

Facility Name & ID Number Imboden Creek Living Center

0036574 Report Period Beginning: 10/01/00 Ending: 09/30/01

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>34,675</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>34,675</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>5,954</u>	<u>21,332</u>	<u>3,363</u>	<u>30,649</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>5,954</u>	<u>21,332</u>	<u>3,363</u>	<u>30,649</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.39%

D. How many bed-hold days during this year were paid by Public Aid?

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 09/08/90

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 95 and days of care provided 3,363

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/90/01 Fiscal Year: 09/30/01

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

STATE OF ILLINOIS

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/00 Ending: 09/30/01

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	190,721	23,937	6,818	221,476		221,476	221,476			1
2	Food Purchase		209,562		209,562	(21,270)	188,292	188,292			2
3	Housekeeping	78,351	24,309		102,660		102,660	102,660			3
4	Laundry	35,229	18,350		53,579		53,579	53,579			4
5	Heat and Other Utilities			79,955	79,955		79,955	79,955			5
6	Maintenance	41,851	21,329	76,186	139,366		139,366	139,366			6
7	Other (specify):*										7
8	TOTAL General Services	346,152	297,487	162,959	806,598	(21,270)	785,328	785,328			8
B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200	13,200			9
10	Nursing and Medical Records	913,620	42,963	6,063	962,646		962,646	962,646			10
10a	Therapy										10a
11	Activities	40,095	4,505	1,333	45,933		45,933	45,933			11
12	Social Services	18,837	40	1,333	20,210		20,210	20,210			12
13	Nurse Aide Training										13
14	Program Transportation					14	14	14			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	972,552	47,508	21,929	1,041,989	14	1,042,003	1,042,003			16
C. General Administration											
17	Administrative	156,799		3,130	159,929		159,929	159,929			17
18	Directors Fees										18
19	Professional Services			13,354	13,354		13,354	13,354			19
20	Dues, Fees, Subscriptions & Promotions			27,102	27,102		27,102	(456)	26,646		20
21	Clerical & General Office Expenses	107,685	17,288	17,455	142,428		142,428	(9,458)	132,970		21
22	Employee Benefits & Payroll Taxes			230,248	230,248	21,270	251,518	(5,626)	245,892		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,996	3,996		3,996	3,996			24
25	Other Admin. Staff Transportation			3,553	3,553	(14)	3,539	3,539			25
26	Insurance-Prop.Liab.Malpractice			56,216	56,216		56,216	56,216			26
27	Other (specify):* Non allowable			29,005	29,005		29,005	(29,005)			27
28	TOTAL General Administration	264,484	17,288	384,059	665,831	21,256	687,087	(44,545)	642,542		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,583,188	362,283	568,947	2,514,418		2,514,418	(44,545)	2,469,873		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 Living Center #0036574 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			68,005	68,005		68,005	67,771	135,776		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			52	52		52	213,445	213,497		32
33	Real Estate Taxes			82,318	82,318		82,318		82,318		33
34	Rent-Facility & Grounds			516,000	516,000		516,000	(516,000)			34
35	Rent-Equipment & Vehicles			2,190	2,190		2,190		2,190		35
36	Other (specify):*										36
37	TOTAL Ownership			668,565	668,565		668,565	(234,784)	433,781		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		68,942	224,547	293,489		293,489		293,489		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			52,013	52,013		52,013		52,013		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		68,942	276,560	345,502		345,502		345,502		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,583,188	431,225	1,514,072	3,528,485		3,528,485	(279,329)	3,249,156		45

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

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

0036574

Report Period Beginning: **10/01/00**

Ending: **09/30/01**

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	OHF 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	(9,458)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,467)	30		9
10	Interest and Other Investment Income	(23,886)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(790)	27		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				18
19	Entertainment	(2,519)	27		19
20	Contributions	(16,896)	27		20
21	Owner or Key-Man Insurance	(5,626)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,333)	27		24
25	Fund Raising, Advertising and Promotional	(1,961)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,898)		\$	30

OHF 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	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)	(195,431)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (195,431)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (279,329)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Imboden Creek Living Center

ID# 0036574
Report Period Beginning: 10/01/00
Ending: 09/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	PAC Dues	\$ (456)	20	1
2	Gifts	(506)	27	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
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	(962)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

10/01/00

Ending:

09/30/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(456)	0	0	0	0	0	0	0	0	0	0	(456)	20
21	Clerical & General Office Expenses	(9,458)	0	0	0	0	0	0	0	0	0	0	(9,458)	21
22	Employee Benefits & Payroll Taxes	(5,626)	0	0	0	0	0	0	0	0	0	0	(5,626)	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):*	(29,005)	0	0	0	0	0	0	0	0	0	0	(29,005)	27
28	TOTAL General Administration	(44,545)	0	0	0	0	0	0	0	0	0	0	(44,545)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,545)	0	0	0	0	0	0	0	0	0	0	(44,545)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

10/01/00

Ending:

09/30/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(15,467)	83,238	0	0	0	0	0	0	0	0	0	67,771 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(23,886)	237,331	0	0	0	0	0	0	0	0	0	213,445 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(516,000)	0	0	0	0	0	0	0	0	0	(516,000) 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	(39,353)	(195,431)	0	(234,784) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(83,898)	(195,431)	0	(279,329) 45								

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

0036574

Report Period Beginning: **10/01/00**

Ending: **09/30/01**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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)
1	V	34 Rent	\$ 516,000	John & Martha Brinkoetter	100.00%	\$	(516,000) 1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	83,238	83,238 2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	237,331	237,331 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		\$ 516,000			\$ 320,569	\$ * (195,431) 14

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/00 Ending: 09/30/01

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	100.00		40	100.00	Salary	\$ 51,676	17,1	1	
2	Martha Brinkoetter	Clerical	Clerical	100.00		40	100.00	Salary	32,918	21,1	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11											11	
12											12	
13									TOTAL	\$ 84,594		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 Living Center # 0036574 Report Period Beginning: 10/01/00 Ending: 09/30/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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 Living Center** # **0036574** Report Period Beginning: **10/01/00** Ending: **09/30/01**

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	Union Planters Bank		X	Real Estate Loan	\$25,052.00	04/27/01	\$ 3,302,473	\$ 3,174,891	04/27/06	7.0000	\$ 237,331	1									
2												2									
3												3									
4												4									
5	Interest Income										(23,886)	5									
	Working Capital																				
6	Miscellaneous		X								52	6									
7												7									
8												8									
9	TOTAL Facility Related				\$25,052.00		\$ 3,302,473	\$ 3,174,891			\$ 213,497	9									
	B. Non-Facility Related*																				
10												10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$	14									
15	TOTALS (line 9+line14)						\$ 3,302,473	\$ 3,174,891			\$ 213,497	15									

* 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.)

Facility Name & ID Number **Imboden Creek Living Center**# **0036574** Report Period Beginning: **10/01/00** Ending: **09/30/01****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 2000 report.			\$	56,025	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.)			\$	77,593	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	21,568	3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	60,750	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 19 _____ 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.			\$	82,318	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	64,795	8	FOR OHF USE ONLY	
		1997	66,654	9	13	FROM R. E. TAX STATEMENT FOR 2000 \$
		1998	68,936	10	14	PLUS APPEAL COST FROM LINE 5 \$
		1999	74,093	11	15	LESS REFUND FROM LINE 6 \$
		2000	77,594	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Accrual = 77,594 x 9/12 = 58,195 + 2,555 (estimated increase) = 60,750						

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 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 Martha Brinkoetter/Shirley Heisserer

TELEPHONE (217) 422-7150 FAX #: (217) 423-6100

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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>04-12-27-231-008</u>	<u>L 0001 B 00 South Franklin Estates</u>	\$ <u>71,754.38</u>	\$ <u>71,754.38</u>
2. <u>04-12-27-278-010</u>	<u>00000105 W. Imboden Dr</u>	\$ <u>5,839.42</u>	\$ <u>5,839.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>77,593.80</u>	\$ <u>77,593.80</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 X NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Imboden Creek Living Center# 0036574 Report Period Beginning:10/01/00 Ending:09/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,960 B. General Construction Type: Exterior Brick Frame Wood Number of Stories OneC. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

10/01/00

Ending:

09/30/01

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF 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	\$	40	\$ 69,324	\$ 69,324	\$ 766,362	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sewer Improvements	1991		15,000		20	750	750	8,250	9
10	Landscaping	1992		2,460	246	10	246		2,296	10
11	Landscaping - Yard Pad	1992		1,000	100	10	100		925	11
12	Carpeting	1992		584	58	10	58		584	12
13	Decorate Act, Room	1992		852	85	10	85		788	13
14	Electrical	1993		2,550	255	10	255		2,189	14
15	Carpeting	1993		791	79	10	79		679	15
16	Carpeting	1993		747	75	10	75		653	16
17	Door	1993		657	66	10	66		520	17
18	Rose Garden Fence	1995		2,495	249	10	249		1,476	18
19	Carpeting	1996		1,121	112	10	112		635	19
20	Drive & Parking Lot	1996		2,065	206	10	206		1,100	20
21	Concrete Drive Service Doors	1995		2,100	210	10	210		1,242	21
22	Carpeting	1997		29,333	2,933	10	2,933		11,489	22
23	Landscaping	1998		2,387	239	10	239		776	23
24	Carpeting	1999		2,258	226	10	226		546	24
25	Curtains	1999		937	94	10	94		164	25
26	Landscaping	2000		877	88	10	88		154	26
27	Carpeting	2000		2,321	232	10	232		309	27
28	Carpeting	2000		3,981	398	10	398		498	28
29	Baseboards for Bathrooms	2000		720	72	10	72		90	29
30	Shower Room Tile	2000		2,954	295	10	295		369	30
31	Baseboards for Bathrooms	2000		466	47	10	47		55	31
32	Floor Covering	2000		1,032	103	10	103		103	32
33	New Roof	2000		51,000	5,100	10	5,100		5,525	33
34	Roof Drains	2000		3,691	369	10	369		369	34
35	Deck	2000		2,668	267	10	267		267	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

STATE OF ILLINOIS

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

10/01/00

Ending:

Page 12A
09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Tile Installation	2000	\$ 1,380	\$ 138	10	\$ 138	\$	\$ 172	37
38	Floor Covering	2000	532	53	10	53		53	38
39	Deck & Handrails	2001	27,848	2,089	10	2,089		2,089	39
40	Siding	2000	1,475	148	10	148		148	40
41	Kitchen Floor/Baseboards	2001	8,244	137	10	137		137	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,949,473	\$ 14,769		\$ 84,843	\$ 70,074	\$ 811,012	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:

10/01/00

Ending:

09/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 452,436	\$ 27,875	\$ 41,789	\$ 13,914	5	\$ 275,972	71
72	Current Year Purchases	10,746	1,259	1,259		5	1,259	72
73	Fully Depreciated Assets	107,696					107,696	73
74								74
75	TOTALS	\$ 570,878	\$ 29,134	\$ 43,048	\$ 13,914		\$ 384,927	75

D. Vehicle Depreciation (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	Staff	1994 Ford Explorer	1995	\$ 20,973	\$	\$	\$	5	\$ 20,973	76
77	Staff	1992 Toyota 4 X 4	1996	10,201	851	851		5	10,201	77
78	Staff	2001 Ford F150	2000	35,174	7,034	7,034		5	8,206	78
79	Staff	See attached		86,267	16,217		(16,217)	5	31,088	79
80	TOTALS			\$ 152,615	\$ 24,102	\$ 7,885	\$ (16,217)		\$ 70,468	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)	\$ 3,784,812	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,005	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,776	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,771	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,266,407	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 - Related Party
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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: \$ 2,190 Description: Ice Machine 1,261 and Dishwasher 929
 (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 aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	39,3	hrs	\$	1,949	\$ 115,203	\$	1,949	\$ 115,203	1
2	Licensed Speech and Language Development Therapist	39,3	hrs		63	3,252		63	3,252	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3	hrs		1,832	106,093		1,832	106,093	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			40,057	2,256		42,313	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies 17,791, Lab 3,654, IV Therapy 5,183	39,2					26,628		26,628	13
14	TOTAL			\$	3,844	\$ 264,605	\$ 28,884	3,844	\$ 293,489	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 10/01/00

Ending:

09/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/01

(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	\$ 3,951	\$ 568,273 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	535,845	539,935 3
4	Supply Inventory (priced at cost)	14,775	14,775 4
5	Short-Term Investments		5
6	Prepaid Insurance	66,502	68,347 6
7	Other Prepaid Expenses	215	215 7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Intercompany</u>	721,335	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,342,623	\$ 1,191,545 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	161,526	161,526 15
16	Equipment, at Historical Cost	228,499	445,210 16
17	Accumulated Depreciation (book methods)	(186,489)	(337,982) 17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (spe <u>Misc.</u>)		450 22
23	Other(specify): <u>Tax Deposit</u>		112,183 23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 203,536	\$ 381,387 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,546,159	\$ 1,572,932 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 65,448	\$ 65,602 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	60,783	62,404 30
31	Accrued Taxes Payable (excluding real estate taxes)	14,692	14,725 31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,250	68,850 32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		4,953 35
Other Current Liabilities(specify):			
36	<u>Advance Billing</u>	233,264	233,263 36
37			1,700 37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 430,437	\$ 451,497 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)	\$ 430,437	\$ 451,497 46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,115,722	\$ 1,121,435 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,546,159	\$ 1,572,932 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 722,909	1
2	Restatements (describe):		2
3	Reclassify prior year sale of goodwill on Sullivan Living		3
4	Center recorded as a distribution on Imboden Creek	370,000	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,092,909	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	374,943	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	(352,130)	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)	\$ 22,813	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)	\$ 1,115,722	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,866,726	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,866,726	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	1,000	24
25	Interest and Other Investment Income***	23,886	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,886	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	9,275	28
28a	Telephone Charges	7,289	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,564	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,908,176	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	806,598	31
32	Health Care	1,041,989	32
33	General Administration	665,831	33
B. Capital Expense			
34	Ownership	668,565	34
C. Ancillary Expense			
35	Special Cost Centers	293,489	35
36	Provider Participation Fee	52,013	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,528,485	40
41	Income before Income Taxes (line 30 minus line 40)**	379,691	41
42	Income Taxes	(4,748)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 374,943	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Living Center**

0036574

Report Period Beginning: 10/01/00

Ending:

09/30/01

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	2,046	2,086	\$ 43,318	\$ 20.77	1
2	Assistant Director of Nursing	1,767	1,767	28,569	16.17	2
3	Registered Nurses	3,032	3,152	49,214	15.61	3
4	Licensed Practical Nurses	18,548	19,215	235,265	12.24	4
5	Nurse Aides & Orderlies	55,569	57,427	468,371	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,400	2,567	21,637	8.43	8
9	Activity Director	1,982	2,086	18,051	8.65	9
10	Activity Assistants	3,057	3,186	22,044	6.92	10
11	Social Service Workers	1,983	2,086	18,837	9.03	11
12	Dietician					12
13	Food Service Supervisor	1,943	2,086	23,160	11.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,765	24,770	167,561	6.76	15
16	Dishwashers					16
17	Maintenance Workers	3,516	3,698	41,851	11.32	17
18	Housekeepers	11,725	12,190	78,351	6.43	18
19	Laundry	5,647	5,791	35,229	6.08	19
20	Administrator	1,942	2,086	82,240	39.42	20
21	Assistant Administrator	1,942	2,086	22,883	10.97	21
22	Other Administrative	2,086	2,086	51,676	24.77	22
23	Office Manager					23
24	Clerical	6,540	6,252	107,685	17.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,834	1,969	15,950	8.10	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Restorative	2,080	2,120	29,121	13.74	32
33	Other(specify) Care Plan	1,813	1,893	22,175	11.71	33
34	TOTAL (lines 1 - 33)	155,217	160,599	\$ 1,583,188 *	\$ 9.86	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	149	\$ 6,818	1,3	35
36	Medical Director	72	13,200	9,3	36
37	Medical Records Consultant	46	2,000	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	600	10,3	39
40	Physical Therapy Consultant	69	3,463	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,333	11,3	44
45	Social Service Consultant	24	1,333	12,3	45
46	Other(specify) Management	78	3,130	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	582	\$ 31,877		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	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 10/01/00Ending: 09/30/01**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. State Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,281 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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 of Public Aid during this cost report period. \$ 52,013
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 of Public Aid, 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. \$ 21,270 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. See Sch XIX-G
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? .4%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1997 Chrysler Town & Country	24,115	\$ 4,823	\$	\$ (4,823)	5	\$ 19,694	76
77	Staff	2001 Lexus	62,152	11,394		(11,394)	5	11,394	77
78									78
79									79
80	TOTALS		86,267	\$ 16,217	\$ 0	\$ (16,217)		\$ 31,088	80

E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		
28	Gain on Sale of Assets	2,000	28
28	Income Tax Refund	7,275	28
28	SUBTOTAL Other Revenue (lines 28)	\$ 9,275	28