

Facility Name & ID Number Odd Fellow-Rebekah Home

0010223 Report Period Beginning: 07/01/12 Ending: 06/30/13

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	29,263	9,695	5,609	44,567	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,263	9,695	5,609	44,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? 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 _____ and days of care provided 5,609

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL 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:

07/01/12

Ending:

06/30/13

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	341,045	34,884		375,929		375,929	375,929			1
2	Food Purchase		352,185		352,185		352,185	352,185			2
3	Housekeeping	175,719	26,025		201,744		201,744	201,744			3
4	Laundry	66,213	14,089		80,302		80,302	80,302			4
5	Heat and Other Utilities			205,941	205,941		205,941	205,941			5
6	Maintenance	174,214	90,012	77,456	341,682		341,682	341,682			6
7	Other (specify):*										7
8	TOTAL General Services	757,191	517,195	283,397	1,557,783		1,557,783	1,557,783			8
	B. Health Care and Programs										
9	Medical Director			7,992	7,992		7,992	7,992			9
10	Nursing and Medical Records	2,296,516	170,973	9,287	2,476,776		2,476,776	2,476,776			10
10a	Therapy		283,782	805,712	1,089,494	(337,704)	751,790	751,790			10a
11	Activities	123,130	8,260		131,390		131,390	131,390			11
12	Social Services	85,245		5,421	90,666		90,666	90,666			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,504,891	463,015	828,412	3,796,318	(337,704)	3,458,614	3,458,614			16
	C. General Administration										
17	Administrative	89,246			89,246		89,246	89,246			17
18	Directors Fees										18
19	Professional Services			358,178	358,178		358,178	(6,630)	351,548		19
20	Dues, Fees, Subscriptions & Promotions			152,958	152,958	(88,695)	64,263	(44,212)	20,051		20
21	Clerical & General Office Expenses	299,492	20,854	32,010	352,356		352,356	352,356			21
22	Employee Benefits & Payroll Taxes			798,186	798,186		798,186	798,186			22
23	Inservice Training & Education			6,924	6,924		6,924	6,924			23
24	Travel and Seminar			15,854	15,854		15,854	(13,855)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			160,745	160,745		160,745	160,745			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)			27
28	TOTAL General Administration	388,738	20,854	1,542,855	1,952,447	(88,695)	1,863,752	(82,697)	1,781,055		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,650,820	1,001,064	2,654,664	7,306,548	(426,399)	6,880,149	(82,697)	6,797,452		29

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

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

Facility Name & ID Number

Odd Fellow-Rebekah Home

#0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			249,604	249,604		249,604		249,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,026	3,026		3,026	(10,538)	(7,512)			32
33	Real Estate Taxes			956	956		956	(956)				33
34	Rent-Facility & Grounds							(24,378)	(24,378)			34
35	Rent-Equipment & Vehicles			26,366	26,366		26,366		26,366			35
36	Other (specify):*											36
37	TOTAL Ownership			279,952	279,952		279,952	(35,872)	244,080			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					337,704	337,704		337,704			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,695	88,695		88,695			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					426,399	426,399		426,399			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,650,820	1,001,064	2,934,616	7,586,500		7,586,500	(118,569)	7,467,931			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(24,378)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,538)			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	(956)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(13,855)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,630)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(44,212)			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)	\$ (118,569)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (118,569)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Odd Fellow-Rebekah Home

Report Period Beginning: 07/01/12
 Ending: 06/30/13

ID# 0010223

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(6,630)	19	22
23				23
24		(18,000)	27	24
25		(44,212)	20	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		(68,842)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow-Rebekah Home# 0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,630)	0	0	0	0	0	0	0	0	0	0	(6,630)	19
20	Fees, Subscriptions & Promotions	(44,212)	0	0	0	0	0	0	0	0	0	0	(44,212)	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	(13,855)	0	0	0	0	0	0	0	0	0	0	(13,855)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(82,697)	0	0	0	0	0	0	0	0	0	0	(82,697)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,697)	0	0	0	0	0	0	0	0	0	0	(82,697)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow-Rebekah Home# 0010223

Report Period Beginning:

07/01/12 Ending:06/30/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	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	(10,538)	0	0	0	0	0	0	0	0	0	0	(10,538)	32
33	Real Estate Taxes	(956)	0	0	0	0	0	0	0	0	0	0	(956)	33
34	Rent-Facility & Grounds	(24,378)	0	0	0	0	0	0	0	0	0	0	(24,378)	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	(35,872)	0	0	0	0	0	0	0	0	0	0	(35,872)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(118,569)	0	0	0	0	0	0	0	0	0	0	(118,569)	45

Facility Name & ID Number

Odd Fellow-Rebekah Home

0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13

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
Eugene Etherton	BOD					
Richard Jones	BOD					
Richard Herring	BOD					
Hugo Block	BOD					
Annette Mecalo	BOD					
Valerie Dotson	BOD					
Jean Taylor	BOD					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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)

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

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

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

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

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

Facility Name & ID Number Odd Fellow-Rebekah Home

0010223

Report Period Beginning:

07/01/12

Ending: 06/30/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Odd Fellow-Rebekah Home

0010223

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bond-City of Mattoon		x	Construction of addition	\$20,000.00	09/02/94	\$	\$ 133,750			\$ 3,026	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$20,000.00		\$	\$ 133,750			\$ 3,026	9					
B. Non-Facility Related*																	
10	Interest Income										(10,538)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			(10,538)	14					
15	TOTALS (line 9+line14)						\$	\$ 133,750			(7,512)	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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 2013 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:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow-Rebekah Home COUNTY _____

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 2012 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 2012.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		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 a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Odd Fellow-Rebekah Home

0010223 Report Period Beginning:

07/01/12 Ending:

06/30/13

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				\$ <u>437,500</u>	1
2					2
3	TOTALS			\$ <u>437,500</u>	3

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									27
28									28
29									29
30									30
31									31
32									32
33									33
34					185,850		185,850		34
35									35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Odd Fellow-Rebekah Home

0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13

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	Roof	1997	\$ 349,692	\$		\$	\$	\$	37
38	Architect Fees	1997	3,203						38
39	Wallpaper	1997	2,692						39
40	Water Hydrant	1997	5,430						40
41	Sinks, Cabinets	1997	496						41
42	Baseboards	1997	350						42
43	Woodframe Shed	1997	7,704						43
44									44
45	Water Heater	1998	14,664						45
46	Painting & Wallcovering	1998	4,567						46
47	Double drive gate & locks	1998	982						47
48									48
49	Carpet cleaning	1999	919						49
50	Exterior doors	1999	1,481						50
51	Water Heater	1999	7,660						51
52	Room renovations (wall coverings, tile, electrical)	1999	5,494						52
53	Decorating	1999	1,052						53
54	Window parts	1999	541						54
55									55
56	Baseboards, wallpaper	2000	1,120						56
57	Power panels	2000	2,722						57
58	Electrical outlets	2000	561						58
59									59
60									60
61	Booster Installation	2000	2,032						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,228,866	\$ 185,850		\$ 185,850	\$	\$	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:

07/01/12

Ending:

06/30/13

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		\$ 6,228,866	\$ 185,850		\$ 185,850	\$	\$	1
2									2
3	Heat Exchanger	2002	4,724						3
4	LAN	2002	3,142						4
5	Water Heater	2002	7,397						5
6	Interior Renovations -- Entry Way	2002	7,493						6
7									7
8	Boiler	2003	1,941						8
9	Compressor	2003	6,361						9
10	Temperature control	2003	1,941						10
11	A/C Unit	2003	1,000						11
12	Smoke Detectors	2003	1,882						12
13	Lobby renovations: Wall paper, paint, floor coverings	2003	41,598						13
14	Kitchen Hood	2003	1,840						14
15	Firewall / Roof safty improvments	2003	32,502						15
16	Water Heater	2003	7,300						16
17									17
18	Lobby renovations: Wall paper, paint, floor coverings	2004	4,694						18
19	Water Heater	2004	2,516						19
20	Alzheimer Unit renovations: Wall paper, paint, floor coverings	2004	47,811						20
21	Alarm System	2004	2,863						21
22	Nurse Station	2004	29,661						22
23	Wallcoverings	2004	19,247						23
24	Wall Guards	2004	9,409						24
25	Corrodor Renovations	2004	15,153						25
26	Emergency Systems	2004	1,535						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,480,876	\$ 185,850		\$ 185,850	\$	\$	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:

07/01/12

Ending:

06/30/13

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		\$ 6,480,876	\$ 185,850		\$ 185,850	\$	\$	1
2									2
3	Wire Access Doors	2005	3,568						3
4	Resident Room Remodel-- paint	2005	9,616						4
5	Compressor	2005	868						5
6	Grease Trap	2005	9,545						6
7	Garbage Disposal	2005	1,049						7
8	Fire Protection System	2005	3,332						8
9	2 Heat/ Cool Unit	2005	1,943						9
10	Heat Exchanger	2005	924						10
11	Security System	2005	1,095						11
12	Dinning room Remodel--Paint/Wallpaper/carpet	2005	7,114						12
13	Insurance Proceeds--roof repair	2005	(16,568)						13
14									14
15	Dinning room Remodel--Paint/Wallpaper/carpet	2006	20,984						15
16	Roof/Fence Replacement	2006	21,748						16
17	Sidewalk	2006	1,637						17
18	Remodel Therapeutic Rehab Unit	2006	28,486						18
19									19
20	Remodel Therapeutic Rehab Unit (paint, carpet, fixtures)	2007	4,343						20
21	Roof top compressor	2007	1,362						21
22	Wiring for IT	2007	4,200						22
23	Heat Exchanger	2007	988						23
24	West Wing Remodel--Paint/Wallpaper/carpet	2007	5,534						24
25	Water Heater	2007	12,335						25
26	Roof repair	2007	1,157						26
27	Compressor	2007	1,237						27
28	HVAC unit	2007	967						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,608,340	\$ 185,850		\$ 185,850	\$	\$	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:

07/01/12

Ending:

06/30/13

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 12C, Carried Forward		\$ 6,608,340	\$ 185,850		\$ 185,850	\$	\$	1
2									2
3	Compressor	2008	1,446						3
4	Bather	2008	1,673						4
5	Heat Exchanger	2008	5,760						5
6	Light Fixture	2008	812						6
7	Doors	2008	6,986						7
8	Boiler	2008	1,114						8
9	Wander Guard	2008	2,968						9
10	Floor Tile	2008	2,283						10
11	PTAC Unit	2008	971						11
12	Roof -- Harmony Corridor	2008	7,630						12
13	Vent Sleeves	2008	1,275						13
14	Blinds	2008	1,143						14
15	Fire System	2008	3,424						15
16	Compressor	2008	1,295						16
17	Ridge Vent	2008	4,330						17
18	Employee Entrance Door	2008	1,343						18
19									19
20	Hallway Floor Replacement	2009	104,987						20
21	Heat Exchanger	2009	5,714						21
22									22
23	New Roof	2010	125,051						23
24	Water Meter valve	2010	3,113						24
25	Awning Front Entrance	2010	3,630						25
26	Water Heater	2010	11,977						26
27	Paint, Floor Tiles (Rehab to Home Rooms)	2010	3,158						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,910,423	\$ 185,850		\$ 185,850	\$	\$	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:

07/01/12

Ending:

06/30/13

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 12D, Carried Forward		\$ 6,910,423	\$ 185,850		\$ 185,850	\$	\$	1
2									2
3	Compressor	2011	7,961						3
4	Dryer Enclosure	2011	11,862						4
5	Water Heater	2011	12,800						5
6	Concrete Patio Floor	2011	2,675						6
7									7
8	Pavillion Roof	2012	3,975						8
9	Compressor	2012	2,986						9
10	Parking Lot Patch & Seal	2012	6,923						10
11	Rooftop A/C	2012	6,305						11
12	Water Heater	2012	10,173						12
13									13
14	Therapy Room Remodel-Cabinets	2013	1,431						14
15	Therapy Room Remodel-Countertops	2013	1,062						15
16	Therapy Room Remodel-Electrical	2013	1,667						16
17	Therapy Room Remodel-Materials	2013	982						17
18	Lobby A/C	2013	3,511						18
19	Lighting Retrofit	2013	5,781						19
20	Furnaces	2013	6,998						20
21	Yale doors (8)	2013	2,942						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)		\$ 7,000,457	\$ 185,850		\$ 185,850	\$	\$	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:

07/01/12

Ending:

06/30/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,771,333	\$ 63,754	\$ 63,754	\$		\$	71
72	Current Year Purchases	77,213						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,848,546	\$ 63,754	\$ 63,754	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,286,503	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 249,604	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,604	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Odd Fellow-Rebekah Home

0010223

Report Period Beginning: 07/01/12

Ending: 06/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 26,366 Description: Televisions and copiers

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/12 Ending: 06/30/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 259,101	\$		\$ 259,101	1
2	Licensed Speech and Language Development Therapist		hrs				148,490			148,490	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				343,742	457		344,199	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					283,325		283,325	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						54,379			54,379	13
14	TOTAL			\$			\$ 805,712	\$ 283,782		\$ 1,089,494	14

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

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

Ending:

06/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/13

(last day of reporting year)

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	\$ 1,469,477	\$	1
2	Cash-Patient Deposits	13,556		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,019,512		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,551		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,118,293		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,704,389	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,641,259		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,718,564		16
17	Accumulated Depreciation (book methods)	(6,761,550)		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)	\$ 2,598,273	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,302,662	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 276,645	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,556		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	316,353		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,302		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	132,903		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 756,759	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	133,750		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 133,750	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 890,509	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,412,153	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,302,662	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,762,366	1
2	Restatements (describe):		2
3	Audit Reclassifications	372,477	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,134,843	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	277,310	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)	\$ 277,310	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)	\$ 7,412,153	24 *

* This must agree with page 17, line 47.

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	\$ 7,366,195	1
2	Discounts and Allowances for all Levels	(2,611,159)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,755,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,577,357	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,577,357	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	24,378	16
17	Sale of Drugs	465,151	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26,684	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 516,213	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,204	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,204	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)	\$ 7,863,810	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,557,783	31
32	Health Care	3,796,318	32
33	General Administration	1,952,447	33
B. Capital Expense			
34	Ownership	279,952	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,586,500	40
41	Income before Income Taxes (line 30 minus line 40)**	277,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 277,310	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? yes 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

0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13

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	1,854	1,912	\$ 62,569	\$ 32.72	1
2	Assistant Director of Nursing	1,916	1,960	54,221	27.66	2
3	Registered Nurses	13,531	13,860	358,914	25.90	3
4	Licensed Practical Nurses	27,004	27,897	598,851	21.47	4
5	CNAs & Orderlies	98,645	101,082	1,189,804	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,796	1,882	32,157	17.09	8
9	Activity Director					9
10	Activity Assistants	10,554	10,832	123,130	11.37	10
11	Social Service Workers	5,680	5,873	85,245	14.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,988	28,835	341,045	11.83	15
16	Dishwashers					16
17	Maintenance Workers	11,355	11,887	174,214	14.66	17
18	Housekeepers	15,468	15,918	175,719	11.04	18
19	Laundry	6,743	6,901	66,213	9.59	19
20	Administrator	1,900	2,080	89,246	42.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,573	16,266	299,492	18.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,007	247,185	\$ 3,650,820 *	\$ 14.77	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	\$ 0		35
36	Medical Director	7,992		36
37	Medical Records Consultant	1,960		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,290		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	5,421		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,663		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
David Standerfer			\$ 89,246	Workers' Compensation Insurance	\$ 93,587	IDPH License Fee	\$		
				Unemployment Compensation Insurance	41,096	Advertising: Employee Recruitment		1,931	
				FICA Taxes	279,288	Health Care Worker Background Check (Indicate # of checks performed _____)		3,132	
				Employee Health Insurance	347,019	Patient Background Checks			
				Employee Meals		PR		23,247	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions		10,182	
				Other Benefits	37,196	License & Fees		4,806	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,246			Less: Public Relations Expense		(23,247)	
B. Administrative - Other						Non-allowable advertising		(225)	
Description			Amount			Yellow page advertising	(
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 798,186		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,826
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Heritage Operations Group	Mgt		\$ 326,128				Out-of-State Travel	\$	
Pelman & Dold	Audit		19,420						
Somerset	403B Audit		6,000				In-State Travel		
								13,747	
								22	
							Seminar Expense	2,085	
								(13,855)	
							Entertainment Expense	(
Legal adj to Zero			6,630						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 358,178	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,999	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Odd Fellow-Rebekah Home# 0010223

Report Period Beginning:

07/01/12

Ending:

06/30/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 88,695
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 9,704
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	1,469,477				1,009	1,009 PETTY C 1,469,477
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,019,512
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	1,019,512				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 83,551
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	83,551				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 1,718,564
1409	LAND	0				1,460	(1,483,157)
1450	FURNITURE & EQUIPMENT	1,718,564				1,475	1,475 CODE AI 7,641,259
1460	ACCUM DEPR-FURN & EQU	-1,483,157				1,490	1,490 ACCUM] (5,278,393)
1475	BUILDING & IMPROVEMEN	7,641,259				1,530	1,530 RESIDEN 13,556
1490	ACCUM DEPR-BUILDING	-5,278,393				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	13,556				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC 3,118,293
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (276,645)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	3,118,293				2,100	2,100 ACCRUE (84,418)
2010	ACCOUNTS PAYABLE	-276,645				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-84,418				2,110	2,110 ACCRUE (231,935)
2110	ACCRUED VACATION PAY	-231,935				2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(17,302)	
2125	FICA TAX PAYABLE	-17,302	-17,302	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI		
2240	UNITED WAY			2,246	2,250 401K W/F		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE G.		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(132,903)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-132,903		2,400	2,400 CURRENT PORTION OF LT DE		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(13,556)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(133,750)	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DE		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINI	(7,134,843)	
2460	INCOME TAXES PAYABLE					net incom	(277,310)
2512	DUE TO RESIDENTS	-13,556					
2600	MORTGAGE PAYABLE	-133,750					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-7,134,843					
2970	PROFIT/LOSS FOR PERIOD	-277,310					
3007.1	PATIENT DAYS-PRIVATE	9,695					3,007

3007.2	PATIENT DAYS-IPA	29,263						3,007
3007.3	PATIENT DAYS-MEDICARE	5,609						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-7,261,180	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-82,994	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-465,151	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,577,357	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,611,159	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	-24,378		6	0	6	-24,378	3,530
3530	13 BEAUTY SHOP	0		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-22,021		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-25,529		0	0	0	0	4,110
3600	21 MISC INCOME	-1,155		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	280,937	299,492	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	89,246	89,246	17	1	0	0	4,120
4115	VACATION & SICK - G&A	18,555		21	1	0	0	4,121
4120 4475	EMPLOYEE BENEFITS	14,723	798,186	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	17,060		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	5,413		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	20,854	20,854	21	2	0	0	4,275
4260	TELEPHONE	32,010	32,010	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,924	6,924	23	3	16	0 **	4,280
4280	GENERAL TRAVEL	13,747	15,854	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	22		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	2,085		24	3	19	-13,855 ***	4,289
4290	HELP WANTED ADVERTISING	1,931	152,958	20	3	0	0 -88,695	4,290
4291	PROMOTIONAL ADVERTISING	20,965		20	3	25	-20,965	4,291
4292	PUBLIC RELATIONS	23,247		20	3	25	-23,247	4,292
4300	LICENSES & FEES	93,501		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	10,182		20	3	17	-225	4,310
4320	CONTRIBUTIONS	0		27	3	20	0	4,320
4350	PROFESSIONAL FEES	34,233	358,178	19	3	22	-6,630	4,350
4355	MEDICAL DIRECTOR	7,992	7,992	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSI	1,960		10	3	0	0	4,364
4363	PHARMACIST FEES	6,290		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	5,421	5,421	12	3	0	0	4,383
4370	TV RENTAL	9,943		35	3	5	0	4,390
4380	INCOME TAXES		18,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	3,132		20	3	26	0	4,401
4400	PAYROLL TAXES	311,120		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	9,264		22	3	0	0	4,420
4410	GROUP INSURANCE	347,019		22	3	0	0	4,430
4420	LIABILITY INSURANCE	160,745	160,745	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	93,587		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	323,945		19	3	34	0 **	4,460
4460	BAD DEBTS	18,000		27	3	24	-18,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	956	956	33	3	0	-956	4,486
4600	LEASED EQUIPMENT	16,423	26,366	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	160,124	174,214	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	14,090		6	1	0	0	4,510
5130	ELECTRIC	115,555	205,941	5	3	0	0	4,600
5131	NATURAL GAS	26,850		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	63,536		5	3	0	0	5,130
5134	TRASH COLLECTION	18,320	77,456	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	15,603	90,012	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	74,409		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	59,136		6	3	0	0	5,140
5210	DIETARY WAGES	317,155	341,045	1	1	0	0	5,160
5220	DIETARY SICK & VAC	23,890		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	361,889	352,185	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	8,775	34,884	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	8,308		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	17,801		1	2	0	0	5,260
5295	MEAL CREDIT	-9,704		2	2	0	0	5,270
5310	LAUNDRY WAGES	62,897	66,213	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,316		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,172	14,089	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	8,917		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	163,422	175,719	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	12,297		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	9,833	26,025	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	16,192		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,296,516	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	335,886		10	1	0	0	6,020
6030	DON WAGES	62,569		10	1	0	0	6,030
6035	ADON	54,221		10	1	0	0	6,035
6040	RN SICK & VACATION	23,028		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	567,661		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	31,190		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,136,275		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	53,529		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	28,665		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,492		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	143,986	170,973	10	2	0	0	7,281
6295	NURSING SUPPLIES	23,188		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	3,799		10	2	0	0	7,391
6490	NURSING OTHER	1,037	9,287	10	3	0	0	7,393
7280	DRUG PURCHASES	267,850	283,782	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	15,475		39	2			7,540
7380	LABORATORY SERVICES	54,379	805,712	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	117,222	123,130	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,908		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	8,260	8,260	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	343,742		39	3	0	0 ***	7,890
7660	PT SUPPLIES	457		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	80,202	85,245	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	5,043		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	259,101		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	148,490		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	3,026	3,026	32	3	14	-10,538	
8130	DEPRECIATION	249,604	249,604	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-10,538		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-4,666		0	0	0	0	
		7,571,296	7,586,500					
			15,204					

GRAND TOTALS -277,310 -118,794
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	9,695	9,695
IPA	29,263	29,263
medicare	5,609	5,609
		44,567

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	29,263
3,007 PATIENT	5,609
	0

3,010 BASIC CH	(7,261,180)
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3,020 BASIC CH	0
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3,030 BASIC CH	0
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	0
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	0
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	0
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3,080 NURSING	(82,994)
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3,081 NURSING	0
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3,082 NURSING	0
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3,083 NURSING	0
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3,100 DRUGS-M	(465,151)
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	0
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3,110 PHYSICAL	(2,577,357)
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	0
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3,112 PHYSICAL	0
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3,113 PHYSICAL	0
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3,140 LABORATORY INCOME	
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	0
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3,152 ST/OT TH	0
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3,153 ST/OT TH	0
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3,185 REHAB/ISOLATION/OTHER CHG	
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3,410 IPA/OTHE	0
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3,411 MEDICAR	0
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3,420 MEDICAR	2,557,211
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3,520 RENT INC	(24,378)
3,530 BEAUTY	0
	0
3,570 VENDING	0
3,590 EQUIPME	(22,021)
3,595 RESIDENT	(25,529)
3,600 MISC INC	(1,155)
4,110 G&A WAC	280,937
4,111 ADMINIS	89,246
4,115 G&A PTO	18,555
4,120 EMPLOYE	14,038
4,130 EMPLOYE	17,060
4,135 EMPLOYE	5,413
4,250 OFFICE S	16,901
4,255 POSTAGE	3,953
4,260 TELEPHO	32,010
4,275 TRAINING	6,924
	0
4,280 GENERAL	13,747
4,281 MEAL EX	22
4,285 EDUCATI	2,085
4,289 MEETING	0
4,290 HELP WA	1,931
4,291 PROMOTI	20,965
4,292 PUBLIC R	23,247
4,300 LICENSE	93,501
4,310 DUES & S	10,182
4,320 CONTRIB	0
4,350 PROFESSI	34,233
4,355 MEDICAL	7,992
	1,960
	6,290

4,364 SOCIAL S	5,421
4,370 TV RENTL	9,943
4,383 BACKGR	3,132
4,390 OTHER T	27
4,400 PAYROLL	311,120
4,401 PAYROLL	9,264
4,410 GROUP IN	347,019
4,420 LIABILIT	160,745
4,430 WORKMA	91,885
4,435 W/C-FIRS'	(145)
4,436 DRUG TE	1,847
4,450 MANAGE	323,945
4,460 BAD DEB'	18,000
4,461 BAD DEB'	53,948
4,470 LOST ITE	0
4,475 UNIFORM	685
4,486 SERVICE	48,703
4,490 MISC EXP	0
4,496 MISC. M.I	0
4,510 REAL EST	956
4,600 LEASED F	16,423
5,110 MAINTEN	160,124
5,120 MAINTEN	14,090
5,130 ELECTRIC	115,555
5,131 NATURAL	26,850
5,133 WATER &	63,536
5,134 TRASH CO	18,320
5,140 PROP/PLA	15,603
5,160 GENERAL	74,409
5,165 MAINTEN	10,433
5,210 DIETARY	317,155
5,220 DIETARY	23,890
5,248 FOOD PUI	361,889

5,250 SUPPLIES	8,775
5,260 REPLACE	8,308
5,270 KITCHEN	17,801
5,295 MEAL INC	(9,704)
5,310 LAUNDRY	62,897
5,340 LAUNDRY	3,316
5,370 REPLACE	5,172
	0
5,390 SUPPLIES	8,917
5,410 HOUSEKE	163,422
5,440 HOUSEKE	12,297
5,480 SUPPLIES	9,833
5,490 SUPPLIES	16,192
6,020 RN WAGE	335,886
6,030 DON WAG	62,569
6,035 ADON WA	54,221
6,040 RN PTO &	23,028
6,120 LPN WAG	567,661
6,140 LPN PTO	31,190
6,220 AIDES WA	1,136,275
6,240 AIDES PT	53,529
	0
	0
	0
6,270 REHAB W	28,665
6,275 REHAB P	3,492
6,290 NURSING	143,986
6,295 NURSING	23,188
6,390 REPLACE	3,799
6,490 OTHER	1,037

7,280 DRUG PU	267,850
7,281 DRUG PU	15,475
7,380 LABORAT	14,559
7,390 X-RAY SE	39,820
	0
7,510 ACTIVITI	117,222
7,540 ACTIVITI	5,908
7,590 ACTIVITI	8,260
7,620 PHYSICAL	343,742
7,660 P.T. SUPP	457
7,710 SOCIAL S	80,202
7,720 SOCIAL S	5,043
7,730 SOCIAL S	0
7,740 OCCUPAT	259,101
7,770 SPEECH T	148,490
7,820 BEAUTIC	0
	0
	0
8,120 INTEREST	3,026
	0
8,130 DEPRECL	249,604
	0
9,510 INTEREST	(10,538)
9,520 MISC NOI	(4,693)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(277,310)</u>

Expenses Fixed Assets

