

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0010223

Facility Name: Odd Fellow Rebekah Home

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

County: Odd Fellow Rebekah Home

Telephone Number: 217 235-5449 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

xx VOLUNTARY, NON-PROFIT
xx Charitable Corp.
Trust
IRS Exemption Code 501

PROPRIETARY GOVERNMENTAL
Individual State
Partnership County
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: (309)8237135
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 7/1/2019 to 6/30/2020
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)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

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

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,309</u>	<u>12,943</u>	<u>3,772</u>	<u>41,024</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>24,309</u>	<u>12,943</u>	<u>3,772</u>	<u>41,024</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.19%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 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 162 and days of care provided 3,772

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	361,568	36,812	11,110	409,490		409,490		409,490			1
2	Food Purchase		375,564		375,564		375,564		375,564			2
3	Housekeeping	183,926	27,674		211,600		211,600		211,600			3
4	Laundry	63,077	15,018		78,095		78,095		78,095			4
5	Heat and Other Utilities			189,999	189,999		189,999		189,999			5
6	Maintenance	210,345	74,194	126,056	410,595		410,595	(21,381)	389,214			6
7	Other (specify):*											7
8	TOTAL General Services	818,916	529,262	327,165	1,675,343		1,675,343	(21,381)	1,653,962			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,305,093	197,289	537,212	3,039,594		3,039,594		3,039,594			10
10a	Therapy		315,286	17,318	332,604	(332,604)						10a
11	Activities	117,005	6,803		123,808		123,808		123,808			11
12	Social Services	88,116		5,007	93,123		93,123		93,123			12
13	CNA Training	1,468			1,468		1,468		1,468			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,511,682	519,378	571,537	3,602,597	(332,604)	3,269,993		3,269,993			16
	C. General Administration											
17	Administrative	115,203			115,203		115,203		115,203			17
18	Directors Fees											18
19	Professional Services			472,319	472,319		472,319	(11,582)	460,737			19
20	Dues, Fees, Subscriptions & Promotions			385,451	385,451	(315,719)	69,732	(56,837)	12,895			20
21	Clerical & General Office Expenses	392,442	27,552	12,587	432,581		432,581		432,581			21
22	Employee Benefits & Payroll Taxes			1,178,919	1,178,919		1,178,919		1,178,919			22
23	Inservice Training & Education			243	243		243		243			23
24	Travel and Seminar			10,911	10,911		10,911	(5,912)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			166,236	166,236		166,236		166,236			26
27	Other (specify):*			6,000	6,000		6,000	(6,000)				27
28	TOTAL General Administration	507,645	27,552	2,232,666	2,767,863	(315,719)	2,452,144	(80,331)	2,371,813			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,838,243	1,076,192	3,131,368	8,045,803	(648,323)	7,397,480	(101,712)	7,295,768			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			234,378	234,378		234,378		234,378			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,730	37,730		37,730		37,730			35
36	Other (specify):*											36
37	TOTAL Ownership			272,108	272,108		272,108		272,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			543,298	543,298	332,604	875,902		875,902			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					315,719	315,719		315,719			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			543,298	543,298	648,323	1,191,621		1,191,621			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,838,243	1,076,192	3,946,774	8,861,209		8,861,209	(101,712)	8,759,497			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.)

	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	(21,381)			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				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	(10,000)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,204)			17
18	Fines and Penalties				18
19	Entertainment	(5,912)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,582)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(54,633)			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)	\$ (101,712)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (101,712)		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

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		(1,582)	19	11
12		(10,000)	19	12
13		(6,000)	27	13
14		(54,633)	20	14
15		(2,204)	20	15
16		(21,381)	6	16
17		(5,912)	24	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				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	(101,712)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

7/1/2019

Ending:

6/30/2020**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	(21,381)	0	0	0	0	0	0	0	0	0	0	(21,381)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,381)	0	0	0	0	0	0	0	0	0	0	(21,381)	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	(11,582)	0	0	0	0	0	0	0	0	0	0	(11,582)	19
20	Fees, Subscriptions & Promotions	(56,837)	0	0	0	0	0	0	0	0	0	0	(56,837)	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	(5,912)	0	0	0	0	0	0	0	0	0	0	(5,912)	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):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	TOTAL General Administration	(80,331)	0	0	0	0	0	0	0	0	0	0	(80,331)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(101,712)	0	0	0	0	0	0	0	0	0	0	(101,712)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(101,712)	0	0	0	0	0	0	0	0	0	0	(101,712)	45

VII. RELATED PARTIES

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

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

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	
1	Board Members are not compensated for their services				0	0			\$ 0		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.

Ending: 5/30/2020

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:	2015	8		
	2016	9		
	2017	10		
	2018	11		
	2019	12		
Not for profit - no real estate taxes due				

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2019 \$ 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow Rebekah Home COUNTY Odd Fellow Rebekah Hom
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 2019 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 2019.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

1

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	Nursing Facility		1977	\$ 437,500	1
2					2
3	TOTALS			\$ 437,500	3

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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						182,272		182,272			36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	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	2012 Improvements		30,362						43
44									44
45	Therapy Room Remodel-Cabinets	2013	1,431						45
46	Therapy Room Remodel-Countertops	2013	1,062						46
47	Therapy Room Remodel-Electrical	2013	1,667						47
48	Therapy Room Remodel-Materials	2013	982						48
49	Lobby A/C	2013	3,511						49
50	Lighting Retrofit	2013	5,781						50
51	Furnaces	2013	6,998						51
52	Yale doors (8)	2013	2,942						52
53									53
54	Facility cabling for new Nurse Call System	2014	259,332						54
55	Rooftop HVAC Purchase and Installation-Main Living Area	2014	6,580						55
56	Bather acquisition and installation	2014	12,679						56
57	Air conditioner for computer room	2014	4,178						57
58	Rooftop HVAC Purchase and Installation-Kitchen	2014	8,534						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,291,760	\$ 182,272		\$ 182,272	\$	\$	70

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,291,760	\$ 182,272		\$ 182,272	\$	\$	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	\$ 182,272		\$ 182,272	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,697,750	\$ 182,272		\$ 182,272	\$	\$	1
2									2
3	Replace sidewalk	2019	5,175						3
4	Install rooftop AC unit	2019	7,426						4
5	Replace automatic entry door	2019	17,850						5
6	Update dry system component of fire sprinkler	2019	4,447						6
7	Replace sprinkler system piping - Harmony Wing (Phase I)	2019	121,154						7
8	Install new smoke detectors	2019	3,785						8
9	Main service replacement - electrical	2019	6,942						9
10									10
11	Replace sprinkler system piping - Phase II	2020	110,100						11
12	Repair water main - driveway	2020	6,253						12
13	Repair sewer - Harmony Unit - South Wing	2020	21,463						13
14	Replace fire and smoke acutaors	2020	3,434						14
15									15
16	Corridor remodeling project - main building:	2020	483,042						16
17	Demolished and replaced all corridor ceiling tile, drywall								17
18	and flooring. Demolished and replaced public bathroom								18
19	walls and flooring. Installed new paneling, rails and trim.								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)		\$ 8,488,821	\$ 182,272		\$ 182,272	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,133,638	\$ 44,133	\$ 44,133	\$		\$	71
72	Current Year Purchases	63,846						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,197,484	\$ 44,133	\$ 44,133	\$		\$	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	\$		\$
77	Transport	2011 Ford Sport Top Van	2011	37,262					
78	Maintenance	2001 Chevy Silverado	2010	7,800					
79									
80	TOTALS			\$ 100,872	\$ 7,973	\$ 7,973	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	11,224,677
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	234,378
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	234,378
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 37,730 Description:
(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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,468		1,468
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,468	\$	\$ 1,468
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,468			

(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.

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	

(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.)										
		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	\$		\$ 179,042	\$		\$ 179,042	1
2	Licensed Speech and Language Development Therapist		hrs			127,721			127,721	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			236,535	0		236,535	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				315,286		315,286	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,318			17,318	13
14	TOTAL			\$		\$ 560,616	\$ 315,286		\$ 875,902	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	\$ 2,644,308	\$	1
2	Cash-Patient Deposits	33,431		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	179,645		3
4	Supply Inventory (priced at FIFO)	25,488		4
5	Short-Term Investments			5
6	Prepaid Insurance	84,029		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,969,075		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,935,976	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	9,227,120		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,070,998		16
17	Accumulated Depreciation (book methods)	(8,494,713)		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)	\$ 2,803,405	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,739,381	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 586,673	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,431		28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	419,552		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,760		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	19,570		36
37	Deferred Stimulus	455,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,718,986	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	946,992		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)	\$ 946,992	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,665,978	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,073,403	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,739,381	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,104,773	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,104,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(31,370)	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)	\$ (31,370)	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)	\$ 8,073,403	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,419,986	1
2	Discounts and Allowances for all Levels	(2,207,694)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,212,292	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,011,912	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,011,912	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	21,381	16
17	Sale of Drugs	564,680	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,598	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 603,659	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,976	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)	\$ 8,829,839	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,675,343	31
32	Health Care	3,602,597	32
33	General Administration	2,767,863	33
	B. Capital Expense		
34	Ownership	272,108	34
	C. Ancillary Expense		
35	Special Cost Centers	543,298	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)*	\$ 8,861,209	40
41	Income before Income Taxes (line 30 minus line 40)**	(31,370)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (31,370)	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# 0010223Report Period Beginning: 7/1/2019Ending: 6/30/2020

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	1,888	2,009	\$ 70,944	\$ 35.31	1
2	Assistant Director of Nursing	1,888	2,009	61,297	30.51	2
3	Registered Nurses	21,650	23,032	665,662	28.90	3
4	Licensed Practical Nurses	16,886	17,963	410,800	22.87	4
5	CNAs & Orderlies	71,226	75,773	1,061,457	14.01	5
6	CNA Trainees	91	97	1,468	15.13	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,863	1,983	34,933	17.62	8
9	Activity Director					9
10	Activity Assistants	8,997	9,571	117,005	12.22	10
11	Social Service Workers	5,243	5,578	88,116	15.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,460	28,149	361,568	12.84	15
16	Dishwashers					16
17	Maintenance Workers	13,457	14,316	210,345	14.69	17
18	Housekeepers	15,061	16,023	183,926	11.48	18
19	Laundry	5,780	6,148	63,077	10.26	19
20	Administrator	1,955	2,080	115,203	55.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,777	17,848	392,442	21.99	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)	209,222	222,579	\$ 3,838,243 *	\$ 17.24	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 11,110		35
36	Medical Director		12,000		36
37	Medical Records Consultant		770		37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,113		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		5,007		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		527,551		52
53	TOTAL (lines 50 - 52)		\$ 527,551		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. NA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx 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. \$ 315,719
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,628
- (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? NA
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Pehlman & Dold, 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. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees.

OddFellow Rebekah Home
2020 Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	315,286
Purchased Hospital Services		1,144
Purchased Laboratory Services		11,433
Purchased Radiology Services		4,741
Amount Reclassified to Line 39	\$	<u><u>332,604</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	(88,938)
Provider Assesment Fee - \$6.07		<u>(226,781)</u>
		<u><u>(315,719)</u></u>
Provider Participation Fee		<u><u>315,719</u></u>