

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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 Living Center

**Address:** 180 West Imboden Drive Decatur 62521  
 Number City Zip Code

**County:** Macon

**Telephone Number:** (217) 422-6464 **Fax #** (217) 422-9418

**HFS ID Number:** 37-1122149

**Date of Initial License for Current Owners:** 09/08/1980

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** William Q. Collins **Telephone Number:** (217) 423-6000

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) <u>See Accountants' Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>Thomas K. Leach</u> <u>Member</u>	
	(Firm Name & Address) <u>Sleeper, Disbrow, Morrison, Tarro &amp; Lively, LLC</u> <u>P.O. Box 1460, Decatur, IL 62525-1460</u>	
	(Telephone) <u>(217) 423-6000</u> Fax # <u>(217) 423-6100</u>	

**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 Living Center

# 0036574 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,115</u>	<u>18,414</u>	<u>4,181</u>	<u>31,710</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>9,115</u>	<u>18,414</u>	<u>4,181</u>	<u>31,710</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.45%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 09/08/1990

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 4,069

Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number      Imboden Creek Living Center      #      0036574      Report Period Beginning:      01/01/07      Ending:      12/31/07

**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	
	<b>A. General Services</b>											
1	Dietary	241,488	26,956	20,312	288,756		288,756		288,756			1
2	Food Purchase		276,754		276,754	(71,358)	205,396		205,396			2
3	Housekeeping	119,811	34,600		154,411		154,411		154,411			3
4	Laundry	72,601	18,382	40	91,023		91,023		91,023			4
5	Heat and Other Utilities			106,018	106,018		106,018	3,192	109,210			5
6	Maintenance	47,783	38,308	60,821	146,912		146,912	6,354	153,266			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>481,683</b>	<b>395,000</b>	<b>187,191</b>	<b>1,063,874</b>	<b>(71,358)</b>	<b>992,516</b>	<b>9,546</b>	<b>1,002,062</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,466,837	72,041	10,785	1,549,663		1,549,663		1,549,663			10
10a	Therapy											10a
11	Activities	47,066	1,422	2,391	50,879		50,879		50,879			11
12	Social Services	25,930		1,457	27,387		27,387		27,387			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,539,833</b>	<b>73,463</b>	<b>37,433</b>	<b>1,650,729</b>		<b>1,650,729</b>		<b>1,650,729</b>			16
	<b>C. General Administration</b>											
17	Administrative	193,612			193,612		193,612	40,746	234,358			17
18	Directors Fees											18
19	Professional Services			10,909	10,909		10,909	15,242	26,151			19
20	Dues, Fees, Subscriptions & Promotions			19,329	19,329		19,329	215	19,544			20
21	Clerical & General Office Expenses	30,723	14,979	25,113	70,815		70,815	75,137	145,952			21
22	Employee Benefits & Payroll Taxes			364,543	364,543	71,358	435,901	17,303	453,204			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,007	5,007		5,007	438	5,445			24
25	Other Admin. Staff Transportation			895	895		895		895			25
26	Insurance-Prop.Liab.Malpractice			76,040	76,040		76,040	2,479	78,519			26
27	Other (specify):* <b>Nondeductible exp</b>			48,897	48,897		48,897	(48,897)				27
28	<b>TOTAL General Administration</b>	<b>224,335</b>	<b>14,979</b>	<b>550,733</b>	<b>790,047</b>	<b>71,358</b>	<b>861,405</b>	<b>102,663</b>	<b>964,068</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,245,851</b>	<b>483,442</b>	<b>775,357</b>	<b>3,504,650</b>		<b>3,504,650</b>	<b>112,209</b>	<b>3,616,859</b>			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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			40,980	40,980	40,980	88,373	129,353			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						163,979	163,979			32
33	Real Estate Taxes			91,611	91,611	91,611	5,731	97,342			33
34	Rent-Facility & Grounds			498,000	498,000	498,000	(486,298)	11,702			34
35	Rent-Equipment & Vehicles			1,932	1,932	1,932		1,932			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			632,523	632,523	632,523	(228,215)	404,308			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		137,397	431,094	568,491	568,491		568,491			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	<b>TOTAL Special Cost Centers</b>		137,397	483,107	620,504	620,504		620,504			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,245,851	620,839	1,890,987	4,757,677	4,757,677	(116,006)	4,641,671			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: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,049)	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	750	30		9
10	Interest and Other Investment Income	(31,317)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,261)	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	(622)	27		19
20	Contributions	(9,854)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,533)	27		24
25	Fund Raising, Advertising and Promotional	(12,974)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(2,653)	27		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (92,513)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(280,303)		34
35	Other- Attach Schedule	256,810		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (23,493)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (116,006)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Gifts	\$ (2,653)	27
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	<b>Total</b>	(2,653)	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/07

Ending:

12/31/07**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)	
	<b>A. General Services</b>													
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	3,192	0	0	0	0	0	0	0	0	3,192	5
6	Maintenance	0	0	6,354	0	0	0	0	0	0	0	0	6,354	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>9,546</b>	<b>0</b>	<b>9,546</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	40,746	0	0	0	0	0	0	0	0	40,746	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	15,242	0	0	0	0	0	0	0	0	15,242	19
20	Fees, Subscriptions & Promotions	0	0	215	0	0	0	0	0	0	0	0	215	20
21	Clerical & General Office Expenses	(13,049)	0	88,186	0	0	0	0	0	0	0	0	75,137	21
22	Employee Benefits & Payroll Taxes	0	0	17,303	0	0	0	0	0	0	0	0	17,303	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	438	0	0	0	0	0	0	0	0	438	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	2,479	0	0	0	0	0	0	0	0	2,479	26
27	Other (specify):*	(48,897)	0	0	0	0	0	0	0	0	0	0	(48,897)	27
28	<b>TOTAL General Administration</b>	<b>(61,946)</b>	<b>0</b>	<b>164,609</b>	<b>0</b>	<b>102,663</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(61,946)</b>	<b>0</b>	<b>174,155</b>	<b>0</b>	<b>112,209</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center

# 0036574

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	750	83,239	4,384	0	0	0	0	0	0	0	0	88,373	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,317)	134,458	60,838	0	0	0	0	0	0	0	0	163,979	32
33	Real Estate Taxes	0	0	5,731	0	0	0	0	0	0	0	0	5,731	33
34	Rent-Facility & Grounds	0	(498,000)	11,702	0	0	0	0	0	0	0	0	(486,298)	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	<b>TOTAL Ownership</b>	<b>(30,567)</b>	<b>(280,303)</b>	<b>82,655</b>	<b>0</b>	<b>(228,215)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(92,513)</b>	<b>(280,303)</b>	<b>256,810</b>	<b>0</b>	<b>(116,006)</b>	<b>45</b>							

Facility Name & ID Number Imboden Creek Living Center

# 0036574

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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
John & Martha Brinkoetter	100			Imboden Gardens	Decatur	Assisted Living

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$	John & Martha Brinkoetter	100.00%	\$	\$(498,000)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	83,239	83,239	2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	134,458	134,458	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		\$			\$ 217,697	\$ * (280,303)	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: 01/01/07 Ending: 12/31/07

## 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		26	66.00	Salary	\$ 62,676	17,7	1
2	Martha Brinkoetter	Clerical	Clerical	100.00		26	66.00	Salary	29,994	21,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,670		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: 01/01/07

Ending: 12/31/07

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 Imboden Creek Gardens  
 Street Address 185 W. Imboden Drive  
 City / State / Zip Code Decatur, IL 62521  
 Phone Number ( 217) 233-1425  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Days 48,777	2	\$ 4,910	\$	31,710	\$ 3,192	1
2	6	Supplies-Repairs	Days 48,777	2	336		31,710	218	2
3	6	Repairs & Maintenance	Days 48,777	2	9,438		31,710	6,136	3
4	17	Wages-Administrative	Days 48,777	2	62,676	62,676	31,710	40,746	4
5	19	Professional Services	Days 48,777	2	23,446		31,710	15,242	5
6	20	License & Fees	Days 48,777	2	170		31,710	111	6
7	20	Dues & Subscriptions	Days 48,777	2	160		31,710	104	7
8	21	Wages-Clerical	Days 48,777	2	124,065	124,065	31,710	80,655	8
9	21	Office Supplies	Days 48,777	2	5,216		31,710	3,391	9
10	21	Telephone	Days 48,777	2	4,201		31,710	2,731	10
11	21	Miscellaneous Office	Days 48,777	2	2,167		31,710	1,409	11
12	22	Payroll Taxes	Days 48,777	2	25,287		31,710	16,439	12
13	22	Workers' Comp Insurance	Days 48,777	2	606		31,710	394	13
14	22	Employee Insurance	Days 48,777	2	171		31,710	111	14
15	22	Employee Incentives	Days 48,777	2	552		31,710	359	15
16	24	Travel & Seminar	Days 48,777	2	674		31,710	438	16
17	26	Insurance	Days 48,777	2	3,813		31,710	2,479	17
18	30	Depreciation	Days 48,777	2	6,744		31,710	4,384	18
19	32	Interest	Days 48,777	2	93,582		31,710	60,838	19
20	33	Real Estate Taxes	Days 48,777	2	8,816		31,710	5,731	20
21	34	Rent	Days 48,777	2	18,000		31,710	11,702	21
22									22
23									23
24									24
25	TOTALS				\$ 395,030	\$ 186,741		\$ 256,810	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Regions Bank		X	Real Estate Loan	\$17,632.00	04/27/01	\$ 3,302,473	\$ 2,647,063	04/05/09	5.0000	\$ 134,458	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Regions Bank		X	Line of Credit	Interest Only	10/12/05	1,000,000	1,000,000	02/12/08	7.2500	51,550	6								
7	Regions Bank		X	Line of Credit	Interest Only	12/21/07	200,000	180,175	12/21/08	7.2500	9,288	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$17,632.00		\$ 4,502,473	\$ 3,827,238			\$ 195,296	9								
<b>B. Non-Facility Related*</b>																				
10				Interest Income							(31,317)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(31,317)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,502,473	\$ 3,827,238			\$ 163,979	15								

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

**2006 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 \_\_\_\_\_

TELEPHONE (217) 422-7150 FAX #: (217) 422-9418

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 001 D 00 South Franklin Estates</u>	\$ <u>90,943.02</u>	\$ <u>90,943.02</u>
2. <u>04-12-27-278-010</u>	<u>N1/2 NE1/4 SE1/4 NE1/4 EXC N100</u>	\$ <u>8,751.38</u>	\$ <u>5,689.29</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>99,694.40</u>	\$ <u>96,632.31</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Imboden Creek Living Center

# 0036574 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 33,960 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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).

---

---

---

---

---

---

---

---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>143,748</u>	<u>1988</u>	<u>\$ 111,846</u>	1
2					2
3	<b>TOTALS</b>	<b>143,748</b>		<b>\$ 111,846</b>	<b>3</b>

Facility Name & ID Number **Imboden Creek Living Center**# **0036574**

Report Period Beginning:

**01/01/07**

Ending:

**12/31/07****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1990	1990	\$ 2,772,947	\$	40	\$ 69,324	\$ 69,324	\$ 1,199,637	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Sewer Improvements		1991	15,000		20	750	750	12,938	9
10		Landscaping		1992	2,460		10			2,460	10
11		Landscaping-Yard Pad		1992	1,000		10			1,000	11
12		Carpeting		1992	584		10			584	12
13		Decorate Activity Room		1992	852		10			852	13
14		Electrical		1993	2,550		10			2,550	14
15		Carpeting		1993	791		10			791	15
16		Carpeting		1993	747		10			747	16
17		Door		1993	657		10			657	17
18		Rose Garden Fence		1995	2,495		10			2,495	18
19		Carpeting		1996	1,121		10			1,121	19
20		Drive & Parking Lot		1996	2,065		10			2,065	20
21		Concrete Drive Service Doors		1995	2,100		10			2,100	21
22		Carpeting		1997	29,333	2,444	10	2,444		29,333	22
23		Landscaping		1998	2,387	239	10	239		2,268	23
24		Carpeting		1999	2,258	226	10	226		1,957	24
25		Curtains		1999	937	94	10	94		750	25
26		Landscaping		2000	877	88	10	88		702	26
27		Carpeting		2000	2,321	232	10	232		1,760	27
28		Carpeting		2000	3,981	398	10	398		2,986	28
29		Baseboards for Bathrooms		2000	720	72	10	72		540	29
30		Shower Room Tile		2000	2,954	295	10	295		2,215	30
31		Baseboards for Bathrooms		2000	466	47	10	47		346	31
32		Floor Covering		2000	1,032	103	10	103		748	32
33		New Roof		2000	51,000	5,100	10	5,100		37,400	33
34		Roof Drains		2000	3,691	369	10	369		2,676	34
35		Deck		2000	2,668	267	10	267		1,934	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 &amp; ID Number Imboden Creek Living Center

# 0036574

Report Period Beginning:

01/01/07

Ending:

12/31/07

## XI. 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	
	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	\$	\$ 1,035	37
38	Floor Covering	2000	532	53	10	53		386	38
39	Deck & Handrails	2001	27,848	2,785	10	2,785		19,494	39
40	Siding	2000	1,475	147	10	147		1,069	40
41	Kitchen Floor/Baseboards	2001	8,244	824	10	824		5,290	41
42	Carpeting	2002	1,972		10	128	128	878	42
43	Security System	2002	8,338		10	678	678	4,478	43
44	Outside Door	2002	912		10	59	59	369	44
45	Underground Cable System	2002	9,178		10	597	597	4,172	45
46	Glass Door	2002	1,321		10	86	86	611	46
47	Carpeting	2002	2,732	273	10	273		1,571	47
48	Dining Room Carpeting	2002	11,734	1,173	10	1,173		6,453	48
49	Fire Alarm System	2002	17,894	1,790	10	1,790		9,395	49
50	Roof	2003	5,250		10	341	341	1,818	50
51	Sprinklers	2003	5,970	597	10	597		2,537	51
52	New Water Guard System	2003	2,044	205	10	205		869	52
53	Step by Step Floors	2004	2,723	273	10	273		908	53
54	Nurses Station	2005	21,300	2,130	10	2,130		5,325	54
55	Carpeting-Nurse's Station	2006	3,579	358	10	358		626	55
56	Bathroom Fixture	2007	3,540	295	10	295		295	56
57	Bathroom Flooring	2007	296	20	10	20		20	57
58	Building Awning	2007	2,675	223	10	223		223	58
59	Therapy Room Fixture	2007	1,072	36	10	36		36	59
60	All Body Rebound	2007	643	21	10	21		21	60
61	Powermatic	2007	3,767	125	10	125		125	61
62	Upper and Lower	2007	425	14	10	14		14	62
63	Activity Room	2007	2,665	67	10	67		67	63
64	Vinyl Flooring	2007	2,694	90	10	90		90	64
65	Wallcovering	2007	21,358	90	10	90		90	65
66	Bathroom Flooring	2007	451	30	10	30		30	66
67	Ceiling Light Fixture	2007	432	4	10	4		4	67
68	Desk & Breakfst	2007	500	29	10	29		29	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,084,938	\$ 21,764		\$ 93,727	\$ 71,963	\$ 1,383,940	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: 01/01/07 Ending: 12/31/07

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	\$ 429,237	\$ 16,191	\$ 32,509	\$ 16,318	5	\$ 322,213	71
72	Current Year Purchases	55,447	3,025	3,117	92	5	3,117	72
73	Fully Depreciated Assets	296,150				5	296,150	73
74								74
75	TOTALS	\$ 780,834	\$ 19,216	\$ 35,626	\$ 16,410		\$ 621,480	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	1992 Toyota 4 X 4	1996	\$ 10,201	\$	\$	\$	5	\$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174				5	35,173	77
78	Staff	2001 Lexus LS430	2000	66,573				5	66,573	78
79										79
80	TOTALS			\$ 111,948	\$	\$	\$		\$ 111,947	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)		\$ 4,089,566	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 40,980	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 129,353	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 88,373	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,117,367	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?

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	<b>TOTAL</b>				\$			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 1,932 Description: Ice Machine \$275 & Dishwasher \$1,657

(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	<b>TOTAL</b>		\$	\$	21

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39,3 & 39,2	hrs	\$	4,246	\$ 152,510	\$	4,246	\$ 152,510	1
2	Licensed Speech and Language Development Therapist	39,3 & 39,2	hrs		2,015	118,510		2,015	118,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3 & 39,2	hrs		3,415	160,074	121	3,415	160,195	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Med Supplies, Lab IV</u>	<u>39,2</u>					<u>137,276</u>		<u>137,276</u>	13
14	<b>TOTAL</b>			\$	9,676	\$ 431,094	\$ 137,397	9,676	\$ 568,491	14

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

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 11,514	\$ 3,940	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,464,263	1,608,875	3
4	Supply Inventory (priced at <u>cost</u> )	21,968	29,366	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,598	55,633	6
7	Other Prepaid Expenses		1,315	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	1,558,395		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,096,738	\$ 1,699,129	10
	<b>B. Long-Term Assets</b>			
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	270,020	304,236	15
16	Equipment, at Historical Cost	401,379	724,648	16
17	Accumulated Depreciation (book methods)	(450,196)	(728,461)	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>Deposit</u> )	42,217	42,217	22
23	Other(specify): <u>Note Receivable Stockholder</u>		757,655	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 263,420	\$ 1,100,295	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,360,158	\$ 2,799,424	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 359,847	\$ 402,095	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		61,060	28
29	Short-Term Notes Payable		1,180,175	29
30	Accrued Salaries Payable	94,227	131,377	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,918	13,463	31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,852	227,441	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Advanced Billing</u>	252,089	380,148	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 799,933	\$ 2,395,759	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 799,933	\$ 2,395,759	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,560,225	\$ 403,665	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,360,158	\$ 2,799,424	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,977,184	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,977,184	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	583,041	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 583,041	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,560,225	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/07Ending: 12/31/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,329,459	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,329,459	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	10,460	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 10,460	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Memorial Income</u>	445	28
28a	<u>Miscellaneous Income</u>	353	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 798	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,340,718	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,063,874	31
32	Health Care	1,650,729	32
33	General Administration	790,047	33
<b>B. Capital Expense</b>			
34	Ownership	632,523	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	568,491	35
36	Provider Participation Fee	52,013	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,757,677	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	583,041	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 583,041	43

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

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

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

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

Facility Name & ID Number Imboden Creek Living Center

# 0036574

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	2,080	2,082	\$ 60,779	\$ 29.19	1
2	Assistant Director of Nursing	2,080	2,082	38,145	18.32	2
3	Registered Nurses	3,919	4,115	79,839	19.40	3
4	Licensed Practical Nurses	19,899	21,058	376,327	17.87	4
5	CNAs & Orderlies	76,099	79,390	762,041	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,083	2,183	25,161	11.53	9
10	Activity Assistants	2,757	2,880	21,905	7.61	10
11	Social Service Workers	2,080	2,082	25,930	12.45	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,082	33,585	16.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,085	25,176	207,903	8.26	15
16	Dishwashers					16
17	Maintenance Workers	3,490	2,617	47,783	18.26	17
18	Housekeepers	13,639	14,187	119,811	8.45	18
19	Laundry	8,409	8,693	72,601	8.35	19
20	Administrator	2,080	2,081	123,588	59.39	20
21	Assistant Administrator	2,080	2,081	31,628	15.20	21
22	Other Administrative	2,080	2,081	38,396	18.45	22
23	Office Manager					23
24	Clerical	2,226	2,227	30,723	13.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,122	22,858	10.77	31
32	Other Health Care(specify)	5,573	5,934	82,457	13.90	32
33	Other(specify) <u>Care Plan Coordin</u>	2,080	2,082	44,391	21.32	33
34	TOTAL (lines 1 - 33)	180,795	187,235	\$ 2,245,851 *	\$ 11.99	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	132	\$ 20,312	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	6	2,700	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10,3	39
40	Physical Therapy Consultant	141	7,457	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	28	10,3	43
44	Activity Consultant	6	1,078	11,3	44
45	Social Service Consultant	6	1,457	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	340	\$ 56,432		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number Imboden Creek Living Center

# 0036574

Report Period Beginning: 01/01/07

Ending: 12/31/07

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Luther	Administrative		\$ 123,588	Workers' Compensation Insurance	\$ 60,676	IDPH License Fee	\$ 6,406	
Molly Carpenter	Asst Admin		31,628	Unemployment Compensation Insurance	45,489	Advertising: Employee Recruitment		
Diane Hunt	Human Resources		38,396	FICA Taxes	176,897	Health Care Worker Background Check (Indicate # of checks performed)	2,304	
				Employee Health Insurance	85,597	Patient Background Checks		
				Employee Meals	71,358	Licenses	956	
				Illinois Municipal Retirement Fund (IMRF)*		II Health Care Association	5,438	
				Incentives	12,389	Internet Subscription	2,768	
				Uniforms	(169)	Dues & Subscriptions	1,672	
				Other	653			
				Innoculations	314	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 193,612	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,544
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
							Out-of-State Travel	
							In-State Travel	
							1,240	
							Seminar Expense	
							4,205	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 5,445	
10,909								

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Health Care Assoc. \$5,438
- (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. \$ 36,539 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 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, 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. \$ 71,358 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? 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. \$ 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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 \$5,000, 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.

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Utilities	\$ 3,192	5	1
2	Supplies-Repairs	218	6	2
3	Repairs & Maintenance	6,136	6	3
4	Wages-Administrative	40,746	17	4
5	Professional Services	15,242	19	5
6	License & Fees	111	20	6
7	Dues & Subscriptions	104	20	7
8	Wages-Clerical	80,655	21	8
9	Office Supplies	3,391	21	9
10	Telephone	2,731	21	10
11	Miscellaneous office	1,409	21	11
12	Payroll Taxes	16,439	22	12
13	Workers' Comp Insurance	394	22	13
14	Employee Insurance	111	22	14
15	Employee Incentives	359	22	15
16	Travel & Seminar	438	24	16
17	Insurance	2,479	26	17
18	Depreciation	4,384	30	18
19	Interest	60,838	32	19
20	Real Estate Taxes	5,731	33	20
21	Rent	11,702	34	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	<b>Total</b>	256,810		49