

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: Coles

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 C 3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Daniel Curry Telephone Number: 309-823-7164

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2024 to 06/30/2025 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) Daniel Curry

(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
2200 Churchill Rd.
Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	162	Skilled (SNF)	162	59,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	10,426	7,421	6,067	147	13,444	4,468	1,656	43,629	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	10,426	7,421	6,067	147	13,444	4,468	1,656	43,629	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.78%

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 certified beds. number of certified beds 162

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL ☒ 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: 07/01/2024 Ending: 06/30/2025

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	481,268	46,501	14,799	542,568		542,568		542,568			1
2	Food Purchase		435,426		435,426		435,426		435,426			2
3	Housekeeping	227,543	48,336		275,879		275,879		275,879			3
4	Laundry	100,400	13,174		113,574		113,574		113,574			4
5	Heat and Other Utilities			271,812	271,812		271,812		271,812			5
6	Maintenance	235,416	96,063	65,563	397,042		397,042		397,042			6
7	Other (specify):*											7
8	TOTAL General Services	1,044,627	639,500	352,174	2,036,301		2,036,301		2,036,301			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,566,151	256,423	1,576,896	5,399,470	283,613	5,683,083		5,683,083			10
10a	Therapy		422,137	19,103	441,240	(431,071)	10,169		10,169			10a
11	Activities	157,493	10,692		168,185		168,185		168,185			11
12	Social Services	71,171		6,101	77,272		77,272		77,272			12
13	CNA Training	3,146	10,750		13,896		13,896		13,896			13
14	Program Transportation											14
15	Other (specify):* Employee Scholarship	7,311		5,525	12,836		12,836		12,836			15
16	TOTAL Health Care and Programs	3,805,272	700,002	1,619,625	6,124,899	(147,458)	5,977,441		5,977,441			16
	C. General Administration											
17	Administrative	132,748		49,346	182,094	(49,346)	132,748		132,748			17
18	Directors Fees											18
19	Professional Services			664,590	664,590	38,638	703,228	(23,372)	679,856			19
20	Dues, Fees, Subscriptions & Promotions			840,828	840,828	(738,976)	101,852	(52,263)	49,589			20
21	Clerical & General Office Expenses	559,510	47,891	174,346	781,747	(283,074)	498,673		498,673			21
22	Employee Benefits & Payroll Taxes			1,558,413	1,558,413		1,558,413		1,558,413			22
23	Inservice Training & Education			6,110	6,110		6,110		6,110			23
24	Travel and Seminar			14,947	14,947		14,947	(9,948)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			332,790	332,790		332,790		332,790			26
27	Other (specify):* Lost Resident Items			306,818	306,818		306,818	(306,738)	80			27
28	TOTAL General Administration	692,258	47,891	3,948,188	4,688,337	(1,032,758)	3,655,579	(392,321)	3,263,258			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,542,157	1,387,393	5,919,987	12,849,537	(1,180,216)	11,669,321	(392,321)	11,277,000			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			233,017	233,017		233,017		233,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			4,296	4,296		4,296	(4,296)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			55,972	55,972		55,972	(20,884)	35,088			35
36	Other (specify):*											36
37	TOTAL Ownership			293,285	293,285		293,285	(25,180)	268,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			591,915	591,915	441,240	1,033,155		1,033,155			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					738,976	738,976		738,976			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			591,915	591,915	1,180,216	1,772,131		1,772,131			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,542,157	1,387,393	6,805,187	13,734,737		13,734,737	(417,501)	13,317,236			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	(20,884)			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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(9,863)			17
18	Fines and Penalties	(225,498)			18
19	Entertainment	(9,948)			19
20	Contributions	(40)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,372)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,200)			24
25	Fund Raising, Advertising and Promotional	(42,400)			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 Real estate taxes paid on non resident prop	(4,296)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (417,501)		\$	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))	\$ (417,501)		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	xx		14,780	10a	43
44	Hospital Services	xx		651,408	10a	44
45	Other-Attach Schedule	xx		5,296	10a	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 671,484		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (9,477)	20
2	Other Expenses Related to Lobbying Activities		
3			
4			
5			
6			
7			
8			
9			
10			
11	(81,200)	27	
12	(4,296)	33	
13	(225,498)	27	
14	(32,923)	20	
15	(9,863)	20	
16	(20,884)	35	
17	(9,948)	24	
18	(23,372)	19	
19	(40)	27	
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(417,501)	

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[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
Board of Directors List Attached						
(Not for profit Board-No individual						
ownership)						

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

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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 (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								\$		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 6/30/2025

Fax Number

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

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	No Debt						\$					\$	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.)

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.

2024 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 2024 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 2024.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to providecopies 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? [xx] (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? [xx] (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. List the bed capacity for the building if it differs from the licensed total. Same
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES [xx] 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:

07/01/2024

Ending:

06/30/2025

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			1996	40	1,867,245	46,681	40	46,681			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											35
36	Book Depreciation					59,688		59,688			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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	2005 Improvements	2005	\$ 22,486	\$		\$	\$	\$	37
38	2006 Improvements	2006	72,855						38
39	2007 Improvements	2007	32,123						39
40	2008 Improvements	2008	44,453						40
41	2009 Improvements	2009	110,701						41
42	2010 Improvements	2010	146,929						42
43	2011 Improvements	2011	35,298						43
44	2012 Improvements	2012	30,362						44
45	2013 Improvements	2013	24,374						45
46	2014 Improvements	2014	291,303						46
47	2015 Improvements	2015	103,885						47
48	2016 Improvements	2016	90,520						48
49	2017 Improvements	2017	164,776						49
50									50
51	Install Carrier Rooftop HVAC unit	2018	7,757	517	15	517			51
52	Replace Control Panel	2018	11,075	738	15	738			52
53	Roof Replacement - Partial	2018	18,105	1,207	15	1,207			53
54	Install Compressor - Harmony wing	2018	9,872	658	15	658			54
55	Replacement of main service line	2018	92,906	6,194	15	6,194			55
56	Replace sidewalk	2019	5,175	345	15	345			56
57	Install rooftop AC unit	2019	7,426	495	15	495			57
58	Replace automatic entry door	2019	17,850	1,190	15	1,190			58
59	Update dry system component of fire sprinkler	2019	4,447	296	15	296			59
60	Replace sprinkler system piping - Harmony Wing (Phase I)	2019	121,154	8,077	15	8,077			60
61	Install new smoke detectors	2019	3,785	252	15	252			61
62	Main service replacement - electrical	2019	6,942	463	15	463			62
63									63
64	Replace sprinkler system piping - Phase II	2020	110,100	7,340	15	7,340			64
65	Repair water main - driveway	2020	6,253	417	15	417			65
66	Repair sewer - Harmony Unit - South Wing	2020	21,463	1,431	15	1,431			66
67	Replace fire and smoke acutaors	2020	3,434	229	15	229			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,098,685	\$ 136,218		\$ 136,218	\$	\$	70

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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		\$ 8,098,685	\$ 136,218		\$ 136,218	\$	\$	1
2	Corridor remodeling project - main building:	2020	483,042	32,203	15	32,203			2
3	Demolished and replaced all corridor ceiling tile, drywall								3
4	and flooring. Demolished and replaced public bathroom								4
5	walls and flooring. Installed new paneling, rails and trim.								5
6									6
7	Electrical panel replacement	2020	2,998	200	15	200			7
8									8
9	5 ton Roof top unit (RTU) heating/coolong unit replaced -	2021	8,120	541	15	541			9
10	Replace (2) resident room PTAC units	2021	7,084	472	15	472			10
11									11
12	Install roof top AC unit	2022	9,995	666	15	666			12
13	Install new entrance doors to the Harmony (dementia0 unit	2022	24,331	1,622	15	1,622			13
14	(Horton Proslide doors)								14
15	Construction of gazebo on building grounds - costs include	2022	10,966	731	15	731			15
16	concrete foundation, lumber, shingles, paint and labor								16
17									17
18	Replaced fire sprinkler system air compressor	2023	4,324	288	15	288			18
19	Reconstruct water main thru pipe replacement	2023	7,570	505	15	505			19
20	Replaced fire sprinkler system piping - attic	2023	2,880	192	15	192			20
21									21
22	Furnish and install new water boiler	2024	13,910	927	15	927			22
23	Install new isolation valves and repair water leak on main	2024	10,360	691	15	691			23
24	corridor water line								24
25	Purchase and install limed oak flooring - resident rooms	2024	5,670	378	15	378			25
26	Furnish and install new split central air condenser and coil-	2024	33,685	2,246	15	2,246			26
27	South East Harmony Wing (15 ton unit)								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,723,620	\$ 177,880		\$ 177,880	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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		\$ 8,723,620	\$ 177,880		\$ 177,880	\$	\$	1
2									2
3	Replace (4) PTAC units - resident rooms	2025	2,832	189	15	189			3
4	Remove and replace metal roof section	2025	19,280	964	15	964			4
5	Remove and replace shingle roof - ABC section	2025	10,988	610	15	610			5
6	Apply sealant to main parking lot	2025	20,941	1,280	15	1,280			6
7	Replace water heater	2025	11,000	611	15	611			7
8	Replace RTU in the west nurse station	2025	10,089	561	15	561			8
9	Replace fire sprinkler piping in leaking walls and ceilings	2025	35,547	1,382	15	1,382			9
10	Replaced water heater - kitchen and laundry area	2025	34,150	1,328	15	1,328			10
11	Replaced curtains and cubicle curtain tracks in 59 rooms	2025	28,249	785	15	785			11
12	Replaced 500,000 btu fast recovery water heater and expansion tank	2025	38,625	1,073	15	1,073			12
13	Replaced chimney flashing - Harmony unit NW corner	2025	2,986	83	15	83			13
14	Replaced leaking roof top RTU with new unit	2025	15,023	167	15	167			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)		\$ 8,953,330	\$ 186,913		\$ 186,913	\$	\$	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	\$ 2,377,915	\$ 38,476	\$ 38,476	\$		\$	71
72	Current Year Purchases	52,081						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,429,996	\$ 38,476	\$ 38,476	\$		\$	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	2022 Chrysler Voyager	2023	\$ 53,398	\$ 7,628	\$ 7,628	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 53,398	\$ 7,628	\$ 7,628	\$		\$	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)	\$ 11,874,224	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,017	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 233,017	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	Initial repair costs - vehicle	\$ 21,536	92
93	crash into building. Destroyed		93
94	(2) resident rooms		94
95		\$ 21,536	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: \$ 55,972 Description: Oxygen concentrators, copiers and printers
(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	None		\$	\$	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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		10,750		10,750
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,146		3,146
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,896	\$	\$ 13,896
10	SUM OF line 9, col. 1 and 2 (e)	\$ 13,896			

- (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.)

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	\$		\$ 233,768	\$		\$ 233,768	1
2	Licensed Speech and Language Development Therapist		hrs			91,355			91,355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			266,792	0		266,792	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				422,137		422,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					19,103			19,103	13
14	TOTAL			\$		\$ 611,018	\$ 422,137		\$ 1,033,155	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	\$ 1,308,881	\$	1
2	Cash-Patient Deposits	49,166		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,169,706		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,369		6
7	Other Prepaid Expenses	5,713		7
8	Accounts Receivable (owners or related parties)	3,084,272		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,689,107	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	437,500		13
14	Buildings, at Historical Cost	9,161,222		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,305,374		16
17	Accumulated Depreciation (book methods)	(9,652,314)		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):	21,536		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,273,318	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,962,425	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 804,943	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,166		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	360,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	67,800		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	61,802		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,343,895	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,343,895	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,618,530	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,962,425	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,667,900	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,667,900	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,049,370)	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)	\$ (1,049,370)	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)	\$ 6,618,530	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 12,835,251	1
2	Discounts and Allowances for all Levels	(2,607,256)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,227,995	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,572,850	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,572,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	131,668	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	20,884	16
17	Sale of Drugs	639,139	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,829	19
20	Radiology and X-Ray	301	20
21	Other Medical Services	38,802	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 846,623	23
	D. Non-Operating Revenue		
24	Contributions	26,938	24
25	Interest and Other Investment Income***	3,483	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,421	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment rental	7,478	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,478	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,685,367	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,036,301	31
32	Health Care	6,124,899	32
33	General Administration	4,688,337	33
	B. Capital Expense		
34	Ownership	293,285	34
	C. Ancillary Expense		
35	Special Cost Centers	591,915	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)*	\$ 13,734,737	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,049,370)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,049,370)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,302,836.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,655,182.62	45
46	MMAI-Medicaid is the Primary Payer	1,353,146.38	46
47	MMAI-Medicare is the Primary Payer	29,038.00	47
48	Private Pay	3,477,835.87	48
49	Medicare Part A	1,011,615.00	49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify) Medicare Cost Report Settlement	39,384.00	52
53	Other-(specify) Medicare Bad Debts	-69,571.00	53
54	Other-(specify) Private insurance	428,528.13	54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,227,995	56

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	1,832	1,928	\$ 87,070	\$ 45.16	1
2	Assistant Director of Nursing	3,300	3,474	150,570	43.34	2
3	Registered Nurses	19,364	20,384	783,174	38.42	3
4	Licensed Practical Nurses	25,107	26,428	834,411	31.57	4
5	CNAs & Orderlies	68,231	71,822	1,686,200	23.48	5
6	CNA Trainees	214	214	3,146	14.70	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,037	1,092	24,726	22.64	8
9	Activity Director					9
10	Activity Assistants	8,716	9,175	157,493	17.17	10
11	Social Service Workers	3,063	3,224	71,171	22.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,573	25,866	481,268	18.61	15
16	Dishwashers					16
17	Maintenance Workers	11,643	12,256	235,416	19.21	17
18	Housekeepers	13,247	13,945	227,543	16.32	18
19	Laundry	6,036	6,354	100,400	15.80	19
20	Administrator	1,976	2,080	132,748	63.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,173	22,287	559,510	25.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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) Scholarships	247	247	7,311	29.60	33
34	TOTAL (lines 1 - 33)	209,759	220,776	\$ 5,542,157 *	\$ 25.10	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		\$ 14,799	Ln 1 Col 3	35
36	Medical Director		12,000	Ln 9 Col 3	36
37	Medical Records Consultant		2,338	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,169	Ln 10a Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		6,101	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,407		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	732	\$ 50,505	Ln10 Col 3	50
51	Licensed Practical Nurses	6,499	331,462	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	38,128	1,181,975	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	45,359	\$ 1,563,942		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	9,477
	9,477 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	9,477
	9,477 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	18,954
	18,954 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	5,000	Line	10
----	-------	------	----
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	738,976
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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? 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.

No
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	None	Has any meal income been offset against related costs?	Indicate the amount.	\$	3,926
----	------	--	----------------------	----	-------
- (12)

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

\$	
----	--

No
- (13)

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

Yes

Firm Name:
- (14)

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

Yes
- (15)

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.

[illegible]

Odd Fellow Rebekah Home
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	422,137
Purchased Hospital Services		989
Purchased Laboratory Services		12,608
Purchased Radiology Services		5,506
Amount Reclassified to Line 39	\$	<u>441,240</u>

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

<u>Line Item</u>		
Provider Participation Fee		<u>738,976</u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>		
Pharmacy Consultant	\$	<u>10,169</u>

4. Schedule V - Lines 21 & 17 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>		
MDS Coordinators/Care Planners - Line 21, Col 1	\$	(241,649)
Medical Records Specialists - Line 21, Col 1		(41,425)
Minimum Data Set Consultants - Line 17, Col 3		<u>(10,708)</u>
	\$	<u>(293,782)</u>
Nursing & Medical Records Line 10	\$	<u>293,782</u>

5. Schedule V - Line 17 to Line 19 - Reclass Administrative to Professional Services

<u>Line Item</u>		
Hospital Liasion Services - Line 17, Col 3	\$	<u>(38,638)</u>
Professional Services - Line 19, Col 3	\$	<u>38,638</u>