	0
3,153	3,153	ST/OT THERAPY-I	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER DISCC	0
3,411	3,411	MEDICARE PT B-I	0
3,420	3,420	MEDICARE DISCC	2,765,278
3,500			
3,520	3,520	RENT INCOME	(21,879)
3,530	3,530	BEAUTY SHOP	0
3,560			0
3,570	3,570	VENDING INCOME	0
3,590	3,590	EQUIPMENT REN'	12,902
3,595	3,595	RESIDENT TRANS	(20,345)
3,600	3,600	MISC INCOME	(1,671)
4,110	4,110	G&A WAGES	350,990
4,111	4,111	ADMINISTRATOR	109,646
4,115	4,115	G&A PTO & RESE	27,257
4,120	4,120	EMPLOYEE BENE	18,193
4,121			0
4,130	4,130	EMPLOYEE SCHC	24,036
4,135	4,135	EMPLOYEE SCHC	19,313
4,250	4,250	OFFICE SUPPLIES	9,576
4,255	4,255	POSTAGE	2,882
4,260	4,260	TELEPHONE	30,695
4,275	4,275	TRAINING & EMPL	4,335
4,276			(6)
4,280	4,280	GENERAL TRAVE	10,584
4,281	4,281	MEAL EXPENSE F	10
4,285	4,285	EDUCATION/SEMI	838
4,289	4,289	MEETINGS EXPEI	1,776
4,290	4,290	HELP WANTED AI	7,737
4,291	4,291	PROMOTIONAL AI	17,746
4,292	4,292	PUBLIC RELATIOI	20,750
4,300	4,300	LICENSE & FEES	89,276
4,310	4,310	DUES & SUBSCRI	17,785
4,320	4,320	CONTRIBUTIONS	0
4,350	4,350	PROFESSIONAL F	30,738
4,355	4,355	MEDICAL DIRECT	12,000
4,362			2,080
4,363			7,386
4,364	4,364	SOCIAL SERV/AC'	5,206
4,370	4,370	TV RENTAL	3,595
4,383	4,383	BACKGROUND CI	2,696
4,390	4,390	OTHER TAXES	0
4,400	4,400	PAYROLL TAXES	311,231
4,401	4,401	PAYROLL TAXES	11,381
4,410	4,410	GROUP INSURAN	565,678
4,420	4,420	LIABILITY INSURA	163,050
4,430	4,430	WORKMAN'S COI	172,525
4,435	4,435	W/C-FIRST AID CL	0
4,436	4,436	DRUG TESTING M	2,414
4,450	4,450	MANAGEMENT FE	396,090
4,460	4,460	BAD DEBTS	18,000
4,461	4,461	BAD DEBTS	94,814
4,470	4,470	LOST ITEMS-RESI	0
4,475	4,475	UNIFORM EXP/PE	1,230
4,486	4,486	SERVICE CONTR/	71,948
4,490	4,490	MISC EXPENSE	6,376
4,496	4,496	MISC. M.I.S. EXPE	9,906
4,510	4,510	REAL ESTATE TA:	0
4,600	4,600	LEASED EQUIPME	31,652
5,110	5,110	MAINTENANCE W	172,946
5,120	5,120	MAINTENANCE P'	17,910
5,130	5,130	ELECTRIC	104,460
5,131	5,131	NATURAL GAS	25,689
5,133	5,133	WATER & SEWER	62,275
5,134	5,134	TRASH COLLECTI	12,312
5,140	5,140	PROP/PLANT REF	14,676
5,160	5,160	GENERAL REPAIR	90,516
5,165	5,165	MAINTENANCE C(	12,654
5,210	5,210	DIETARY WAGES	314,680
5,220	5,220	DIETARY PTO & R	30,664
5,248	5,248	FOOD PURCHASE	367,538
5,250	5,250	SUPPLIES DISHW	8,393
5,260	5,260	REPLACEMENT-D	3,882
5,270	5,270	KITCHEN SUPPLIE	15,384
5,295	5,295	MEAL INCOME	(11,012)
5,310	5,310	LAUNDRY WAGES	58,375
5,340	5,340	LAUNDRY PTO & I	4,327
5,370	5,370	REPLACEMENT-L	4,942
5,380			0
5,390	5,390	SUPPLIES	9,046
5,410	5,410	HOUSEKEEPING \	162,245
5,440	5,440	HOUSEKEEPING I	14,723
5,480	5,480	SUPPLIES-CLEAN	27,725
5,490	5,490	SUPPLIES-HOUSE	(983)
6,020	6,020	RN WAGES	659,583
6,030	6,030	DON WAGES	66,133
6,035	6,035	ADON WAGES	56,425
6,040	6,040	RN PTO & RESER	47,970
6,120	6,120	LPN WAGES	388,892
6,140	6,140	LPN PTO & RESEI	45,327
6,220	6,220	AIDES WAGES	1,038,348
6,240	6,240	AIDES PTO & RES	73,297
6,245		RN CONTR	0
6,246		LPN CONTR	0
6,247		AIDES CONTR	174,898
6,250			16,022
6,255			871
6,260			0
6,270	6,270	REHAB WAGES	30,378
6,275	6,275	REHAB PTO & RE	2,678
6,290	6,290	NURSING SUPPLI	138,112
6,295	6,295	NURSING SUPPLI	15,637
6,390	6,390	REPLACEMENT-N	638
6,490	6,490	OTHER	185
7,280	7,280	DRUG PURCHASE	316,146
7,281	7,281	DRUG PURCHASE	19,114
7,380	7,380	LABORATORY SE	8,390
7,391	7,390	X-RAY SERVICES	7,132
7,393			1,635
7,510	7,510	ACTIVITIES WAGE	113,934
7,540	7,540	ACTIVITIES PTO 8	9,969
7,590	7,590	ACTIVITIES SUPP	9,058
7,620	7,620	PHYSICAL THERA	338,087
7,660	7,660	P.T. SUPPLY - BIL	84
7,710	7,710	SOCIAL SERVICE	72,774
7,720	7,720	SOCIAL SERVICE	4,650
7,730	7,730	SOCIAL SERVICE-	0
7,740	7,740	OCCUPATIONAL 1	258,569
7,750			
7,770	7,770	SPEECH THERAP	139,027
7,820	7,820	BEAUTICIAN FEE	0
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			0
8,130	8,130	DEPRECIATION	216,810
8,150			0
9,510	9,510	INTEREST INCOM	(9,767)
9,520	9,520	MISC NON-OPER/	10,000
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			443,185

Expenses Fixed Assets 0

G/L RECAP CENSUS

OddFellow Rebekah Home
2018 Cost Report
Supplemental Schedules
Reclassification Entries

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

Line Item		
Purchased Drugs and Medications	$	335,260
Purchased Hospital Services		1,635
Purchased Laboratory Services		8,390
Purchased Radiology Services		7,132
Amount Reclassified to Line 39	$	352,417

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

Line Item		
Provider Participation Fee - $1.50	$	(88,695)
Provider Assesment Fee - $6.07		(218,787)
		(307,482)
Provider Participation Fee		307,482