

Facility Name & ID Number Imboden Creek Living Center

0036574 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	95	Skilled (SNF)	95	34,675	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	95	TOTALS	95	34,675	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	7,657	14,172	5,410	27,239	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,657	14,172	5,410	27,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.56%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/8/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/8/1990 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 95 and days of care provided 5,177

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Imboden Creek Livng Center # 0036574 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	269,200	33,149	21,610	323,959		323,959		323,959		1
2	Food Purchase		253,575		253,575		253,575	(975)	252,600		2
3	Housekeeping	118,503	40,766		159,269		159,269		159,269		3
4	Laundry	78,639	15,123		93,762		93,762		93,762		4
5	Heat and Other Utilities			133,657	133,657		133,657	(11,818)	121,839		5
6	Maintenance	72,666	21,260	65,098	159,024		159,024	(2,125)	156,899		6
7	Other (specify):*										7
8	TOTAL General Services	539,008	363,873	220,365	1,123,246		1,123,246	(14,918)	1,108,328		8
	B. Health Care and Programs										
9	Medical Director			22,800	22,800		22,800		22,800		9
10	Nursing and Medical Records	2,014,241	170,903	9,125	2,194,269		2,194,269		2,194,269		10
10a	Therapy	99,058	1,509	692,145	792,712		792,712		792,712		10a
11	Activities	123,367	2,467	5,162	130,996		130,996		130,996		11
12	Social Services	67,039		1,812	68,851		68,851		68,851		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,303,705	174,879	731,044	3,209,628		3,209,628		3,209,628		16
	C. General Administration										
17	Administrative	154,325			154,325		154,325		154,325		17
18	Directors Fees										18
19	Professional Services			34,248	34,248		34,248	(350)	33,898		19
20	Dues, Fees, Subscriptions & Promotions			34,601	34,601		34,601	(20,192)	14,409		20
21	Clerical & General Office Expenses	283,102	18,616	74,012	375,730		375,730	(37,248)	338,482		21
22	Employee Benefits & Payroll Taxes			452,974	452,974		452,974		452,974		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,814	14,814		14,814		14,814		24
25	Other Admin. Staff Transportation			1,912	1,912		1,912		1,912		25
26	Insurance-Prop.Liab.Malpractice			63,647	63,647		63,647		63,647		26
27	Other (specify):*										27
28	TOTAL General Administration	437,427	18,616	676,208	1,132,251		1,132,251	(57,790)	1,074,461		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,280,140	557,368	1,627,617	5,465,125		5,465,125	(72,708)	5,392,417		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 Imboden Creek Livng Center

#0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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			101,573	101,573		101,573	51,735	153,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,266	5,266		5,266	266,622	271,888			32
33	Real Estate Taxes			105,369	105,369		105,369	5,193	110,562			33
34	Rent-Facility & Grounds			585,300	585,300		585,300	(585,300)				34
35	Rent-Equipment & Vehicles			9,190	9,190		9,190		9,190			35
36	Other (specify):*											36
37	TOTAL Ownership			806,698	806,698		806,698	(261,750)	544,948			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,245	33,875	172,120		172,120		172,120			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,813	185,813		185,813		185,813			42
43	Other (specify):*			2,346,983	2,346,983		2,346,983	(2,346,983)				43
44	TOTAL Special Cost Centers		138,245	2,566,671	2,704,916		2,704,916	(2,346,983)	357,933			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,280,140	695,613	5,000,986	8,976,739		8,976,739	(2,681,441)	6,295,298			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	(11,818)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,589)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(975)	02		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				17
18	Fines and Penalties	(3,015)	21		18
19	Entertainment	(260)	21		19
20	Contributions	(1,333)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(350)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,807)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,436)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,379,504)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,432,087)		\$	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)	(249,354)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (249,354)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,681,441)		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

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 1/1/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	TELEPHONE INCOME	\$ (5,467)	21	1
2	FINANCE CHARGE INCOME	(3,061)	21	2
3	PUBLIC FINGERPRINT INCOME	(1,346)	20	3
4	MISC INCOME	(13,420)	21	4
5	BANK CHARGES	(8,086)	21	5
6	MISC FLOWERS	(764)	21	6
7	GIFTS RESIDENTS	(406)	21	7
8	ICG/IL/IMBODEN EXP	(2,346,983)	43	8
9	LOBBYING/PAC DUES	(2,454)	20	9
10	DUES	(585)	20	10
11	TRANSPORTATION	(2,125)	6	11
12	RE TAX ADJ	5,193	33	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				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	(2,379,504)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(975)	0	0	0	0	0	0	0	0	0	0	(975)	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	(11,818)	0	0	0	0	0	0	0	0	0	0	(11,818)	5
6	Maintenance	(2,125)	0	0	0	0	0	0	0	0	0	0	(2,125)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,918)	0	0	0	0	0	0	0	0	0	0	(14,918)	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	(350)	0	0	0	0	0	0	0	0	0	0	(350)	19
20	Fees, Subscriptions & Promotions	(20,192)	0	0	0	0	0	0	0	0	0	0	(20,192)	20
21	Clerical & General Office Expenses	(37,248)	0	0	0	0	0	0	0	0	0	0	(37,248)	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(57,790)	0	0	0	0	0	0	0	0	0	0	(57,790)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,708)	0	0	0	0	0	0	0	0	0	0	(72,708)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(17,589)	69,324	0	0	0	0	0	0	0	0	0	51,735	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	266,622	0	0	0	0	0	0	0	0	0	266,622	32
33	Real Estate Taxes	5,193	0	0	0	0	0	0	0	0	0	0	5,193	33
34	Rent-Facility & Grounds	0	(585,300)	0	0	0	0	0	0	0	0	0	(585,300)	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	(12,396)	(249,354)	0	0	0	0	0	0	0	0	0	(261,750)	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):*	(2,346,983)	0	0	0	0	0	0	0	0	0	0	(2,346,983)	43
44	TOTAL Special Cost Centers	(2,346,983)	0	0	0	0	0	0	0	0	0	0	(2,346,983)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,432,087)	(249,354)	0	0	0	0	0	0	0	0	0	(2,681,441)	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
JOHN & MARTHA BRINKOETTER	85.66			IMBODEN GARDENS	DECATUR	ASSISTED LIVING
AIMEE BEEMER	3.59					
JULIE SMITH	3.59					
ANDREW BRINKOETTER	3.59					
JODI POWELL	3.59					

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	34 Rent	\$ 585,300	John & Martha Brinkoetter	100.00%	\$	(585,300)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	69,324	69,324	2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	266,622	266,622	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		\$ 585,300			\$ 335,946	\$ * (249,354)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning: 1/1/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Imboden Creek Livng Center # 0036574 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	John Brinkoetter	President	Administrative	42.83	None	26	65.00	Salary	\$ 40,739	17-1	1
2	Martha Brinkoetter	Shareholder	Administrative	42.83	None	26	65.00	Salary	19,549	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,288		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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending: 12/31/18

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

Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	Regions Bank		X	Real Estate Loan			\$	\$ 4,912,687	10/1/2020	5.7196	\$ 266,622	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Regions Bank		X	Line of Credit				102,822			8,102	6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$ 5,015,509			\$ 274,724	9						
B. Non-Facility Related*																		
10	Allocated to Independent Living										(2,836)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (2,836)	14						
15	TOTALS (line 9+line14)						\$	\$ 5,015,509			\$ 271,888	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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 2017 report.	\$	109,868	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.)	\$	112,773	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,905	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	107,657	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.	\$	110,562	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	102,966	8
	2014	103,005	9
	2015	109,389	10
	2016	114,920	11
	2017	112,773	12

2018 Accrual:

Nursing Home: \$98,554 and Corp Office Alloc to Nursing Home: \$14,005 X .65 = \$9,103 = \$107,657

2110/2140/2150/2160/2170 Imboden Place and Independent Living: \$135,581

Total Accrual per Page 17, Line 32: \$243,238

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Imboden Creek Livng Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036574

CONTACT PERSON REGARDING THIS REPORT Rhonda Luther

TELEPHONE (217) 422-7150 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-12-27-231-013</u>	<u>Long Term Care Facility</u>	\$ <u>98,610.02</u>	\$ <u>98,610.02</u>
2. <u>04-12-27-278-010</u>	<u>Long Term Care Facility</u>	\$ <u>14,163.00</u>	\$ <u>9,206.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>112,773.02</u></u>	\$ <u><u>107,816.02</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? X 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Imboden Creek Living Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036574

CONTACT PERSON REGARDING THIS REPORT Rhonda Luther

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,960 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).

Imboden Creek Gardens - Assisted Living Facility

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 143,748, 1988, \$ 111,846, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 143,748, (blank), \$ 111,846, 3.

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	95		1990	1990	\$ 2,772,947	\$ 69,324	40	\$ 69,324	\$	\$ 1,962,201	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1991		15,000		20				9
10	Various		1992		3,460		20				10
11	Various		1993		3,207		20				11
12	Various		1995		4,595		20				12
13	Various		1996		2,065		20				13
14	Various		1998		2,387		20				14
15	Various		2000		65,231		20				15
16	Various		2001		27,848		20				16
17	Various		2002		47,144		20				17
18	Various		2003		13,264		20				18
19	Various		2005		21,300		20				19
20	Various		2007		34,024		20			36,699	20
21	Various		2008		175,206		20			181,302	21
22	Various		2009		10,150		20	1,015	1,015	9,643	22
23	Various		2010		18,602		20	1,860	1,860	15,036	23
24	Various		2011		2,641		20	264	264	1,848	24
25	Various		2012		17,055		20	1,706	1,706	11,567	25
26	Various		2013		6,721		20	672	672	3,472	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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	Parking Lot	2015	\$ 210,134	\$	10	\$ 21,377	\$ 21,377	\$ 65,943	37
38	Flooring - Resident Dining Room	2015	14,019		10	1,402	1,402	5,257	38
39	Shower Room Tile, Plumbing, Electric-Resident Wing Jodi	2015	6,580		10	658	658	2,569	39
40	Shower Wall Tile, Cabinets & Plumbing-Resident Wing Jodi	2015	24,820		25	993	993	3,226	40
41	Generator Upgrades	2015	9,635		10	963	963	2,970	41
42	Parking Lot	2016	4,900		20	245	245	735	42
43	Plumbing And Replacing Tiles In Shower Rooms	2016	15,678		20	784	784	2,352	43
44	Parking Lot	2016	4,370		20	219	219	656	44
45	Flooring - Physical Therapy	2016	3,244		20	162	162	486	45
46	Privacy Fence	2016	5,431		20	272	272	815	46
47	A/C Units	2016	23,196		20	1,160	1,160	1,390	47
48	Flooring - Activity Room	2016	3,069		20	153	153	460	48
49	Dumpster Doors - Lower Level	2016	6,807		20	340	340	1,021	49
50	Apollo System Upgrade	2017	14,842		20	742	742	1,484	50
51	Exit Panel Installation - Activities Door & Front Door	2017	4,418		20	221	221	442	51
52	Roof Drains	2017	34,405		20	1,720	1,720	3,440	52
53	Rooftop Unit	2018	5,580		10	233	233	233	53
54	Control System to Elevator	2018	2,512		10	63	63	63	54
55	Security Door	2018	2,630		10	197	197	197	55
56	Boiler Control Panel	2018	4,596		10	421	421	421	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Financial Statement Depreciation			101,573			(101,573)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	70

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

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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19								19
20								20
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Livng Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
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25								25
26								26
27								27
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29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
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29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Living Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

Facility Name & ID Number **Imboden Creek Livng Center**

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	1
2								2
3								3
4								4
5								5
6								6
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,643,713	\$ 170,897		\$ 107,166	\$ (63,731)	\$ 2,315,928	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 930,731	\$	\$ 43,474	\$ 43,474	10	\$ 825,870	71
72	Current Year Purchases	25,630		1,674	1,674	10	2,204	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 956,361	\$	\$ 45,148	\$ 45,148		\$ 828,074	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		2001 Ford F150 Truck	2000	\$ 35,174	\$	\$	\$	5	\$ 35,174	76
77		2001 Lexus LX 3240	2000	66,573				5	66,573	77
78		2012 Dodge Caravan	2013	18,353		994	994	5	11,994	78
79										79
80	TOTALS			\$ 120,100	\$	\$ 994	\$ 994		\$ 113,741	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)	\$ 4,832,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,897	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 153,308	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,589)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,257,743	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 Imboden Creek Livng Center

0036574

Report Period Beginning: 1/1/18

Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 9,190 Description: Dishwashing machine \$480, Therapy equip \$8,710

(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 checked="" 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	10-03	hrs	\$		\$ 284,788	\$		\$ 284,788	1
2	Licensed Speech and Language Development Therapist	10-03	hrs			100,543			100,543	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-03	hrs			306,814	271		307,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				138,245		138,245	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab & X-ray</u>	39-3					33,875		33,875	12
13	Other (specify):									13
14	TOTAL			\$		\$ 692,145	\$ 172,391		\$ 864,536	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 **12/31/18**

(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	\$ (49,849)	\$	1
2	Cash-Patient Deposits	5,130		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	469,666		3
4	Supply Inventory (priced at)	30,268		4
5	Short-Term Investments			5
6	Prepaid Insurance	57,803		6
7	Other Prepaid Expenses	13,855		7
8	Accounts Receivable (owners or related parties)	148,150		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 675,023	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,933		15
16	Equipment, at Historical Cost	959,691		16
17	Accumulated Depreciation (book methods)	(1,462,266)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,335		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,335)		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)	\$ 602,358	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,277,381	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 301,288	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,125		28
29	Short-Term Notes Payable	102,822		29
30	Accrued Salaries Payable	204,856		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	243,238		32
33	Accrued Interest Payable			33
34	Deferred Compensation	133,320		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER FUNDS	52,508		36
37	ADVANCE BILLING	62,650		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,105,807	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,105,807	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 171,574	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,277,381	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 341,006	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJ	(43,592)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 297,414	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	23,315	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	(149,155)	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)	\$ (125,840)	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)	\$ 171,574	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 1/1/18

Ending: 12/31/18

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	\$ 5,891,090	1
2	Discounts and Allowances for all Levels	(984,667)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,906,423	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,519,842	6
7	Oxygen	34,788	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,554,630	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	1	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	5,467	15
16	Rental of Facility Space		16
17	Sale of Drugs	142,439	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,492	19
20	Radiology and X-Ray	11,765	20
21	Other Medical Services	17,140	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 197,304	23
D. Non-Operating Revenue			
24	Contributions	1,080	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,080	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	19,642	28
28a	Independent Living/ICG	2,320,975	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,340,617	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,000,054	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,123,246	31
32	Health Care	3,209,628	32
33	General Administration	1,132,251	33
B. Capital Expense			
34	Ownership	806,698	34
C. Ancillary Expense			
35	Special Cost Centers	2,519,103	35
36	Provider Participation Fee	185,813	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,976,739	40
41	Income before Income Taxes (line 30 minus line 40)**	23,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 23,315	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 979,328	44
45	Private Pay - Net Inpatient Revenue	2,990,663	45
46	Medicare - Net Inpatient Revenue	980,229	46
47	Other-(specify) Private Insurance	26,708	47
48	Other-(specify) Mcr Pt B/Bad Debts	(70,505)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,906,423	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not complete** 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 Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	8,320	8,320	\$ 229,933	\$ 27.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,948	8,144	220,186	27.04	3
4	Licensed Practical Nurses	21,007	23,619	527,185	22.32	4
5	CNAs & Orderlies	77,786	79,606	997,807	12.53	5
6	CNA Trainees	1,225	1,225	11,930	9.74	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,321	7,705	99,058	12.86	8
9	Activity Director	2,080	2,080	34,999	16.83	9
10	Activity Assistants	8,878	9,250	88,368	9.55	10
11	Social Service Workers	3,640	3,640	67,039	18.42	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,987	14.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,065	25,209	238,213	9.45	15
16	Dishwashers					16
17	Maintenance Workers	4,364	4,433	72,666	16.39	17
18	Housekeepers	11,139	11,547	118,503	10.26	18
19	Laundry	8,264	8,446	78,639	9.31	19
20	Administrator	2,080	2,080	94,037	45.21	20
21	Assistant Administrator					21
22	Other Administrative	2,704	2,704	60,288	22.30	22
23	Office Manager					23
24	Clerical	10,217	10,312	283,102	27.45	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	1,978	2,074	27,200	13.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,096	212,474	\$ 3,280,140 *	\$ 15.44	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	480	\$ 21,610	01-03	35
36	Medical Director	Monthly	22,800	09-03	36
37	Medical Records Consultant	35	2,408	10-03	37
38	Nurse Consultant			10-03	38
39	Pharmacist Consultant	Monthly	6,717	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,812	11-03	44
45	Social Service Consultant	27	1,812	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	569	\$ 57,159		49

C. CONTRACT NURSES

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

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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 Imboden Creek Living Center# 0036574

Report Period Beginning:

1/1/18

Ending:

12/31/18**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. IL Health Care Association \$6,726
- (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? N/A
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,000 Line 10-02
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 185,813
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 benefit on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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