

Facility Name & ID Number Odd Fellow Rebekah Home

0010223 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,282	13,479	4,598	42,359	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,282	13,479	4,598	42,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.64%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1977

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 162 and days of care provided 4,598

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: 7/1/2016 Ending: 6/30/2017

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	351,300	32,810		384,110		384,110		384,110		1
2	Food Purchase		362,654		362,654		362,654		362,654		2
3	Housekeeping	180,806	32,813		213,619		213,619		213,619		3
4	Laundry	64,162	15,042		79,204		79,204		79,204		4
5	Heat and Other Utilities			220,068	220,068		220,068		220,068		5
6	Maintenance	178,846	102,942	77,839	359,627		359,627	(24,361)	335,266		6
7	Other (specify):*										7
8	TOTAL General Services	775,114	546,261	297,907	1,619,282		1,619,282	(24,361)	1,594,921		8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	2,432,344	169,796	30,575	2,632,715		2,632,715		2,632,715		10
10a	Therapy		375,593	67,978	443,571	(443,496)	75		75		10a
11	Activities	127,145	9,695		136,840		136,840		136,840		11
12	Social Services	83,708		4,953	88,661		88,661		88,661		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,643,197	555,084	116,506	3,314,787	(443,496)	2,871,291		2,871,291		16
	C. General Administration										
17	Administrative	106,224			106,224		106,224		106,224		17
18	Directors Fees										18
19	Professional Services			448,138	448,138		448,138	(3,446)	444,692		19
20	Dues, Fees, Subscriptions & Promotions			387,580	387,580	(322,384)	65,196	(44,917)	20,279		20
21	Clerical & General Office Expenses	367,171	28,432	26,650	422,253		422,253		422,253		21
22	Employee Benefits & Payroll Taxes			1,111,249	1,111,249		1,111,249		1,111,249		22
23	Inservice Training & Education			6,442	6,442		6,442	(1,443)	4,999		23
24	Travel and Seminar			15,061	15,061		15,061	(10,062)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			160,486	160,486		160,486		160,486		26
27	Other (specify):*			18,000	18,000		18,000	(18,000)			27
28	TOTAL General Administration	473,395	28,432	2,173,606	2,675,433	(322,384)	2,353,049	(77,868)	2,275,181		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,891,706	1,129,777	2,588,019	7,609,502	(765,880)	6,843,622	(102,229)	6,741,393		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:

7/1/2016

Ending:

6/30/2017

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			274,940	274,940		274,940		274,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(865)	(865)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,240	31,240		31,240		31,240			35
36	Other (specify):*											36
37	TOTAL Ownership			306,180	306,180		306,180	(865)	305,315			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			735,799	735,799	443,496	1,179,295		1,179,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					322,384	322,384		322,384			42
43	Other (specify):*			1,991	1,991		1,991	(1,991)				43
44	TOTAL Special Cost Centers			737,790	737,790	765,880	1,503,670	(1,991)	1,501,679			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,891,706	1,129,777	3,631,989	8,653,472		8,653,472	(105,085)	8,548,387			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(24,361)			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	(865)			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	(1,443)			17
18	Fines and Penalties	(1,991)			18
19	Entertainment	(10,062)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,446)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(44,917)			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)	\$ (105,085)		\$	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))	\$ (105,085)		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

ID# 0010223

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19		(24,361)	6	19
20				20
21				21
22		(3,446)	19	22
23				23
24		(18,000)	27	24
25		(1,443)	23	25
26		(44,917)	20	26
27		0	29	27
28		(1,991)	43	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	(94,158)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(24,361)	0	0	0	0	0	0	0	0	0	0	(24,361)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(24,361)	0	(24,361)	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	(3,446)	0	0	0	0	0	0	0	0	0	0	(3,446)	19
20	Fees, Subscriptions & Promotions	(44,917)	0	0	0	0	0	0	0	0	0	0	(44,917)	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	(1,443)	0	0	0	0	0	0	0	0	0	0	(1,443)	23
24	Travel and Seminar	(10,062)	0	0	0	0	0	0	0	0	0	0	(10,062)	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	(77,868)	0	(77,868)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102,229)	0	(102,229)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	(865)	0	0	0	0	0	0	0	0	0	0	(865)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(865)	0	0	0	0	0	0	0	0	0	0	(865)	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):*	(1,991)	0	0	0	0	0	0	0	0	0	0	(1,991)	43
44	TOTAL Special Cost Centers	(1,991)	0	0	0	0	0	0	0	0	0	0	(1,991)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(105,085)	0	0	0	0	0	0	0	0	0	0	(105,085)	45

VII. RELATED PARTIES

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

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

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.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending: 5/30/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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		7	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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10	Interest Income											(865)						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$ (865)						
15	TOTALS (line 9+line14)						\$	\$				\$ (865)						

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 2016 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 2017 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:	2012	8	
	2013	9	
	2014	10	
	2015	11	
	2016	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016 \$	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.

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

7/1/2016

Ending:

6/30/2017

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

Facility Name & ID Number **Odd Fellow Rebekah Home**

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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					200,494		200,494		34
35									35
36									36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	\$ 200,494		\$ 200,494	\$	\$	70

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 200,494		\$ 200,494	\$	\$	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	\$ 200,494		\$ 200,494	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 200,494		\$ 200,494	\$	\$	1
2									2
3	Wire Access Doors	2005	3,568						3
4	Resident Room Remodel-- paint	2005	9,616						4
5	Compressor	2005	868						5
6	Grease Trap	2005	9,545						6
7	Garbage Disposal	2005	1,049						7
8	Fire Protection System	2005	3,332						8
9	2 Heat/ Cool Unit	2005	1,943						9
10	Heat Exchanger	2005	924						10
11	Security System	2005	1,095						11
12	Dinning room Remodel--Paint/Wallpaper/carpet	2005	7,114						12
13	Insurance Proceeds--roof repair	2005	(16,568)						13
14									14
15	Dinning room Remodel--Paint/Wallpaper/carpet	2006	20,984						15
16	Roof/Fence Replacement	2006	21,748						16
17	Sidewalk	2006	1,637						17
18	Remodel Therapeutic Rehab Unit	2006	28,486						18
19									19
20	Remodel Therapeutic Rehab Unit (paint, carpet, fixtures)	2007	4,343						20
21	Rooftop compressor	2007	1,362						21
22	Wiring for IT	2007	4,200						22
23	Heat Exchanger	2007	988						23
24	West Wing Remodel--Paint/Wallpaper/carpet	2007	5,534						24
25	Water Heater	2007	12,335						25
26	Roof repair	2007	1,157						26
27	Compressor	2007	1,237						27
28	HVAC unit	2007	967						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,608,340	\$ 200,494		\$ 200,494	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 200,494		\$ 200,494	\$	\$	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	\$ 200,494		\$ 200,494	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 200,494		\$ 200,494	\$	\$	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	Facility cabling for new Nurse Call System	2014	259,332						23
24	Rooftop HVAC Purchase and Installation-Main Living Area	2014	6,580						24
25	Bather acquisition and installation	2014	12,679						25
26	Air conditioner for computer room	2014	4,178						26
27	Rooftop HVAC Purchase and Installation-Kitchen	2014	8,534						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,291,760	\$ 200,494		\$ 200,494	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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 12E, Carried Forward		\$ 7,291,760	\$ 200,494		\$ 200,494	\$	\$	1
2									2
3	Carrier Rooftop Unit - Laundry	2015	6,690						3
4	Replaced Water Heater	2015	12,860						4
5	Replacement of Exterior Signage	2015	3,899						5
6	Security System Installation - Door Controls & Tag Readers	2015	6,878						6
7	Replaced Sidewalk Entrance to Front Door	2015	3,450						7
8	Installation of and Rewiring of Kitchen Receptacles	2015	3,141						8
9	Acquisition and Installation of Walk-In Freezer/Cooler	2015	48,547						9
10	Replace Compressor - Harmony Unit - Southeast Corner	2015	6,965						10
11	Dining Hall Air Conditioner Replacements with Coils	2015	11,455						11
12									12
13									13
14	Carrier Rooftop Unit - Northwest Hallway	2016	7,980						14
15	New Fence and Enclosure for Trash Bin Area	2016	4,200						15
16	(3) Progressive Flow Water Softeners	2016	23,289						16
17	Replace Sidewalk - Building Front	2016	3,075						17
18	Boiler Replacement - Harmony Area North	2016	19,706						18
19	Carrier Rooftop Unit - Main	2016	7,716						19
20	(2) 120 Gallon Hot Water Heaters	2016	24,554						20
21									21
22	(2) Generators	2017	112,159						22
23	Install Carrier roof top ac unit	2017	7,716						23
24	Parking lot overlay	2017	40,001						24
25	Replace valve- sprinkler system	2017	4,900						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,650,941	\$ 200,494		\$ 200,494	\$	\$	34

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

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 2,055,276	\$ 74,446	\$ 74,446	\$		\$	71
72	Current Year Purchases	14,570						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,069,846	\$ 74,446	\$ 74,446	\$		\$	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)	\$ 10,158,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 274,940	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 274,940	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: 7/1/2016

Ending: 6/30/2017

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 31,240 Description: Office equipment

(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.

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	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	\$		\$ 249,660	\$		\$ 249,660	1
2	Licensed Speech and Language Development Therapist		hrs			135,090			135,090	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			351,049	75		351,124	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				375,518		375,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					67,978			67,978	13
14	TOTAL			\$		\$ 803,777	\$ 375,593		\$ 1,179,370	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2017**

(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	\$ 1,169,832	\$	1
2	Cash-Patient Deposits	18,630		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,535,119		3
4	Supply Inventory (priced at <u>FIFO</u>)	37,689		4
5	Short-Term Investments			5
6	Prepaid Insurance	73,679		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,131,508		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,966,457	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,296,334		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,939,864		16
17	Accumulated Depreciation (book methods)	(7,832,336)		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)	\$ 2,403,862	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,370,319	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 463,934	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,630		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	375,696		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,553		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>	76,093		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 940,906	\$	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)	\$ 940,906	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,429,413	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,370,319	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,540,991	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,540,991	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,578)	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)	\$ (111,578)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,429,413	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,008,176	1
2	Discounts and Allowances for all Levels	(2,982,104)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,026,072	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,770,195	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,770,195	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	24,361	16
17	Sale of Drugs	683,289	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,112	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 734,762	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,865	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,865	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,541,894	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,619,282	31
32	Health Care	3,314,787	32
33	General Administration	2,675,433	33
B. Capital Expense			
34	Ownership	306,180	34
C. Ancillary Expense			
35	Special Cost Centers	737,790	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,653,472	40
41	Income before Income Taxes (line 30 minus line 40)**	(111,578)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (111,578)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	1,762	1,872	\$ 66,422	\$ 35.48	1
2	Assistant Director of Nursing	1,789	1,903	57,294	30.11	2
3	Registered Nurses	17,321	18,427	506,183	27.47	3
4	Licensed Practical Nurses	22,092	23,502	519,330	22.10	4
5	CNAs & Orderlies	90,029	95,776	1,252,037	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,780	1,894	31,078	16.41	8
9	Activity Director					9
10	Activity Assistants	9,782	10,406	127,145	12.22	10
11	Social Service Workers	5,381	5,724	83,708	14.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,748	27,392	351,300	12.82	15
16	Dishwashers					16
17	Maintenance Workers	10,722	11,406	178,846	15.68	17
18	Housekeepers	14,380	15,298	180,806	11.82	18
19	Laundry	5,836	6,208	64,162	10.34	19
20	Administrator	1,955	2,080	106,224	51.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,624	16,621	367,171	22.09	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)	224,201	238,509	\$ 3,891,706 *	\$ 16.32	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	13,000	36
37	Medical Records Consultant	2,080	37
38	Nurse Consultant		38
39	Pharmacist Consultant	7,727	39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant	4,953	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 27,760	49

C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$ 0	50
51	Licensed Practical Nurses	0	51
52	Certified Nurse Assistants/Aides	7,172	52
53	TOTAL (lines 50 - 52)	\$ 7,172	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
David Standefer			\$ 106,224	Workers' Compensation Insurance	\$ 191,210	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,238	Advertising: Employee Recruitment	5,717	
				FICA Taxes	297,716	Health Care Worker Background Check (Indicate # of checks performed)	3,490	
				Employee Health Insurance	575,358	Patient Background Checks		
				Employee Meals		PR	19,223	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	11,428	
				Other Benefits	27,727	License & Fees	4,417	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,224			Less: Public Relations Expense	(19,223)	
B. Administrative - Other						Non-allowable advertising	(4,773)	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,279	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,111,249			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$		
Heritage Operations Group	Management		\$ 413,966				Out-of-State Travel	\$
Pehlman and Dold	Audit		19,216					
Sulaski & Webb	Audit - 401(k)		5,000				In-State Travel	
Michigan Peer Review Inc	Consulting		2,420					12,136
ADP	Payroll tax filing		1,607					0
Principal Financial	Plan consulting		2,483				Seminar Expense	2,925
								(10,062)
							Entertainment Expense	()
Legal adj to Zero			3,446				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 448,138	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223Report Period Beginning: 7/1/2016Ending: 6/30/2017**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. HCCI
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 322,384
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? _____ Indicate the amount. \$ 12,317
- (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) 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Odd Fellow Rebekah Home
2017 Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 375,518
Purchased Hospital Services	39,115
Purchased Laboratory Services	12,490
Purchased Radiology Services	16,373
Amount Reclassified to Line 39	\$ <u>443,496</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (88,695)
Provider Assesment Fee - \$6.07	<u>(233,689)</u>
	<u>(322,384)</u>
Provider Participation Fee	<u>322,384</u>