EXPEDITED PAYMENT PROGRAM
CASH POSITION STATEMENT

FACILITY NAME _____

CITY_____

Statement Date: _____/_____/____ (Must be at the end of a month)

Information provided must be less than sixty days old.

A. CURRENT ASSETS

	CURRENT ASSETS	On Statement Date	Last Year End
1.	Cash on Hand and in Banks	$	$
2.	Cash-Patient Deposits		
3.	Accounts & Short Term Notes Receivable-Patients		
4.	Allowance for Bad Debts	( )	( )
5.	Supply Inventory		
6.	Short-Term Investments		
7.	Prepaid Insurance		
8.	Other Prepaid Expenses		
9.	Accounts Receivable (owners or related parties)		
10.	Other (Specify)		
11.	TOTAL Current Assets (sum of lines 1 thru 10)	$	$

B. CURRENT LIABILITIES

	CURRENT LIABILITIES	On Statement Date	Last Year End
12.	Accounts Payable	$	$
13.	Officer=s Accounts Payable		
14.	Accounts Payable-Patient Deposits		
15.	Short-Term Notes Payable		
16.	Accrued Salaries Payable		
17.	Accrued Taxes Payable (excluding real estate taxes)		
18.	Accrued Real Estate Taxes		
19.	Accrued Interest Payable		
20.	Deferred Compensation		
21.	Federal and State Income Taxes (Other Current Liabilities (specify)		
22.	Other (Specify)		
23.	Other (Specify)		
24.	TOTAL Current Liabilities (sum of lines 12 thru 23)		

Current Ratios _____|_____|_____

*Current liabilities should not include amounts payable to owners or related parties.

B. OTHER INVESTMENTS AS OF STATEMENT DATE

1. Long-Term Investments $_____
2. Funded Depreciation Account $_____
3. Long-Term Care Notes Receivable $_____
4. Unrestricted Long Term Investments $_____
   (Total of lines 1, 2 and 3)
5. Restricted Funds (Restricted by donors or other entities outside the control of the facility owners or directors) $_____

C. DENIALS OF APPLICATIONS TO BORROW WORKING CAPITAL FUNDS

Have you applied for a loan of working capital funds from a financial institution during the past ninety (90) days? _____

If so, were you denied a loan? _____

D. DIVIDENDS

Total of dividends paid to owners during the last 24 months. $_____

E. OWNER AND RELATED PARTY TRANSACTIONS

1. Total salaries and fees paid to owners and related parties during the last ninety (90) days. $_____

2. Total fees paid to members of the board of directors during the last ninety (90) days. (DO NOT DUPLICATE AMOUNTS REPORTED ON LINE 1 ABOVE) $_____

3. Were any supplies, services or rentals purchased from owners or related parties during the last ninety (90) days at a cost higher than the cost incurred by the owner or related party? _____

   IF YES, ATTACH A SCHEDULE TO PROVIDE DETAILS.

   Total amount paid in excess of cost. $_____

4. Amount payable to owners and related parties $_____
(DO NOT INCLUDE THIS AMOUNT WITH CURRENT LIABILITIES ON PAGE 1)

F. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the cash position statement dated _____ and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements.

(Signed) _____

(Type or Print Name) _____

(Title) _____

Date Signed _____

Contact Person _____

Phone # _____ Fax #_____

Email address _____

NOTE: Fax completed statement with current roster to the Bureau of Long Term Care at 217-557-5061.

Please contact the Bureau of Health Finance at 217-524-4489 for any questions about completion of this form.