FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 (Number) Decatur (City) 62521 (Zip Code)

County: Macon

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Robert A. Disbrow, Partner
(Firm Name & Address) Sikich LLP, P.O. Box 1460, Decatur, IL 62525-1460
(Telephone) (217) 423-6000 Fax # (217) 423-6100

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	95	34,675	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,191	15,833	4,945	30,969	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,191	15,833	4,945	30,969	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.31%

D. How many bed-hold days during this year were paid by the Department?
65 (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 [X]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 95 and days of care provided 4,563

Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,604	28,749	22,770	310,123		310,123		310,123			1
2	Food Purchase		238,053		238,053	(118,224)	119,829		119,829			2
3	Housekeeping	153,250	38,343		191,593		191,593		191,593			3
4	Laundry	84,180	22,479	40	106,699		106,699		106,699			4
5	Heat and Other Utilities			98,991	98,991		98,991	3,753	102,744			5
6	Maintenance	47,408	30,410	92,234	170,052		170,052	6,264	176,316			6
7	Other (specify):*											7
8	TOTAL General Services	543,442	358,034	214,035	1,115,511	(118,224)	997,287	10,017	1,007,304			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,808,929	95,609	8,642	1,913,180		1,913,180		1,913,180			10
10a	Therapy											10a
11	Activities	47,814	897	2,139	50,850		50,850		50,850			11
12	Social Services	52,762		1,080	53,842		53,842		53,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,909,505	96,506	34,661	2,040,672		2,040,672		2,040,672			16
	C. General Administration											
17	Administrative	59,119			59,119		59,119	157,414	216,533			17
18	Directors Fees											18
19	Professional Services			36,019	36,019		36,019	31,196	67,215			19
20	Dues, Fees, Subscriptions & Promotions			17,038	17,038		17,038	137	17,175			20
21	Clerical & General Office Expenses	56,590	11,957	35,542	104,089		104,089	68,930	173,019			21
22	Employee Benefits & Payroll Taxes			390,068	390,068	118,224	508,292	20,381	528,673			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,570	6,570		6,570	83	6,653			24
25	Other Admin. Staff Transportation			1,125	1,125		1,125	195	1,320			25
26	Insurance-Prop.Liab.Malpractice			31,463	31,463		31,463	3,180	34,643			26
27	Other (specify):* Nondeductible Exp			129,156	129,156		129,156	(129,156)				27
28	TOTAL General Administration	115,709	11,957	646,981	774,647	118,224	892,871	152,360	1,045,231			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,568,656	466,497	895,677	3,930,830		3,930,830	162,377	4,093,207			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			97,026	97,026		97,026	82,884	179,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							121,510	121,510			32
33	Real Estate Taxes			90,996	90,996		90,996	5,660	96,656			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(498,000)				34
35	Rent-Equipment & Vehicles			400	400		400		400			35
36	Other (specify):*											36
37	TOTAL Ownership			686,422	686,422		686,422	(287,946)	398,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,649	922,502	1,108,151		1,108,151		1,108,151			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		185,649	974,515	1,160,164		1,160,164		1,160,164			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,568,656	652,146	2,556,614	5,777,416		5,777,416	(125,569)	5,651,847			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,387)	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	562	30		9
10	Interest and Other Investment Income	(2,062)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,179)	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	(231)	27		19
20	Contributions	(7,460)	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	(91,896)	27		24
25	Fund Raising, Advertising and Promotional	(27,550)	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 Gifts	(840)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,043)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(297,001)		34
35	Other- Attach Schedule **See Sch VII**	310,475		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13,474		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,569)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (840)	27	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	(840)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Imboden Creek Living Center **#** 0036574 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,753	0	0	0	0	0	0	0	0	3,753	5
6	Maintenance	0	0	6,264	0	0	0	0	0	0	0	0	6,264	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	10,017	0	0	0	0	0	0	0	0	10,017	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	157,414	0	0	0	0	0	0	0	0	157,414	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	31,196	0	0	0	0	0	0	0	0	31,196	19
20	Fees, Subscriptions & Promotions	0	0	137	0	0	0	0	0	0	0	0	137	20
21	Clerical & General Office Expenses	(8,387)	0	77,317	0	0	0	0	0	0	0	0	68,930	21
22	Employee Benefits & Payroll Taxes	0	0	20,381	0	0	0	0	0	0	0	0	20,381	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	83	0	0	0	0	0	0	0	0	83	24
25	Other Admin. Staff Transportation	0	0	195	0	0	0	0	0	0	0	0	195	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,180	0	0	0	0	0	0	0	0	3,180	26
27	Other (specify):*	(129,156)	0	0	0	0	0	0	0	0	0	0	(129,156)	27
28	**TOTAL General Administration**	(137,543)	0	289,903	0	0	0	0	0	0	0	0	152,360	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(137,543)	0	299,920	0	0	0	0	0	0	0	0	162,377	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Imboden Creek Living Center** **# 0036574** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	562	78,996	3,326	0	0	0	0	0	0	0	0	82,884	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,062)	122,003	1,569	0	0	0	0	0	0	0	0	121,510	32
33	Real Estate Taxes	0	0	5,660	0	0	0	0	0	0	0	0	5,660	33
34	Rent-Facility & Grounds	0	(498,000)	0	0	0	0	0	0	0	0	0	(498,000)	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	(1,500)	(297,001)	10,555	0	0	0	0	0	0	0	0	(287,946)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(139,043)	(297,001)	310,475	0	0	0	0	0	0	0	0	(125,569)	45

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 498,000	John &Martha Brinkoetter	100.00%	$	$ (498,000)	1
2	V	30	Depreciation		John &Martha Brinkoetter	100.00%	78,996	78,996	2
3	V	32	Interest		John &Martha Brinkoetter	100.00%	122,003	122,003	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			$ 498,000			$ 200,999	$ * (297,001)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$ (3,753)			$	$ 3,753	15
16	V	6	Supplies-Repairs	(1,231)				1,231	16
17	V	6	Repairs & Maintenance	(5,033)				5,033	17
18	V	17	Wages-Administrative	(157,414)				157,414	18
19	V	19	Professional Services	(31,034)				31,034	19
20	V	20	License & Fees	(137)				137	20
21	V	21	Wages-Clerical	(66,290)				66,290	21
22	V	21	Office Supplies	(4,441)				4,441	22
23	V	21	Telephone	(3,031)				3,031	23
24	V	21	Miscellaneous Office	(3,555)				3,555	24
25	V	22	Payroll Taxes	(15,779)				15,779	25
26	V	22	Workers' Comp Insurance	(361)				361	26
27	V	22	Employee Insurance	(3,869)				3,869	27
28	V	22	Uniforms	18				(18)	28
29	V	22	Employee Incentives	(390)				390	29
30	V	24	Travel & Seminar	(83)				83	30
31	V	25	Other Admin Staff Trans	(195)				195	31
32	V	26	Insurance	(3,180)				3,180	32
33	V	30	Depreciation	(3,326)				3,326	33
34	V	32	Interest	(1,569)				1,569	34
35	V	33	Real Estate Taxes	(5,660)				5,660	35
36	V	19	Professional Fees	(162)				162	36
37	V								37
38	V								38
39	Total			$ (310,475)			$ 0	$ * 310,475	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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	30,406	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	$ 93,082		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: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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: (217) 233-1777

	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	5	Utilities	Days	47,759	2	$ 5,788	$	30,969	$ 3,753	1
2	6	Supplies-Repairs	Days	47,759	2	1,898		30,969	1,231	2
3	6	Repairs & Maintenance	Days	47,759	2	7,761		30,969	5,033	3
4	17	Wages-Administrative	Days	47,759	2	242,757	242,757	30,969	157,414	4
5	19	Professional Fees	Days	47,759	2	47,860		30,969	31,034	5
6	20	License & Fees	Days	47,759	2	212		30,969	137	6
7	21	Wages-Clerical	Days	47,759	2	102,229	102,229	30,969	66,290	7
8	21	Office Supplies	Days	47,759	2	6,848		30,969	4,441	8
9	21	Telephone	Days	47,759	2	4,674		30,969	3,031	9
10	21	Miscellaneous Office	Days	47,759	2	5,482		30,969	3,555	10
11	22	Payroll Taxes	Days	47,759	2	24,334		30,969	15,779	11
12	22	Workers' Comp Insurance	Days	47,759	2	556		30,969	361	12
13	22	Employee Insurance	Days	47,759	2	5,966		30,969	3,869	13
14	22	Uniforms	Days	47,759	2	(28)		30,969	(18)	14
15	22	Employee Incentives	Days	47,759	2	602		30,969	390	15
16	24	Travel & Seminar	Days	47,759	2	128		30,969	83	16
17	25	Other Admin Staff Trans	Days	47,759	2	301		30,969	195	17
18	26	Insurance	Days	47,759	2	4,904		30,969	3,180	18
19	30	Depreciation	Days	47,759	2	5,129		30,969	3,326	19
20	32	Interest	Days	47,759	2	2,420		30,969	1,569	20
21	33	Real Estate Taxes	Days	47,759	2	8,729		30,969	5,660	21
22	19	Professional Fees	Days	47,759	2	250		30,969	162	22
23										23
24										24
25	TOTALS					$ 478,800	$ 344,986		$ 310,475	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Regions Bank		X	Real Estate Loan	$54,300.00	10/13/09	$ 7,583,621	$ 7,456,137	10/13/12	5.5100	$ 122,003	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank		X	Line of Credit	Interest Only	10/13/09	500,000		10/13/10	3.2500	1,569	6
7												7
8												8
9	TOTAL Facility Related				$54,300.00		$ 8,083,621	$ 7,456,137			$ 123,572	9
	B. Non-Facility Related*											
10				Interest Income							(2,062)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,062)	14
15	TOTALS (line 9+line14)						$ 8,083,621	$ 7,456,137			$ 121,510	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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:** 01/01/10 **Ending:** 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 93,174	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.)		$ 94,891	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,717	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 94,939	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 96,656	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	97,999	8
	2006	99,694	9
	2007	95,077	10
	2008	96,150	11
	2009	98,030	12

Nursing Home $89,239
Corp Office-allocated $8,792 x .64844323 = $5,701

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 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 William Q. Collins

TELEPHONE (217) 423-6000 FAX #: (217) 423-6100

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-27-231-008	L 001 B 00 South Franklin Estates	$ 89,238.60	$ 89,238.60
2.	04-12-27-278-010	N1/2 NE1/4 SE1/4 NE1/4 EXC N100(	$ 8,791.58	$ 5,700.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 98,030.18	$ 94,939.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	143,748	1988	$ 111,846	1
2					2
3	TOTALS	143,748		$ 111,846	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 1,407,609	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Improvements			1991	15,000		20	562	562	15,000	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		10			29,333	22
23	Landscaping			1998	2,387		10			2,387	23
24	Carpeting			1999	2,258		10			2,258	24
25	Carpeting			1999	937		10			937	25
26	Landscaping			2000	877		10			877	26
27	Carpeting			2000	2,321	97	10	97		2,321	27
28	Carpeting			2000	3,981	199	10	199		3,981	28
29	Baseboards for Bathrooms			2000	720	36	10	36		720	29
30	Shower Room Tile			2000	2,954	148	10	148		2,954	30
31	Baseboards for Bathrooms			2000	466	27	10	27		466	31
32	Floor Covering			2000	1,032	77	10	77		1,032	32
33	New Roof			2000	51,000	3,400	10	3,400		51,000	33
34	Roof Drains			2000	3,691	277	10	277		3,691	34
35	Deck			2000	2,668	200	10	200		2,668	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tile Installation	2000	$ 1,380	$ 69	10	$ 69	$	$ 1,380	37
38	Floor Covering	2000	532	40	10	40		532	38
39	Deck & Handrails	2001	27,848	2,785	10	2,785		27,848	39
40	Siding	2000	1,475	111	10	111		1,475	40
41	Kitchen Floor/Baseboards	2001	8,244	824	10	824		7,763	41
42	Carpeting	2002	1,972		10	128	128	1,263	42
43	Security System	2002	8,338		10	281	281	6,119	43
44	Outside Door	2002	912		10	59	59	547	44
45	Underground Cable System	2002	9,178		10	595	595	5,964	45
46	Glass Door	2002	1,321		10	86	86	870	46
47	Carpeting	2002	2,732	273	10	273		2,391	47
48	Dining Room Carpeting	2002	11,734	1,173	10	1,173		9,974	48
49	Fire Alarm System	2002	17,894	1,789	10	1,789		14,763	49
50	Roof	2003	5,250		10	340	340	2,842	50
51	Sprinklers	2003	5,970	597	10	597		4,328	51
52	New Water Guard System	2003	2,044	204	10	204		1,482	52
53	Step by Step Floors	2004	2,723	272	10	272		1,725	53
54	Nurses Station	2005	21,300	2,130	10	2,130		11,715	54
55	Carpeting-Nurse's Station	2006	3,579	358	10	358		1,700	55
56	Bathroom Fixture	2007	3,540	354	10	354		1,357	56
57	Bathroom Flooring	2007	296	30	10	30		109	57
58	Building Awning	2007	2,675	268	10	268		1,025	58
59	Therapy Room Fixture	2007	1,072	107	10	107		357	59
60	All Body Rebound	2007	643	64	10	64		214	60
61	Powermate Mat Platform	2007	3,767	377	10	377		1,256	61
62	Upper and Lower Cabinets	2007	425	43	10	43		142	62
63	Activity Room	2007	2,665	267	10	267		866	63
64	Vinyl Flooring	2007	2,694	269	10	269		898	64
65	Wallcovering	2007	21,358	2,136	10	2,136		6,498	65
66	Bathroom Flooring	2007	451	45	10	45		165	66
67	Ceiling Light Fixture	2007	432	43	10	43		133	67
68	Deck & Breakfast	2007	500	50	10	50		179	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,084,938	$ 19,139		$ 90,515	$ 71,376	$ 1,662,536	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,084,938	$ 19,139		$ 90,515	$ 71,376	$ 1,662,536	1
2	Remodeling - Wallpaper	2008	6,280	628	10	628		1,832	2
3	Remodeling - Bathrooms	2008	1,170	117	10	117		341	3
4	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		555	4
5	Cornices and Cascases - Front Living	2008	1,503	150	10	150		439	5
6	Fixtures -HD Supply	2008	1,589	159	10	159		463	6
7	Lighting	2008	620	62	10	62		181	7
8	Cascades	2008	9,935	994	10	994		2,815	8
9	Remodeling - HD Facilities Maintenance	2008	296	30	10	30		82	9
10	Remodeling - Lowe's	2008	535	55	10	55		152	10
11	Signage	2008	6,650	665	10	665		1,773	11
12	Light Fixtures	2008	2,183	218	10	218		600	12
13	Light Fixtures	2008	730	73	10	73		201	13
14	Carpeting - Aimee and Andy Hall	2008	25,198	2,520	10	2,520		6,929	14
15	Flooring - VCI	2008	1,866	187	10	187		513	15
16	Carpeting	2008	113,974	11,397	10	11,397		31,343	16
17	Carpeting - Flooring America	2008	10,576	1,058	10	1,058		2,732	17
18	Signage	2008	534	53	10	53		142	18
19	Plumbing and Toilet Fixtures	2008	469	47	10	47		125	19
20	Painting and Wallcovering	2008	4,350	435	10	435		1,088	20
21	Carpeting	2008	7,184	718	10	718		1,856	21
22	Light Fixtures	2008	303	30	10	30		81	22
23	Coves, Base Cabinets and Hardware	2008	725	72	10	72		175	23
24	Bathroom Fixtures	2008	521	52	10	52		117	24
25	Indoor Signs	2008	694	69	10	69		146	25
26	Cabling	2009	961	96	10	96		184	26
27	Vanities	2009	551	55	10	55		101	27
28	HVAC Rooftop Unit	2009	10,150	1,015	10	1,015		1,523	28
29	Cornices	2009	2,343	234	10	234		351	29
30	8 Vanities/Faucets	2009	986	99	10	99		140	30
31	Flooring	2009	364	36	10	36		55	31
32	Sidewalks, stairs	2009	20,060		10	1,301	1,301	2,177	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,320,087	$ 40,648		$ 113,324	$ 72,676	$ 1,721,748	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,320,087	$ 40,648		$ 113,324	$ 72,676	$ 1,721,748	1
2	Windsor Collection	2010	797	100	10	100		100	2
3	5 EasyCare Bed	2010	4,894	857	10	857		856	3
4	2 PTAC P-410A Model	2010	1,245	156	10	156		156	4
5	Awning	2010	18,602	155	10	155		155	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	TOTAL (lines 1 thru 33)		$ 3,345,625	$ 41,916		$ 114,592	$ 72,676	$ 1,723,015	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/10 Ending: 12/31/10

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	$ 728,905	$ 52,594	$ 62,801	$ 10,207	5	$ 452,122	71
72	Current Year Purchases	30,185	2,517	2,517		5	2,517	72
73	Fully Depreciated Assets	347,160				5	334,816	73
74								74
75	TOTALS	$ 1,106,250	$ 55,111	$ 65,318	$ 10,207		$ 789,455	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 LX340	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)	$ 4,675,669	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,027	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,910	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 82,883	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,624,417	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-Related Entity
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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 400 Description: Dishwasher
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39,3	hrs	$	2,996	$ 220,951	$	2,996	$ 220,951	1
2	Licensed Speech and Language Development Therapist	39,3	hrs		920	66,218		920	66,218	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3	hrs		5,839	405,333		5,839	405,333	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy Services					230,000			230,000	12
13	Other (specify): Med Supplies, Lab IV	39,2					185,649		185,649	13
14	TOTAL			$	9,755	$ 922,502	$ 185,649	9,755	$ 1,108,151	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,513	$ 169,392	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	623,139	775,846	3
4	Supply Inventory (priced at Cost)	12,038	18,415	4
5	Short-Term Investments			5
6	Prepaid Insurance	30,062	44,810	6
7	Other Prepaid Expenses	16,773	25,266	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	3,771,178		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,459,703	$ 1,033,729	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	510,648	569,942	15
16	Equipment, at Historical Cost	723,729	1,106,265	16
17	Accumulated Depreciation (book methods)	(700,130)	(1,046,604)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,335		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,335)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): New Construction		44,945	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 534,247	$ 674,548	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,993,950	$ 1,708,277	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 359,833	$ 400,214	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		45,500	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,314	51,337	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,138	33,001	31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,285	237,333	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,651	35
	Other Current Liabilities(specify):			
36	Advance Billing	240,256	369,413	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 747,826	$ 1,139,449	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)**	$ 747,826	$ 1,139,449	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,246,124	$ 568,828	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,993,950	$ 1,708,277	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,797,897	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,797,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	448,227	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)**	$ 448,227	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)**	$ 4,246,124	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,211,942	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,211,942	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	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	8,387	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)**	$ 8,387	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,062	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,062	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Memorial Income	2,985	28
28a	Miscellaneous Income	267	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,252	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,225,643	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,115,511	31
32	Health Care	2,040,672	32
33	General Administration	774,647	33
	B. Capital Expense		
34	Ownership	686,422	34
	C. Ancillary Expense		
35	Special Cost Centers	1,108,151	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)***	$ 5,777,416	40
41	**Income before Income Taxes (line 30 minus line 40)****	448,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 448,227	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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,776	1,787	$ 54,559	$ 30.53	1
2	Assistant Director of Nursing	1,128	1,290	26,268	20.36	2
3	Registered Nurses	4,887	5,021	118,571	23.62	3
4	Licensed Practical Nurses	20,749	24,370	417,731	17.14	4
5	CNAs & Orderlies	87,240	91,332	913,331	10.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,155	2,180	23,711	10.88	9
10	Activity Assistants	2,604	2,706	24,103	8.91	10
11	Social Service Workers	2,009	2,330	52,762	22.64	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,164	37,588	17.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,165	25,347	221,016	8.72	15
16	Dishwashers					16
17	Maintenance Workers	3,006	3,309	47,408	14.33	17
18	Housekeepers	16,199	17,121	153,250	8.95	18
19	Laundry	8,915	9,504	84,180	8.86	19
20	Administrator	2,160	2,161	59,119	27.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,555	4,684	56,590	12.08	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	1,967	2,135	25,818	12.09	31
32	Other Health C: Care Plan Coord	6,538	6,544	137,734	21.05	32
33	Other(specify) Restorative	6,997	7,420	114,917	15.49	33
34	TOTAL (lines 1 - 33)	199,210	211,405	$ 2,568,656 *	$ 12.15	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	481	$ 22,770	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	34	2,348	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	6,260	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,484	11,3	44
45	Social Service Consultant	12	1,080	12,3	45
46	Other(specify)				46
47	Medicare Consulting	32	8,650	19,3	47
48					48
49	TOTAL (lines 35 - 48)	630	$ 65,392		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Molly Carpenter	Administrator		$ 59,119
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,119

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Poisinelli Shughart, PC	Legal	$ 6,531
Brinkoetter Law Office	Legal	5,263
Chapin & Long PC	Legal	2,100
FR&R Healthcare Consultants	Consultants	8,650
Sikich, LLP	Accounting	9,275
BKD, LLP	Medicare Consutants	4,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 36,019

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,717
Unemployment Compensation Insurance	18,915
FICA Taxes	205,723
Employee Health Insurance	104,801
Employee Meals	118,224
Illinois Municipal Retirement Fund (IMRF)*	
Incentives	8,177
Uniforms	1,768
Other	6,106
Innoculations	1,242
TOTAL (agree to Schedule V, line 22, col.8)	$ 528,673

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,650
Health Care Worker Background Check	
(Indicate # of checks performed 101)	2,264
Patient Background Checks 72	944
Licenses	969
Dues & Subscriptions	954
Internet Subscription	482
IL Health Care Association	8,667
IPAC Dues	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,175

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,040
Seminar Expense	3,613
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,653

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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. $8,667**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,749** 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.

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(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. $ **118,224** 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**

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.