FOR BHF USE

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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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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) 422-9148

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: William 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 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed)
(Date)
(Print Name and Title) See Accountant's Compilation Report
(Firm Name & Address) Sikich, LLP, 132 S. Water Street, Suite 300, Decatur, IL 62523
(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: 01/01/12 Ending: 12/31/12

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	34,770	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	34,770	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	7,400	17,710	4,569	29,679	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,400	17,710	4,569	29,679	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.36%

D. How many bed-hold days during this year were paid by the Department?
48 (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 _____

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: 12/31/12 Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	267,140	29,141	22,189	318,470		318,470		318,470			1
2	Food Purchase		240,516		240,516	(129,052)	111,464		111,464			2
3	Housekeeping	129,144	35,557	300	165,001		165,001		165,001			3
4	Laundry	78,944	20,007		98,951		98,951		98,951			4
5	Heat and Other Utilities			91,081	91,081		91,081	3,464	94,545			5
6	Maintenance	82,486	53,710	101,114	237,310		237,310	2,957	240,267			6
7	Other (specify):*											7
8	TOTAL General Services	557,714	378,931	214,684	1,151,329	(129,052)	1,022,277	6,421	1,028,698			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,751,228	83,905	7,131	1,842,264		1,842,264		1,842,264			10
10a	Therapy											10a
11	Activities	61,697	3,504	4,200	69,401		69,401		69,401			11
12	Social Services	72,730		1,744	74,474		74,474		74,474			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,885,655	87,409	35,875	2,008,939		2,008,939		2,008,939			16
	C. General Administration											
17	Administrative	113,505			113,505		113,505	169,975	283,480			17
18	Directors Fees											18
19	Professional Services			10,263	10,263		10,263	20,833	31,096			19
20	Dues, Fees, Subscriptions & Promotions			13,670	13,670		13,670	299	13,969			20
21	Clerical & General Office Expenses	21,834	17,219	30,752	69,805		69,805	79,965	149,770			21
22	Employee Benefits & Payroll Taxes			353,943	353,943	129,052	482,995	25,995	508,990			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,777	9,777		9,777		9,777			24
25	Other Admin. Staff Transportation			1,997	1,997		1,997	942	2,939			25
26	Insurance-Prop.Liab.Malpractice			34,287	34,287		34,287	2,445	36,732			26
27	Other (specify):* Nondeductible Exp			46,130	46,130		46,130	(46,130)				27
28	TOTAL General Administration	135,339	17,219	500,819	653,377	129,052	782,429	254,324	1,036,753			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,578,708	483,559	751,378	3,813,645		3,813,645	260,745	4,074,390			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: 01/01/12 Ending: 12/31/12

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			94,325	94,325		94,325	71,661	165,986			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							114,962	114,962			32
33	Real Estate Taxes			88,280	88,280		88,280	4,105	92,385			33
34	Rent-Facility & Grounds			534,000	534,000		534,000	(534,000)				34
35	Rent-Equipment & Vehicles			400	400		400		400			35
36	Other (specify):*											36
37	**TOTAL Ownership**			717,005	717,005		717,005	(343,272)	373,733			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,065	465,419	573,484		573,484		573,484			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			204,973	204,973		204,973		204,973			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		108,065	670,392	778,457		778,457		778,457			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,578,708	591,624	2,138,775	5,309,107		5,309,107	(82,527)	5,226,580			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: 01/01/12 Ending: 12/31/12

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	(4,197)	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				9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				19
20	Contributions	(7,634)	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	(3,220)	27		24
25	Fund Raising, Advertising and Promotional	(34,764)	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	(512)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,328)		$	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)	(352,075)		34
35	Other- Attach Schedule	319,876		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (32,199)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (82,527)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (512)	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**	(512)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,464	0	0	0	0	0	0	0	0	3,464	5
6	Maintenance	0	0	2,957	0	0	0	0	0	0	0	0	2,957	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	6,421	0	0	0	0	0	0	0	0	6,421	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	169,975	0	0	0	0	0	0	0	0	169,975	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	20,833	0	0	0	0	0	0	0	0	20,833	19
20	Fees, Subscriptions & Promotions	0	0	299	0	0	0	0	0	0	0	0	299	20
21	Clerical & General Office Expenses	(4,197)	0	84,162	0	0	0	0	0	0	0	0	79,965	21
22	Employee Benefits & Payroll Taxes	0	0	25,995	0	0	0	0	0	0	0	0	25,995	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	942	0	0	0	0	0	0	0	0	942	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,445	0	0	0	0	0	0	0	0	2,445	26
27	Other (specify):*	(46,130)	0	0	0	0	0	0	0	0	0	0	(46,130)	27
28	**TOTAL General Administration**	(50,327)	0	304,651	0	0	0	0	0	0	0	0	254,324	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,327)	0	311,072	0	0	0	0	0	0	0	0	260,745	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	69,324	2,337	0	0	0	0	0	0	0	0	71,661	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1)	112,601	2,362	0	0	0	0	0	0	0	0	114,962	32
33	Real Estate Taxes	0	0	4,105	0	0	0	0	0	0	0	0	4,105	33
34	Rent-Facility & Grounds	0	(534,000)	0	0	0	0	0	0	0	0	0	(534,000)	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)	(352,075)	8,804	0	0	0	0	0	0	0	0	(343,272)	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)	(50,328)	(352,075)	319,876	0	0	0	0	0	0	0	0	(82,527)	45

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John & Martha Brinkoetter	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 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	$ 534,000	John & Martha Brinkoetter	100.00%	$	$ (534,000)	1
2	V	30	Depreciation		John & Martha Brinkoetter	100.00%	69,324	69,324	2
3	V	32	Interest		John & Martha Brinkoetter	100.00%	112,601	112,601	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			$ 534,000			$ 181,925	$ * (352,075)	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: 01/01/12 Ending: 12/31/12

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	$	Corporte Center		$ 3,464	$ 3,464	15
16	V	6	Supplies-Repairs		Corporte Center		169	169	16
17	V	6	Repairs & Maintenance		Corporte Center		2,788	2,788	17
18	V	17	Wages-Administrative		Corporte Center		169,975	169,975	18
19	V	19	Professional Fees		Corporte Center		20,833	20,833	19
20	V	20	License & Fees		Corporte Center		202	202	20
21	V	20	Dues & Subscriptions		Corporte Center		97	97	21
22	V	21	Wages-Clerical		Corporte Center		72,836	72,836	22
23	V	21	Office Supplies		Corporte Center		4,337	4,337	23
24	V	21	Telephone		Corporte Center		2,694	2,694	24
25	V	21	Miscellaneous Office		Corporte Center		4,295	4,295	25
26	V	22	Payroll Taxes		Corporte Center		17,896	17,896	26
27	V	22	Workers' Comp Insurance		Corporte Center		1,041	1,041	27
28	V	22	Employee Insurance		Corporte Center		6,991	6,991	28
29	V	22	Uniforms		Corporte Center		1	1	29
30	V	22	Employee Incentives		Corporte Center		74	74	30
31	V	22	EE Innoculations		Corporte Center		(8)	(8)	31
32	V	25	Auto Expense		Corporte Center		942	942	32
33	V	26	Insurance		Corporte Center		2,445	2,445	33
34	V	30	Depreciation		Corporte Center		2,337	2,337	34
35	V	32	Interest		Corporte Center		2,362	2,362	35
36	V	33	Real Estate Taxes		Corporte Center		4,105	4,105	36
37	V				Corporte Center				37
38	V								38
39	Total			$			$ 319,876	$ * 319,876	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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$ 62,847	17,7	1
2	Martha Brinkoetter	Clerical	Clerical	100.00		26	66.00	Salary	30,158	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	$ 93,005		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	45,929	2	$ 5,360	$	29,679	$ 3,464	1
2	6	Supplies-Repairs	Days	45,929	2	261		29,679	169	2
3	6	Repairs & Maintenance	Days	45,929	2	4,314		29,679	2,788	3
4	17	Wages-Administrative	Days	45,929	2	263,041	263,041	29,679	169,975	4
5	19	Professional Fees	Days	45,929	2	32,239		29,679	20,833	5
6	20	License & Fees	Days	45,929	2	312		29,679	202	6
7	20	Dues & Subscriptions	Days	45,929	2	150		29,679	97	7
8	21	Wages-Clerical	Days	45,929	2	112,715	112,715	29,679	72,836	8
9	21	Office Supplies	Days	45,929	2	6,711		29,679	4,337	9
10	21	Telephone	Days	45,929	2	4,169		29,679	2,694	10
11	21	Miscellaneous Office	Days	45,929	2	6,646		29,679	4,295	11
12	22	Payroll Taxes	Days	45,929	2	27,695		29,679	17,896	12
13	22	Workers' Comp Insurance	Days	45,929	2	1,611		29,679	1,041	13
14	22	Employee Insurance	Days	45,929	2	10,819		29,679	6,991	14
15	22	Uniforms	Days	45,929	2	1		29,679	1	15
16	22	Employee Incentives	Days	45,929	2	114		29,679	74	16
17	22	EE Innoculations	Days	45,929	2	(13)		29,679	(8)	17
18	25	Auto Expense	Days	45,929	2	1,457		29,679	942	18
19	26	Insurance	Days	45,929	2	3,783		29,679	2,445	19
20	30	Depreciation	Days	45,929	2	3,616		29,679	2,337	20
21	32	Interest	Days	45,929	2	3,655		29,679	2,362	21
22	33	Real Estate Taxes	Days	45,929	2	6,353		29,679	4,105	22
23										23
24										24
25	TOTALS					$ 495,009	$ 375,756		$ 319,876	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	10/21/11	$ 7,583,621	$ 6,804,625	10/21/16	4.9700	$ 112,601	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank		X	Line of Credit	Interest Only	04/18/12	500,000	176,000	04/18/13	4.2500	2,362	6
7												7
8												8
9	TOTAL Facility Related				$54,300.00		$ 8,083,621	$ 6,980,625			$ 114,963	9
	B. Non-Facility Related*											
10				Interest Income							(1)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1)	14
15	TOTALS (line 9+line14)						$ 8,083,621	$ 6,980,625			$ 114,962	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: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 95,379	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.)		$ 93,891	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,488)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,873	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.		$ 92,385	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	95,077	8
	2008	96,150	9
	2009	98,030	10
	2010	94,939	11
	2011	93,873	12

Nursing Home $88,674
Corp. Office-allocated $8,046 x .646193037 = $5,199

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 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) 423-600 FAX #: (217) 423-6100

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-27-231-008	L001 B 00 South Franklin Estates	$ 88,674.02	$ 88,674.02
2.	04-12-27-278-010	N1/2 NE 1/4 SE1/4 NE1/4 EXC N 10	$ 8,046.00	$ 5,199.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 96,720.02	$ 93,873.28

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 1,546,257	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Improvements			1991	15,000		20			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			1992	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			1993	2,495		10			2,495	18
19	Carpeting			1995	1,121		10			1,121	19
20	Drive & Parking Lot			1996	2,065		10			2,065	20
21	Concrete Drive Service Doors			1996	2,100		10			2,100	21
22	Carpeting			1995	29,333		10			29,333	22
23	Landscaping			1997	2,387		10			2,387	23
24	Carpeting			1998	2,258		10			2,258	24
25	Carpeting			1999	937		10			937	25
26	Landscaping			1999	877		10			877	26
27	Carpeting			2000	2,321		10			2,321	27
28	Carpeting			2000	3,981		10			3,981	28
29	Baseboards for Bathrooms			2000	720		10			720	29
30	Shower Room Tile			2000	2,954		10			2,954	30
31	Baseboards for Bathrooms			2000	466		10			466	31
32	Floor Covering			2000	1,032		10			1,032	32
33	New Roof			2000	51,000		10			51,000	33
34	Roof Drains			2000	3,691		10			3,691	34
35	Deck			2000	2,668		10			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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tile Installation	2000	$ 1,380	$		$	$	$ 1,380	37
38	Floor Covering	2000	532					532	38
39	Deck & Handrails	2001	27,848					27,848	39
40	Siding	2000	1,475					1,475	40
41	Kitchen Floor/Baseboards	2001	8,244					8,244	41
42	Carpeting	2002	1,972			31	31	1,422	42
43	Security System	2002	8,338					6,119	43
44	Outside Doors	2002	912			39	39	645	44
45	Underground Cable System	2002	9,178			99	99	6,658	45
46	Glass Door	2002	1,321			7	7	963	46
47	Carpeting	2002	2,732	68		68		2,732	47
48	Dining Room Carpeting	2002	11,734	587		587		11,734	48
49	Fire Alarm System	2002	17,894	1,342		1,342		17,894	49
50	Roof	2003	5,250			339	339	3,521	50
51	Sprinklers	2003	5,970	597		597		5,522	51
52	New Water Guard System	2003	2,044	204		204		1,891	52
53	Step by Step Floors	2004	2,723	272		272		2,269	53
54	Nurses Station	2005	21,300	2,130		2,130		15,975	54
55	Carpeting-Nurse's Station	2006	3,579	358		358		2,416	55
56	Bathroom Fixture	2007	3,540	354		354		2,065	56
57	Bathroom Flooring	2007	296	30		30		168	57
58	Building Awning	2007	2,675	268		268		1,560	58
59	Therapy Room Fixture	2007	1,072	107		107		572	59
60	All Body Rebound	2007	643	64		64		343	60
61	Powermate Mat Platform	2007	3,767	377		377		2,009	61
62	Upper and Lower Cabinets	2007	425	43		43		227	62
63	Activity Room	2007	2,665	267		267		1,399	63
64	Vinyl Flooring	2007	2,694	269		269		1,437	64
65	Wallcovering	2007	21,358	2,136		2,136		10,769	65
66	Bathroom Flooring	2007	451	45		45		255	66
67	Ceiling Light Fixture	2007	432	43		43		220	67
68	Deck & Breakfast	2007	500	50		50		279	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,084,938	$ 9,611		$ 79,450	$ 69,839	$ 1,823,847	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,084,938	$ 9,611		$ 79,450	$ 69,839	$ 1,823,847	1
2	Remodeling - Wallpaper	2008	6,280	628	10	628		3,088	2
3	Remodeling - Bathrooms	2008	1,170	117	10	117		575	3
4	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		925	4
5	Cornices and Cascades - Front Living	2008	1,503	150	10	150		739	5
6	Fixtures - HD Facilities Maintenance	2008	1,589	159	10	159		781	6
7	Lighting	2008	620	62	10	62		305	7
8	Cascades	2008	9,935	994	10	994		4,802	8
9	Remodeling - HD Facilities Maintenance	2008	296	30	10	30		141	9
10	Remodeling - Lowe's	2008	535	54	10	54		259	10
11	Signage	2008	6,650	665	10	665		3,103	11
12	Light Fixtures	2008	2,183	218	10	218		1,037	12
13	Light Fixtures	2008	730	73	10	73		347	13
14	Carpeting - Aimee and Andy Hall	2008	25,198	2,520	10	2,520		11,969	14
15	Flooring - VCI	2008	1,866	187	10	187		886	15
16	Carpeting	2008	113,974	11,397	10	11,397		54,137	16
17	Carpeting - Flooring America	2008	10,576	1,058	10	1,058		4,847	17
18	Signage	2008	534	53	10	53		249	18
19	Plumbing and Toilet Fixtures	2008	469	47	10	47		219	19
20	Painting and Wallcovering	2008	4,350	435	10	435		1,958	20
21	Carpeting	2008	7,184	719	10	719		3,293	21
22	Light Fixtures	2008	303	30	10	30		142	22
23	Coves, Base Cabinets and Hardware	2008	725	73	10	73		320	23
24	Bathroom Fixtures	2008	521	52	10	52		221	24
25	Indoor Signs	2008	694	69	10	69		283	25
26	Cabling	2009	961	96	10	96		376	26
27	Vanities	2009	551	55	10	55		211	27
28	HVAC Rooftop Unit	2009	10,150	1,015	10	1,015		3,553	28
29	Cornices	2009	2,343	234	10	234		820	29
30	8 Vanities Faucets	2009	986	99	10	99		337	30
31	Flooring-Bathroom	2009	364	36	10	36		128	31
32	Sidewalks, Stairs	2009	20,060		10	1,296	1,296	4,774	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,320,087	$ 31,121		$ 102,256	$ 71,135	$ 1,928,672	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,320,087	$ 31,121		$ 102,256	$ 71,135	$ 1,928,672	1
2	Windsor Collection	2010	797	112	10	112		351	2
3	5 Easycare Beds	2010	4,894	646	10	646		2,310	3
4	2 PTAC P-410A Medel	2010	1,245	174	10	174		548	4
5	Awning	2010	18,602	1,860	10	1,860		3,875	5
6	3 Easycare Beds	2011	3,793	379	10	379		537	6
7	6 Windsor Footboard/Headboard	2011	1,214	121	10	121		162	7
8	8 Pendant Lights	2011	2,641	264	10	264		264	8
9	Fireplace and Stone	2012	2,493	229	10	229		229	9
10	Electrical for Fireplace	2012	862	65	10	65		65	10
11	Fireplace Framing	2012	1,478	123	10	123		123	11
12	Compressor	2012	6,876	516	10	516		516	12
13	Flooring-Hall and Resident Room	2012	5,345	401	10	401		401	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)		$ 3,370,327	$ 36,011		$ 107,146	$ 71,135	$ 1,938,053	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 746,621	$ 55,380	$ 55,904	$ 524	5	$ 534,460	71
72	Current Year Purchases	73,187	2,936	2,936		5	2,936	72
73	Fully Depreciated Assets	379,538					367,297	73
74								74
75	TOTALS	$ 1,199,346	$ 58,316	$ 58,840	$ 524		$ 904,693	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1992 Toyota 4 x 4	1996	$ 10,201	$	$	$	5	$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174				5	35,174	77
78	Staff	2001 Lexus LX340	2000	66,573				5	66,573	78
79										79
80	TOTALS			$ 111,948	$	$	$		$ 111,948	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)	$ 4,793,467	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 94,327	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 165,986	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,659	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,954,694	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39,3	hrs	$	3,189	$ 164,423	$	3,189	$ 164,423	1
2	Licensed Speech and Language Development Therapist	39,3	hrs		2,373	78,207		2,373	78,207	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3	hrs		4,174	222,789		4,174	222,789	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): Med Supplies, Lab IV						108,065		108,065	12
13	Other (specify):									13
14	TOTAL			$	9,736	$ 465,419	$ 108,065	9,736	$ 573,484	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: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$	$	1
2	Cash-Patient Deposits	17,642	101,409	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	892,799	951,816	3
4	Supply Inventory (priced at Cost)	14,490	22,604	4
5	Short-Term Investments			5
6	Prepaid Insurance	37,283	46,931	6
7	Other Prepaid Expenses	9,586	19,518	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	4,942,243		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,914,043	$ 1,142,278	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	535,351	602,760	15
16	Equipment, at Historical Cost	816,187	1,241,889	16
17	Accumulated Depreciation (book methods)	(886,340)	(1,288,164)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,335	29,335	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,335)	(29,335)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): New Construction		195,225	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 465,198	$ 751,710	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,379,241	$ 1,893,988	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 162,396	$ 201,803	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		49,500	28
29	Short-Term Notes Payable		176,000	29
30	Accrued Salaries Payable	63,547	87,719	30
31	Accrued Taxes Payable (excluding real estate taxes)	140,704	152,179	31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,674	223,792	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		4,670	35
	Other Current Liabilities(specify):			
36	Advance Billing	240,256	382,958	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 695,577	$ 1,278,621	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)**	$ 695,577	$ 1,278,621	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,683,664	$ 615,367	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,379,241	$ 1,893,988	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,912,075	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,912,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	771,589	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)**	$ 771,589	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)**	$ 5,683,664	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: 01/01/12 Ending: 12/31/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,075,368	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,075,368	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	4,197	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)**	$ 4,197	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Memorial Income	855	28
28a	Miscellaneous Income	275	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,130	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,080,696	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,151,329	31
32	Health Care	2,008,939	32
33	General Administration	653,377	33
	B. Capital Expense		
34	Ownership	717,005	34
	C. Ancillary Expense		
35	Special Cost Centers	573,484	35
36	Provider Participation Fee	204,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,309,107	40
41	**Income before Income Taxes (line 30 minus line 40)****	771,589	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 771,589	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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.**

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,160	2,161	$ 71,936	$ 33.29	1
2	Assistant Director of Nursing	2,160	2,161	42,385	19.61	2
3	Registered Nurses	2,198	2,198	60,519	27.53	3
4	Licensed Practical Nurses	23,883	23,883	455,303	19.06	4
5	CNAs & Orderlies	75,085	75,085	778,094	10.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,161	29,269	13.54	9
10	Activity Assistants	3,191	3,191	32,428	10.16	10
11	Social Service Workers	4,225	4,228	72,730	17.20	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,161	42,220	19.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,724	24,724	224,920	9.10	15
16	Dishwashers					16
17	Maintenance Workers	6,513	6,515	82,486	12.66	17
18	Housekeepers	13,655	13,656	129,144	9.46	18
19	Laundry	8,949	8,949	78,944	8.82	19
20	Administrator	2,160	2,161	77,383	35.81	20
21	Assistant Administrator	2,160	2,161	36,122	16.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,371	2,371	21,834	9.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,047	2,048	26,996	13.18	31
32	Other Health C: Restorative	15,633	15,636	210,311	13.45	32
33	Other(specify) Care Plan Coord	4,080	4,086	105,684	25.86	33
34	TOTAL (lines 1 - 33)	199,514	199,536	$ 2,578,708 *	$ 12.92	34

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

** See instructions.

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	528	$ 22,189	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	35	1,886	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	5,245	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	1,885	11,3	44
45	Social Service Consultant	12	1,744	12,3	45
46	Other(specify)				46
47	Medicare Consulting	3	265	19,3	47
48					48
49	TOTAL (lines 35 - 48)	652	$ 56,014		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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Molly Carpenter	Administrator	0	$ 77,383
Pam Richards	Admin Asst	0	36,122
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 113,505

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
Duane Morris LLP	Legal	$ 773
Brinkoetter & Hassinger	Legal	350
FR&R Healthcare Consulting	Medicare CR Consulting	265
FR&R Healthcare Consulting	Medicare Cost Report	4,200
Sikich LLP	Medicaid Cost Report	4,200
Sikich LLP	Accounting	475
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,263

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,813
Unemployment Compensation Insurance	32,500
FICA Taxes	208,786
Employee Health Insurance	71,682
Employee Meals	129,052
Illinois Municipal Retirement Fund (IMRF)*	
Innoculations	592
Incentives	8,230
Uniforms	819
Other	516
TOTAL (agree to Schedule V, line 22, col.8)	$ 508,990

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	$
Advertising: Employee Recruitment	1,481
Health Care Worker Background Check	2,106
(Indicate # of checks performed 115)	
Patient Background Checks 88	1,696
Licenses	756
Dues & Subscriptions	1,914
Internet Subscription	993
IL Health Care Association	4,567
IPAC Dues	456
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	471
Seminar Expense	9,306
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,777

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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. $4,567**

(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. $ **27,502** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **204,973**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **129,052** 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.