

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0010223</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Odd Fellow-Rebekah Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/11</u> to <u>06/30/12</u> 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.																							
Address: <u>201 Lafayette Avenue, East</u> <u>Mattoon</u> <u>61938</u>																									
Number City Zip Code																									
County: <u>Coles</u>																									
Telephone Number: <u>(217) 235-5449</u> Fax # <u>()</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David Standerfer</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Craig Ater</u> <u>Exec. VP & CFO</u></td></tr><tr><td>(Firm Name & Address) <u>Heritage Operations Group LLC</u> <u>Bloomington, Ill</u></td></tr><tr><td>(Telephone) <u>(309) 823-7135</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David Standerfer</u>	(Title) <u>Administrator</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Craig Ater</u> <u>Exec. VP & CFO</u>	(Firm Name & Address) <u>Heritage Operations Group LLC</u> <u>Bloomington, Ill</u>	(Telephone) <u>(309) 823-7135</u> Fax # <u>()</u>												
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	(Telephone) <u>(309) 823-7135</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>1977</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____																									

Facility Name & ID Number Odd Fellow-Rebekah Home# 0010223 Report Period Beginning: 07/01/11 Ending: 06/30/12

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,780</u>	<u>9,889</u>	<u>5,290</u>	<u>45,959</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,780</u>	<u>9,889</u>	<u>5,290</u>	<u>45,959</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.51%

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? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

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

Date started 1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 5,290Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: _____ Fiscal Year: _____

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

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						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	323,162	32,962		356,124		356,124		356,124		1
2	Food Purchase		347,239		347,239		347,239		347,239		2
3	Housekeeping	178,293	25,629		203,922		203,922		203,922		3
4	Laundry	51,706	13,040		64,746		64,746		64,746		4
5	Heat and Other Utilities			214,497	214,497		214,497		214,497		5
6	Maintenance	163,839	85,245	67,214	316,298		316,298		316,298		6
7	Other (specify):*										7
8	TOTAL General Services	717,000	504,115	281,711	1,502,826		1,502,826		1,502,826		8
	B. Health Care and Programs										
9	Medical Director			7,992	7,992		7,992		7,992		9
10	Nursing and Medical Records	2,249,301	161,702	11,071	2,422,074		2,422,074		2,422,074		10
10a	Therapy		284,312	716,193	1,000,505	(322,771)	677,734		677,734		10a
11	Activities	122,297	11,350		133,647		133,647		133,647		11
12	Social Services	84,996		4,875	89,871		89,871		89,871		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,456,594	457,364	740,131	3,654,089	(322,771)	3,331,318		3,331,318		16
	C. General Administration										
17	Administrative	84,426			84,426		84,426		84,426		17
18	Directors Fees										18
19	Professional Services			440,378	440,378		440,378	(2,540)	437,838		19
20	Dues, Fees, Subscriptions & Promotions			141,323	141,323	(88,695)	52,628	(31,291)	21,337		20
21	Clerical & General Office Expenses	295,295	21,414	29,260	345,969		345,969		345,969		21
22	Employee Benefits & Payroll Taxes			743,808	743,808		743,808		743,808		22
23	Inservice Training & Education			3,791	3,791		3,791		3,791		23
24	Travel and Seminar			18,168	18,168		18,168	(16,169)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			160,158	160,158		160,158		160,158		26
27	Other (specify):*			18,075	18,075		18,075	(18,000)	75		27
28	TOTAL General Administration	379,721	21,414	1,554,961	1,956,096	(88,695)	1,867,401	(68,000)	1,799,401		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,553,315	982,893	2,576,803	7,113,011	(411,466)	6,701,545	(68,000)	6,633,545		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			251,910	251,910		251,910		251,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,863	15,863		15,863	(2,468)	13,395			32
33	Real Estate Taxes			1,821	1,821		1,821	(1,821)				33
34	Rent-Facility & Grounds							(24,378)	(24,378)			34
35	Rent-Equipment & Vehicles			24,995	24,995		24,995		24,995			35
36	Other (specify):*											36
37	TOTAL Ownership			294,589	294,589		294,589	(28,667)	265,922			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					322,771	322,771		322,771			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,695	88,695		88,695			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					411,466	411,466		411,466			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,553,315	982,893	2,871,392	7,407,600		7,407,600	(96,667)	7,310,933			45

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

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(24,378)			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	(2,468)			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	(1,821)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(16,169)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,540)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(31,291)			25
	Income Taxes and Illinois Personal				
26	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)	\$ (96,667)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,667)		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

Report Period Beginning: ID# 0010223

Ending: 07/01/11

06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,540)	19	22
23				23
24		(18,000)	27	24
25		(31,291)	20	25
26				26
27				27
28				28
29			33	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	(51,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,540)	0	0	0	0	0	0	0	0	0	0	(2,540)	19
20	Fees, Subscriptions & Promotions	(31,291)	0	0	0	0	0	0	0	0	0	0	(31,291)	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	(16,169)	0	0	0	0	0	0	0	0	0	0	(16,169)	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	(68,000)	0	0	0	0	0	0	0	0	0	0	(68,000)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(68,000)	0	0	0	0	0	0	0	0	0	0	(68,000)	29

Summary B

06/30/12

[illegible]

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/11 Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Bond-City of Mattoon		x	Construction of addition	\$20,000.00	09/02/94	\$	203,750			\$	15,863	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related				\$20,000.00		\$	203,750				\$	15,863	9
	B. Non-Facility Related*													
10	Interest Income											(2,468)	10	
11	Allocated Corporate												11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(2,468)	14
15	TOTALS (line 9+line14)						\$	203,750				\$	13,395	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.)

2011 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

TELEPHONE ()
FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,308

B. General Construction Type: Exterior brick Frame wood

Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 437,500	1
2					2
3	TOTALS			\$ 437,500	3

Facility Name & ID Number Odd Fellow-Rebekah Home

#

0010223

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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						184,673		184,673			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

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	2001	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	\$ 184,673		\$ 184,673	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 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	\$ 184,673		\$ 184,673	\$	\$	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	\$ 184,673		\$ 184,673	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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	\$ 184,673		\$ 184,673	\$	\$	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	\$ 184,673		\$ 184,673	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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	\$ 184,673		\$ 184,673	\$	\$	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	\$ 184,673		\$ 184,673	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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	\$ 184,673		\$ 184,673	\$	\$	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	9,293						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,975,203	\$ 184,673		\$ 184,673	\$	\$	34

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

Page 13

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	\$ 1,755,104	\$ 67,237	\$ 67,237	\$		\$	71
72	Current Year Purchases	16,229						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,771,333	\$ 67,237	\$ 67,237	\$		\$	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)	\$ 9,184,036	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 251,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,910	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.

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: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$24,995 Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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

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. /2013 \$

13. /2014 \$

14. /2015 \$

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

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

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

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$		\$ 260,088	\$		\$ 260,088	1
2	Licensed Speech and Language Development Therapist		hrs			72,420			72,420	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			343,024	2,202		345,226	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				282,110		282,110	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					40,661			40,661	13
14	TOTAL			\$		\$ 716,193	\$ 284,312		\$ 1,000,505	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,146,437	\$	1
2	Cash-Patient Deposits	16,749		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,271,735		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,771		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,738,755		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,242,447	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,616,004		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,641,350		16
17	Accumulated Depreciation (book methods)	(6,511,946)		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)	\$ 2,745,408	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,987,855	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 480,815	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,749		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,381		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,274		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	207,520		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,021,739	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	203,750		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)	\$ 203,750	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,225,489	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,762,366	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,987,855	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,240,728	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,240,728	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	521,638	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)	\$ 521,638	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)	\$ 6,762,366	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odd Fellow-Rebekah Home# 0010223Report Period Beginning: 07/01/11Ending: 06/30/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,558,440	1
2	Discounts and Allowances for all Levels	(2,510,594)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,047,846	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,345,527	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,345,527	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	1,222	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,378	16
17	Sale of Drugs	459,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,166	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 507,625	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,468	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		25,772	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,772	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,929,238	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,502,826	31
32	Health Care	3,654,089	32
33	General Administration	1,956,096	33
	B. Capital Expense		
34	Ownership	294,589	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)*	\$ 7,407,600	40
41	Income before Income Taxes (line 30 minus line 40)**	521,638	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 521,638	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,955	2,080	\$ 63,048	\$ 30.31	1
2	Assistant Director of Nursing	1,972	2,064	52,772	25.57	2
3	Registered Nurses	10,979	11,160	276,958	24.82	3
4	Licensed Practical Nurses	29,942	31,850	646,574	20.30	4
5	CNAs & Orderlies	100,101	105,869	1,194,452	11.28	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	828	828	15,497	18.72	8
9	Activity Director					9
10	Activity Assistants	10,823	11,286	122,297	10.84	10
11	Social Service Workers	5,946	6,200	84,996	13.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,374	28,995	323,162	11.15	15
16	Dishwashers					16
17	Maintenance Workers	10,928	11,857	163,839	13.82	17
18	Housekeepers	16,231	16,963	178,293	10.51	18
19	Laundry	5,100	5,743	51,706	9.00	19
20	Administrator	1,900	2,080	84,426	40.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,384	16,122	295,295	18.32	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)	239,463	253,097	\$ 3,553,315 *	\$ 14.04	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		7,992		36
37	Medical Records Consultant		1,900		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,885		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		4,875		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,652		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Odd Fellow-Rebekah Home

0010223

Report Period Beginning:

07/01/11

Ending:

06/30/12

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

David Standerfer

\$ 84,426

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 84,426

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

\$ 405,050

Pelman & Dold

Audit

18,638

Somerset

403B Audit

14,150

Legal adj to Zero

2,540

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 440,378

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 99,124

Unemployment Compensation Insurance

44,557

FICA Taxes

271,829

Employee Health Insurance

306,932

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

0

Other Benefits

21,366

Central Office Allocation

TOTAL (agree to Schedule V, line 22, col.8)

\$ 743,808

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

\$ 0

Advertising: Employee Recruitment

3,417

Health Care Worker Background Check

(Indicate # of checks performed)

3,752

Patient Background Checks

20,873

Dues & Subscriptions

10,753

License & Fees

3,415

Central Office Allocation

Less: Public Relations Expense

(20,873)

Non-allowable advertising

(225)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 21,112

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

16,007

18

Seminar Expense

2,143

(16,169)

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 1,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

Illinois Health Care Association
- (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 years
- (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?

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.

\$ 88,695

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?

yes

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.

\$ 6,583
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

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.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

Sulaski & Webb
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees.

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	1,146,437				1,009		1,009	PETTY C 1,146,437
1010	CASH IN BANK					1,100		1,100	ACCTS R 1,271,735
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	1,271,735				1,110		1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125		1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135		1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140		1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145		1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200		1,200	PREPAID 68,771
1145	A/R SUSPENSE-REFUNDS					1,220		1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300		1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	68,771				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND 0
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU 1,641,350
1409	LAND	0				1,460			(1,419,403)
1450	FURNITURE & EQUIPMENT	1,641,350				1,475		1,475	CODE AI 7,616,004
1460	ACCUM DEPR-FURN & EQU	-1,419,403				1,490		1,490	ACCUM I (5,092,543)
1475	BUILDING & IMPROVEMEN	7,616,004				1,530		1,530	RESIDEN 16,749
1490	ACCUM DEPR-BUILDING	-5,092,543				1,550		1,550	LOAN FE 0
1530	RESIDENT FUNDS	16,749				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	0				1,850		1,850	INTERCC 2,738,755
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN (480,815)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	2,738,755				2,100		2,100	ACCRUE (69,986)
2010	ACCOUNTS PAYABLE	-480,815				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-69,986				2,110		2,110	ACCRUE (228,395)
2110	ACCRUED VACATION PAY	-228,395				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(18,274)	
2125	FICA TAX PAYABLE	-18,274	-18,274	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(207,520)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-207,520		2,400	2,400 CURRENT PORTION OF LT DI		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(16,749)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(203,750)	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DI		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINI	(6,240,728)	
2460	INCOME TAXES PAYABLE					net incom	(521,638)
2512	DUE TO RESIDENTS	-16,749					
2600	MORTGAGE PAYABLE	-203,750					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-6,240,728					
2970	PROFIT/LOSS FOR PERIOD	-521,638					
3007.1	PATIENT DAYS-PRIVATE	9,889					3,007

3007.2	PATIENT DAYS-IPA	30,780						3,007
3007.3	PATIENT DAYS-MEDICARE	5,290						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-7,417,974	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-133,133	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-459,859	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,345,527	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,510,594	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	-24,378		6	0	6	-24,378	3,530
3530	13 BEAUTY SHOP	0		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-1,222		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-7,333		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-21,864		0	0	0	0	4,110
3600	21 MISC INCOME	-302		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	284,312	295,295	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	84,426	84,426	17	1	0	0	4,120
4115	VACATION & SICK - G&A	10,983		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	14,128	743,808	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	3,855		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	3,383		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	21,414	21,414	21	2	0	0	4,275
4260	TELEPHONE	29,260	29,260	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	3,791	3,791	23	3	16	0 **	4,280
4280	GENERAL TRAVEL	16,007	18,168	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	18		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	2,143		24	3	19	-16,169 ***	4,289
4290	HELP WANTED ADVERTISING	3,417	141,323	20	3	0	0 -88,695	4,290
4291	PROMOTIONAL ADVERTISING	10,418		20	3	25	-10,418	4,291
4292	PUBLIC RELATIONS	20,873		20	3	25	-20,873	4,292
4300	LICENSES & FEES	92,110		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	10,753		20	3	17	-225	4,310
4320	CONTRIBUTIONS	75		27	3	20	0	4,320
4350	PROFESSIONAL FEES	35,328	440,378	19	3	22	-2,540	4,350
4355	MEDICAL DIRECTOR	7,992	7,992	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	1,900		10	3	0	0	4,364
4363	PHARMACIST FEES	7,885		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	4,875	4,875	12	3	0	0	4,383
4370	TV RENTAL	6,910		35	3	5	0	4,390
4380	INCOME TAXES		18,075	27	3	26	0	4,400
4383	BACKGROUND CHECKS	3,752		20	3	26	0	4,401
4400	PAYROLL TAXES	307,623		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,763		22	3	0	0	4,420
4410	GROUP INSURANCE	306,932		22	3	0	0	4,430
4420	LIABILITY INSURANCE	160,158	160,158	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	99,124		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	405,050		19	3	34	0 **	4,460
4460	BAD DEBTS	18,000		27	3	24	-18,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	1,821	1,821	33	3	0	-1,821	4,486
4600	LEASED EQUIPMENT	18,085	24,995	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	150,295	163,839	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	13,544		6	1	0	0	4,510
5130	ELECTRIC	136,374	214,497	5	3	0	0	4,600
5131	NATURAL GAS	25,382		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	52,741		5	3	0	0	5,130
5134	TRASH COLLECTION	14,720	67,214	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	20,095	85,245	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	65,150		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	52,494		6	3	0	0	5,140
5210	DIETARY WAGES	299,150	323,162	1	1	0	0	5,160
5220	DIETARY SICK & VAC	24,012		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	353,822	347,239	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	8,613	32,962	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	6,318		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	18,031		1	2	0	0	5,260
5295	MEAL CREDIT	-6,583		2	2	0	0	5,270
5310	LAUNDRY WAGES	48,976	51,706	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,730		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,641	13,040	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	9,399		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	166,545	178,293	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	11,748		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	5,935	25,629	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	19,694		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,249,301	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	263,014		10	1	0	0	6,020
6030	DON WAGES	63,048		10	1	0	0	6,030
6035	ADON	52,772		10	1	0	0	6,035
6040	RN SICK & VACATION	13,944		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	617,785		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	28,789		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,147,726		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	46,726		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	13,644		10	1	0	0	6,390
6275	REHAB SICK & VAC	1,853		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	124,772	161,702	10	2	0	0	7,281
6295	NURSING SUPPLIES	30,445		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	6,485		10	2	0	0	7,391
6490	NURSING OTHER	1,286	11,071	10	3	0	0	7,393
7280	DRUG PURCHASES	268,021	284,312	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	14,089		39	2			7,540
7380	LABORATORY SERVICES	40,661	716,193	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	116,845	122,297	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,452		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	11,350	11,350	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	343,024		39	3	0	0 ***	7,890
7660	PT SUPPLIES	2,202		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	80,184	84,996	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,812		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	260,088		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	72,420		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
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	15,863	15,863	32	3	14	-2,468	
8130	DEPRECIATION	251,910	251,910	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-2,468		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-25,772		0	0	0	0	
		7,379,360	7,407,600					
			28,240					

GRAND TOTALS

-521,638

-96,892

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	9,889	9,889
IPA	30,780	30,780
medicare	5,290	5,290
		45,959
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 9,889

3,007 PATIENT	30,780
3,007 PATIENT	5,290
	0

3,010 BASIC CI	(7,417,974)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(133,133)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(459,859)
	0

3,110 PHYSICAL	(2,345,527)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	
	0

3,152 ST/OT TR	0
3,153 ST/OT TR	0

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	2,402,964
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3,520 RENT IN	(24,378)
3,530 BEAUTY	0
	0
3,570 VENDING	(1,222)
3,590 EQUIPM	(7,333)
3,595 RESIDEN	(21,864)
3,600 MISC INC	(302)
4,110 G&A WA	284,312
4,111 ADMINIS	84,426
4,115 G&A PTC	10,983
4,120 EMPLOY	14,298
4,130 EMPLOY	3,855
4,135 EMPLOY	3,383
4,250 OFFICE S	16,698
4,255 POSTAGE	4,716
4,260 TELEPHC	29,260
4,275 TRAININ	3,791
	0
4,280 GENERA	16,007
4,281 MEAL EX	18
4,285 EDUCAT	2,091
4,289 MEETING	52
4,290 HELP WA	3,417
4,291 PROMOT	10,418
4,292 PUBLIC I	20,873
4,300 LICENSE	92,110
4,310 DUES & F	10,753
4,320 CONTRIB	75
4,350 PROFESS	35,328
4,355 MEDICAL	7,992
	1,900
	7,885

4,364 SOCIAL S	4,875
4,370 TV RENT	6,910
4,383 BACKGR	3,752
4,390 OTHER T	2,000
4,400 PAYROL	307,623
4,401 PAYROL	8,763
4,410 GROUP I	306,932
4,420 LIABILIT	160,158
4,430 WORKM	95,644
4,435 W/C-FIRS	145
4,436 DRUG TE	3,335
4,450 MANAGI	405,050
4,460 BAD DEF	18,000
4,461 BAD DEF	107,630
4,470 LOST ITE	0
4,475 UNIFORM	(170)
4,486 SERVICE	41,244
4,490 MISC EX	0
4,496 MISC. M.	0
4,510 REAL ES	1,821
4,600 LEASED	18,085
5,110 MAINTEN	150,295
5,120 MAINTEN	13,544
5,130 ELECTRI	136,374
5,131 NATURA	25,382
5,133 WATER &	52,741
5,134 TRASH C	14,720
5,140 PROP/PL	20,095
5,160 GENERA	65,150
5,165 MAINTEN	11,250
5,210 DIETARY	299,150
5,220 DIETARY	24,012
5,248 FOOD PU	353,822

5,250 SUPPLIES	8,613
5,260 REPLACEMENTS	6,318
5,270 KITCHEN	18,031
5,295 MEAL IN	(6,583)
5,310 LAUNDRY	48,976
5,340 LAUNDRY	2,730
5,370 REPLACEMENTS	3,641
	0
5,390 SUPPLIES	9,399
5,410 HOUSEKEEPING	166,545
5,440 HOUSEKEEPING	11,748
5,480 SUPPLIES	5,935
5,490 SUPPLIES	19,694
6,020 RN WAGES	263,014
6,030 DONOR WAGES	63,048
6,035 ADONOR WAGES	52,772
6,040 RN PTO & OVERTIME	13,944
6,120 LPN WAGES	617,785
6,140 LPN PTO	28,789
6,220 AIDES WAGES	1,147,726
6,240 AIDES PTO	46,726
	0
	0
	0
6,270 REHABILITATION	13,644
6,275 REHABILITATION	1,853
6,290 NURSING	124,772
6,295 NURSING	30,445
6,390 REPLACEMENTS	6,485
6,490 OTHER	1,286

7,280 DRUG PU	268,021
7,281 DRUG PU	14,089
7,380 LABORA	12,333
7,390 X-RAY S	28,328
	0
7,510 ACTIVIT	116,845
7,540 ACTIVIT	5,452
7,590 ACTIVIT	11,350
7,620 PHYSICA	343,024
7,660 P.T. SUP	2,202
7,710 SOCIAL S	80,184
7,720 SOCIAL S	4,812
7,730 SOCIAL S	0
7,740 OCCUPA	260,088
7,770 SPEECH '	72,420
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	15,863
	0
8,130 DEPRECI	251,910
	0
9,510 INTERES	(2,468)
9,520 MISC NO	(27,772)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(521,638)</u>

Expenses Fixed Assets

