

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0036574

Facility Name: Imboden Creek Livng Center

Address: 180 West Imboden Decatur 62521
Number City Zip Code

County: Macon

Telephone Number: (217) 422-6464 Fax # (217) 422-7849

HFS ID Number:

Date of Initial License for Current Owners: 9/8/1990

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: RHONDA LUTHER Telephone Number: (217) 422-7150
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) CAMILLE B. LOCKHART
PARTNER
(Firm Name & Address) BKD, LLP
P O BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Imboden Creek Livng Center

0036574 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,770</u>	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	<u>95</u>	TOTALS	<u>95</u>	<u>34,770</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,043</u>	<u>12,762</u>	<u>5,774</u>	<u>24,579</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,043</u>	<u>12,762</u>	<u>5,774</u>	<u>24,579</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

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 5,320

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Imboden Creek Livng Center # 0036574 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	327,925	31,873	24,062	383,860		383,860		383,860			1
2	Food Purchase		229,275		229,275		229,275	(880)	228,395			2
3	Housekeeping	153,804	50,270		204,074		204,074		204,074			3
4	Laundry	112,334	22,691		135,025		135,025		135,025			4
5	Heat and Other Utilities			115,452	115,452		115,452	(12,700)	102,752			5
6	Maintenance	70,337	26,845	110,593	207,775		207,775	(1,675)	206,100			6
7	Other (specify):*							(142,333)	(142,333)			7
8	TOTAL General Services	664,400	360,954	250,107	1,275,461		1,275,461	(157,588)	1,117,873			8
	B. Health Care and Programs											
9	Medical Director			15,700	15,700		15,700		15,700			9
10	Nursing and Medical Records	2,296,289	173,443	39,081	2,508,813		2,508,813		2,508,813			10
10a	Therapy	103,526	1,363	811,335	916,224		916,224		916,224			10a
11	Activities	157,166	4,050	1,742	162,958		162,958		162,958			11
12	Social Services	88,548		1,334	89,882		89,882		89,882			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							(437,900)	(437,900)			15
16	TOTAL Health Care and Programs	2,645,529	178,856	869,192	3,693,577		3,693,577	(437,900)	3,255,677			16
	C. General Administration											
17	Administrative	177,346			177,346		177,346		177,346			17
18	Directors Fees											18
19	Professional Services			36,090	36,090		36,090	(9,603)	26,487			19
20	Dues, Fees, Subscriptions & Promotions			22,152	22,152		22,152	(6,093)	16,059			20
21	Clerical & General Office Expenses	361,995	17,778	101,418	481,191		481,191	(24,216)	456,975			21
22	Employee Benefits & Payroll Taxes			506,796	506,796		506,796		506,796			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,670	9,670		9,670		9,670			24
25	Other Admin. Staff Transportation			860	860		860		860			25
26	Insurance-Prop.Liab.Malpractice			72,624	72,624		72,624		72,624			26
27	Other (specify):*							(110,318)	(110,318)			27
28	TOTAL General Administration	539,341	17,778	749,610	1,306,729		1,306,729	(150,230)	1,156,499			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,849,270	557,588	1,868,909	6,275,767		6,275,767	(745,718)	5,530,049			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			81,563	81,563		81,563	58,760	140,323			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36	36		36	182,163	182,199			32
33	Real Estate Taxes			116,869	116,869		116,869	(5,848)	111,021			33
34	Rent-Facility & Grounds			585,300	585,300		585,300	(585,300)				34
35	Rent-Equipment & Vehicles			11,360	11,360		11,360		11,360			35
36	Other (specify):*											36
37	TOTAL Ownership			795,128	795,128		795,128	(350,225)	444,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,770	17,145	187,915		187,915		187,915			39
40	Barber and Beauty Shops	7,188			7,188		7,188		7,188			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,979	168,979		168,979		168,979			42
43	Other (specify):*			2,390,293	2,390,293		2,390,293	(2,390,293)				43
44	TOTAL Special Cost Centers	7,188	170,770	2,576,417	2,754,375		2,754,375	(2,390,293)	364,082			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,856,458	728,358	5,240,454	9,825,270		9,825,270	(3,486,236)	6,339,034			45

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

VI. ADJUSTMENT DETAIL

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

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,700)	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	(10,564)	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	(880)	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	(5,720)	19		17
18	Fines and Penalties	(1,481)	21		18
19	Entertainment	(2,286)	21		19
20	Contributions	(1,825)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,883)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,714)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,107,106)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,152,423)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(333,813)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (333,813)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,486,236)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	TELEPHONE INCOME	\$ (5,707)	21	1
2	TRANSPORTATION INCOME	(1,675)	6	2
3	PUBLIC FINGERPRINT INCOME	(493)	20	3
4	MISC INCOME	(2,228)	21	4
5	BANK CHARGES	(5,974)	21	5
6	MISC-FLOWERS	(782)	21	6
7	GIFTS-RESIDENTS	(1,219)	21	7
8	LOBBYING EXPENSE/PAC DUES	(2,336)	20	8
9	ICG/IMBODEN EXPENSES	(2,390,293)	43	9
10	ADJ RE TAXES	(5,848)	33	10
11	COVID INCOME-ICLC	(142,333)	7	11
12	COVID INCOME-ICLC	(437,900)	15	12
13	COVID INCOME-ICLC	(110,318)	27	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	(3,107,106)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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	(880)	0	0	0	0	0	0	0	0	0	0	(880)	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	(12,700)	0	0	0	0	0	0	0	0	0	0	(12,700)	5
6	Maintenance	(1,675)	0	0	0	0	0	0	0	0	0	0	(1,675)	6
7	Other (specify):*	(142,333)	0	0	0	0	0	0	0	0	0	0	(142,333)	7
8	TOTAL General Services	(157,588)	0	0	0	0	0	0	0	0	0	0	(157,588)	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):*	(437,900)	0	0	0	0	0	0	0	0	0	0	(437,900)	15
16	TOTAL Health Care and Programs	(437,900)	0	0	0	0	0	0	0	0	0	0	(437,900)	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	(9,603)	0	0	0	0	0	0	0	0	0	0	(9,603)	19
20	Fees, Subscriptions & Promotions	(6,093)	0	0	0	0	0	0	0	0	0	0	(6,093)	20
21	Clerical & General Office Expenses	(24,216)	0	0	0	0	0	0	0	0	0	0	(24,216)	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):*	(110,318)	0	0	0	0	0	0	0	0	0	0	(110,318)	27
28	TOTAL General Administration	(150,230)	0	0	0	0	0	0	0	0	0	0	(150,230)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(745,718)	0	0	0	0	0	0	0	0	0	0	(745,718)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Livng Center # 0036574 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(10,564)	69,324	0	0	0	0	0	0	0	0	0	58,760	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	182,163	0	0	0	0	0	0	0	0	0	182,163	32
33	Real Estate Taxes	(5,848)	0	0	0	0	0	0	0	0	0	0	(5,848)	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	(16,412)	(333,813)	0	0	0	0	0	0	0	0	0	(350,225)	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):*	(2,390,293)	0	0	0	0	0	0	0	0	0	0	(2,390,293)	43
44	TOTAL Special Cost Centers	(2,390,293)	0	0	0	0	0	0	0	0	0	0	(2,390,293)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,152,423)	(333,813)	0	0	0	0	0	0	0	0	0	(3,486,236)	45

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	80			IMBODEN GARDENS	DECATUR	ASSISTED LIVING
AIMEE BEEMER	5					
JULIE SMITH	5					
ANDREW BRINKOETTER	5					
JODI DELAHUNTY	5					

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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%	182,163	182,163	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			\$ 251,487	\$ * (333,813)	14

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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.

YESNO

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.

YESNO

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.

YESNO

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.

YESNO

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	\$ *	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.

YESNO

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

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

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: 1/1/2020 Ending: 12/31/2020

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	40.00	None	27	65.00	Salary	\$ 42,860	17-1	1
2	Martha Brinkoetter	Shareholder	Administrative	40.00	None	27	65.00	Salary	20,567	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	\$ 63,427		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:

1/1/2020Ending: 2/31/2020

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

Facility Name & ID Number Imboden Creek Livng Center # 0036574 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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

Ending: 2/31/2020

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Ending: 2/31/2020

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

IL478-2471

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Facility Name & ID Number Imboden Creek Livng Center# 0036574

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Ending: 2/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	Regions Bank		X	Real Estate Loan			\$	4,069,871	10/1/2020	5.0548	\$	182,163	1		
2													2		
3													3		
4													4		
5													5		
	Working Capital														
6	Regions Bank		X	PPP Loan			837,000	837,000		1.0000			6		
7													7		
8													8		
9	TOTAL Facility Related						\$	837,000	\$	4,906,871			9		
	B. Non-Facility Related*														
10	Misc int (net of alloc to IL)											36	10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	36	14	
15	TOTALS (line 9+line14)						\$	837,000	\$	4,906,871			\$	182,199	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2019 report.			\$	106,297	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.)			\$	111,093	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,796	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	106,225	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.			\$	111,021	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	109,389	8	
		2016	114,920	9	
		2017	112,773	10	
		2018	110,177	11	
		2019	111,093	12	
2020 Accrual:					
Nursing Home: \$97,184 and Corp Office Alloc to Nursing Home: \$13,909 X .65 = 9,041 = \$106,225					
2110/2140/2150/2160/2170 Imboden Place and Independent Living \$131,339					
Total Accrual per Page 17, Line 32 = \$237,564					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 04-12-27-231-013	Long Term Care Facility	\$ 97,184.08	\$ 97,184.08
2. 04-12-27-278-010	Long Term Care Facility	\$ 13,909.00	\$ 9,041.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 111,093.08	\$ 106,225.08

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach 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.

A. Square Feet: 33,960

B. General Construction Type: Exterior BrickFrame WoodNumber 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.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	143,748	1988	\$ 111,846	1
2					2
3	TOTALS	143,748		\$ 111,846	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1990	1990	\$ 2,772,947	\$ 69,324	40	\$ 69,324	\$	\$ 2,100,849	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	507	507	10,150	22
23	Various		2010		18,602		20	1,706	1,706	18,602	23
24	Various		2011		2,641		20	264	264	2,376	24
25	Various		2012		17,055		20	1,706	1,706	14,979	25
26	Various		2013		6,721		20	672	672	4,816	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

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$ 21,013	\$ 21,013	\$ 107,969	37
38	Flooring - Resident Dining Room	2015	14,019		10	1,402	1,402	8,061	38
39	Shower Room Tile, Plumbing, Electric-Resident Wing Jodi	2015	6,580		10	658	658	3,885	39
40	Shower Wall Tile, Cabinets & Plumbing-Resident Wing Jodi	2015	24,820		25	993	993	5,212	40
41	Generator Upgrades	2015	9,635		10	964	964	4,898	41
42	Parking Lot	2016	4,900		20	245	245	1,225	42
43	Plumbing And Replacing Tiles In Shower Rooms	2016	15,678		20	784	784	3,920	43
44	Parking Lot	2016	4,370		20	219	219	1,094	44
45	Flooring - Physical Therapy	2016	3,244		20	162	162	810	45
46	Privacy Fence	2016	5,431		20	272	272	1,359	46
47	A/C Units	2016	23,196		20	1,160	1,160	3,710	47
48	Flooring - Activity Room	2016	3,069		20	153	153	766	48
49	Dumpster Doors - Lower Level	2016	6,807		20	340	340	1,701	49
50	Apollo System Upgrade	2017	14,842		20	742	742	2,968	50
51	Exit Panel Installation - Activities Door & Front Door	2017	4,418		20	221	221	884	51
52	Roof Drains	2017	34,405		20	1,720	1,720	6,880	52
53	Rooftop Unit	2018	5,580		10	558	558	1,349	53
54	Control System to Elevator	2018	2,512		10	251	251	565	54
55	Security Door	2018	2,630		10	263	263	723	55
56	Boiler Control Panel	2018	4,596		10	460	460	1,341	56
57	Heat Pumps	2019	6,290		10	629	629	864	57
58	Cabinetry and Materials	2020	4,730		10	355	355	355	58
59	Rooftop Unit	2020	7,200		10	300	300	300	59
60	Kitchen Circuits/sub-panel	2020	3,430		10	200	200	200	60
61									61
62									62
63									63
64									64
65									65
66									66
67	Financial Statement Depreciation			81,563			(81,563)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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
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21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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	TOTAL (lines 1 thru 33)		\$ 3,665,363	\$ 150,887		\$ 108,243	\$ (42,644)	\$ 2,530,812	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	\$936,628	\$	\$30,575	\$30,575		\$846,651	71
72	Current Year Purchases	29,662		1,505	1,505		1,505	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$966,290	\$	\$32,080	\$32,080		\$848,156	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				5	18,353	78
79										79
80	TOTALS			\$120,100	\$	\$	\$		\$120,100	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)	\$4,863,599	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$150,887	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$140,323	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(10,564)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,499,068	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.

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

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: \$ 11,360 Description: Dishwashing machine \$440; Therapy Equip. \$10,920
(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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	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	\$	3,964	\$ 303,191	\$	3,964	\$ 303,191	1
2	Licensed Speech and Language Development Therapist	10-03	hrs		1,617	133,465		1,617	133,465	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-03	hrs		5,165	374,679		5,165	374,679	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 prescrpts				170,770		170,770	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-ray	39-3					17,145		17,145	12
13	Other (specify):									13
14	TOTAL			\$	10,746	\$ 811,335	\$ 187,915	10,746	\$ 999,250	14

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

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,149,698	\$	1
2	Cash-Patient Deposits	5,305		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	655,698		3
4	Supply Inventory (priced at)	39,058		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,547		6
7	Other Prepaid Expenses	13,445		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)	\$ 2,047,901	\$	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	1,172,817		15
16	Equipment, at Historical Cost	960,216		16
17	Accumulated Depreciation (book methods)	(1,579,385)		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)	\$ 553,648	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,601,549	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,858	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,305		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	317,548		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,920		31
32	Accrued Real Estate Taxes(Sch.IX-B)	237,564		32
33	Accrued Interest Payable			33
34	Deferred Compensation	355,547		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	64,765		36
37	Advance Billing/Interco	40,249		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,347,756	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	837,000		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)	\$ 837,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,184,756	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 416,793	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,601,549	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 355,108	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 355,108	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,288	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	(23,599)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ROUNDING	(4)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 61,685	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)	\$ 416,793	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Imboden Creek Livng Center

0036574

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,444,440	1
2	Discounts and Allowances for all Levels	(173,663)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,270,777	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,570,945	6
7	Oxygen	24,209	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,595,154	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	5,707	15
16	Rental of Facility Space		16
17	Sale of Drugs	170,290	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,221	19
20	Radiology and X-Ray	6,374	20
21	Other Medical Services	16,360	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 208,952	23
	D. Non-Operating Revenue		
24	Contributions	1,700	24
25	Interest and Other Investment Income***	298	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,998	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC/COVID INCOME	704,314	28
28a	Independent Living/ICG	2,129,363	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,833,677	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,910,558	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,275,461	31
32	Health Care	3,693,577	32
33	General Administration	1,306,729	33
	B. Capital Expense		
34	Ownership	795,128	34
	C. Ancillary Expense		
35	Special Cost Centers	2,585,396	35
36	Provider Participation Fee	168,979	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,825,270	40
41	Income before Income Taxes (line 30 minus line 40)**	85,288	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 85,288	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,001,952	44
45	Private Pay - Net Inpatient Revenue	2,790,681	45
46	Medicare - Net Inpatient Revenue	1,565,773	46
47	Other-(specify) Private Insurance	107,238	47
48	Other-(specify) Mcr Pt B/Bad Debts	(194,867)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,270,777	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.

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	2,040	2,160	\$ 78,431	\$ 36.31	1
2	Assistant Director of Nursing	2,147	2,187	70,843	32.39	2
3	Registered Nurses	8,340	8,677	279,581	32.22	3
4	Licensed Practical Nurses	23,640	24,746	683,275	27.61	4
5	CNAs & Orderlies	75,029	77,444	1,149,091	14.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,539	5,865	103,526	17.65	8
9	Activity Director	1,967	2,131	41,428	19.44	9
10	Activity Assistants	10,685	10,878	115,738	10.64	10
11	Social Service Workers	3,876	4,320	88,548	20.50	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,160	41,726	19.32	13
14	Head Cook	8,087	8,571	110,537	12.90	14
15	Cook Helpers/Assistants	12,796	13,193	143,711	10.89	15
16	Dishwashers	3,247	3,280	31,951	9.74	16
17	Maintenance Workers	3,465	3,473	70,337	20.25	17
18	Housekeepers	11,440	11,769	153,804	13.07	18
19	Laundry	9,164	9,872	112,334	11.38	19
20	Administrator	2,080	2,160	113,919	52.74	20
21	Assistant Administrator					21
22	Other Administrative	2,808	2,808	63,427	22.59	22
23	Office Manager					23
24	Clerical	11,003	11,111	361,995	32.58	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	2,524	2,540	35,068	13.81	31
32	Other Health Care(specify)					32
33	Other(specify) B&B	479	479	7,188	15.01	33
34	TOTAL (lines 1 - 33)	202,328	209,824	\$ 3,856,458 *	\$ 18.38	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	384	\$ 18,462	01-03	35
36	Medical Director	Monthly	15,700	09-03	36
37	Medical Records Consultant	34	2,351	10-03	37
38	Nurse Consultant		1,218	10-03	38
39	Pharmacist Consultant		6,041	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	22	1,334	11-03	44
45	Social Service Consultant	22	1,334	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	462	\$ 46,440		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	194	\$ 18,042	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	267	11,429	10-03	52
53	TOTAL (lines 50 - 52)	461	\$ 29,471		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

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. IHCA \$7,296
- (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? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,627 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 168,979
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. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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? _____
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.