FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 01/01/05 to 12/31/15 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) Rhonda S. Luther
(Title) Chief Operating Officer

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: 01/01/05 Ending: 12/31/15

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	8,307	17,329	4,189	29,825	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,307	17,329	4,189	29,825	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.01%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 3,556

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: 12/31/15 Fiscal Year: 12/31/15

* 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: 01/01/05 Ending: 12/31/15

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	268,353	27,463	18,290	314,106		314,106		314,106			1
2	Food Purchase		254,125		254,125	(144,540)	109,585		109,585			2
3	Housekeeping	135,430	41,261	215	176,906		176,906		176,906			3
4	Laundry	69,325	14,665		83,990		83,990		83,990			4
5	Heat and Other Utilities			110,428	110,428		110,428	3,144	113,572			5
6	Maintenance	93,876	39,950	64,275	198,101		198,101	1,120	199,221			6
7	Other (specify):* Trash & Waste			11,656	11,656		11,656		11,656			7
8	TOTAL General Services	566,984	377,464	204,864	1,149,312	(144,540)	1,004,772	4,264	1,009,036			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,958,458	159,390	7,871	2,125,719		2,125,719	379	2,126,098			10
10a	Therapy											10a
11	Activities	103,815	2,574	5,321	111,710		111,710		111,710			11
12	Social Services	63,408		1,673	65,081		65,081		65,081			12
13	CNA Training											13
14	Program Transportation			1,175	1,175		1,175		1,175			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,125,681	161,964	38,840	2,326,485		2,326,485	379	2,326,864			16
	C. General Administration											
17	Administrative	126,917			126,917		126,917	188,746	315,663			17
18	Directors Fees											18
19	Professional Services			55,041	55,041		55,041	31,965	87,006			19
20	Dues, Fees, Subscriptions & Promotions			23,567	23,567		23,567	142	23,709			20
21	Clerical & General Office Expenses	22,585	9,345	29,675	61,605		61,605	84,651	146,256			21
22	Employee Benefits & Payroll Taxes			457,999	457,999	144,540	602,539	36,730	639,269			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,970	16,970		16,970	457	17,427			24
25	Other Admin. Staff Transportation							72	72			25
26	Insurance-Prop.Liab.Malpractice			43,832	43,832		43,832	1,698	45,530			26
27	Other (specify):* Nondeductible			63,237	63,237		63,237	(63,237)				27
28	TOTAL General Administration	149,502	9,345	690,321	849,168	144,540	993,708	281,224	1,274,932			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,842,167	548,773	934,025	4,324,965		4,324,965	285,867	4,610,832			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:** 01/01/05 **Ending:** 12/31/15

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			90,305	90,305		90,305	72,640	162,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							98,479	98,479			32
33	Real Estate Taxes			86,828	86,828		86,828	9,461	96,289			33
34	Rent-Facility & Grounds			534,000	534,000		534,000	(534,000)				34
35	Rent-Equipment & Vehicles			480	480		480		480			35
36	Other (specify):*											36
37	**TOTAL Ownership**			711,613	711,613		711,613	(353,420)	358,193			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,359	579,966	681,325		681,325		681,325			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,274	209,274		209,274		209,274			42
43	Other (specify):* **Radiology & Lab**		11,033		11,033		11,033		11,033			43
44	**TOTAL Special Cost Centers**		112,392	789,240	901,632		901,632		901,632			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,842,167	661,165	2,434,878	5,938,210		5,938,210	(67,553)	5,870,657			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: 01/01/05 Ending: 12/31/15

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	(5,672)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(459)	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	(13,435)	27		18
19	Entertainment	(709)	27		19
20	Contributions	(3,978)	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	(19,356)	27		24
25	Fund Raising, Advertising and Promotional	(24,672)	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	(1,764)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,045)		$	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)	(368,059)		34
35	Other- Attach Schedule	370,551		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,492		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,553)		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: 01/01/05

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (445)	27	1
2	Unclaimed Property	(183)	27	2
3	Adjust out depreciation on expensed items.	(1,136)	30	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**	(1,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/15

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	3,144	0	0	0	0	0	0	0	0	3,144	5
6	Maintenance	0	0	1,120	0	0	0	0	0	0	0	0	1,120	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	4,264	0	0	0	0	0	0	0	0	4,264	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	379	0	0	0	0	0	0	0	0	379	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	379	0	0	0	0	0	0	0	0	379	16
	C. General Administration													
17	Administrative	0	0	188,746	0	0	0	0	0	0	0	0	188,746	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	31,965	0	0	0	0	0	0	0	0	31,965	19
20	Fees, Subscriptions & Promotions	0	0	142	0	0	0	0	0	0	0	0	142	20
21	Clerical & General Office Expenses	(5,672)	0	90,323	0	0	0	0	0	0	0	0	84,651	21
22	Employee Benefits & Payroll Taxes	0	0	36,730	0	0	0	0	0	0	0	0	36,730	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	457	0	0	0	0	0	0	0	0	457	24
25	Other Admin. Staff Transportation	0	0	72	0	0	0	0	0	0	0	0	72	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,698	0	0	0	0	0	0	0	0	1,698	26
27	Other (specify):*	(63,237)	0	0	0	0	0	0	0	0	0	0	(63,237)	27
28	**TOTAL General Administration**	(68,909)	0	350,133	0	0	0	0	0	0	0	0	281,224	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(68,909)	0	354,776	0	0	0	0	0	0	0	0	285,867	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/15

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	(1,136)	69,324	4,452	0	0	0	0	0	0	0	0	72,640	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	96,617	1,862	0	0	0	0	0	0	0	0	98,479	32
33	Real Estate Taxes	0	0	9,461	0	0	0	0	0	0	0	0	9,461	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**	(1,136)	(368,059)	15,775	0	0	0	0	0	0	0	0	(353,420)	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)**	(70,045)	(368,059)	370,551	0	0	0	0	0	0	0	0	(67,553)	45

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/05 Ending: 12/31/15

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	94.39			Imboden Gardens	Decatur	Assisted Living
Aimee Beemer	1.87					
Julie Smith	1.87					
Andrew Brinkoetter	1.87					

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	94.39%	$	$ (534,000)	1
2	V	30	Depreciation		John & Martha Brinkoetter	94.39%	69,324	69,324	2
3	V	32	Interest		John & Martha Brinkoetter	94.39%	96,617	96,617	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			$ 165,941	$ * (368,059)	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: 01/01/05 Ending: 12/31/15

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	$	Corporate Center		$ 3,144	$ 3,144	15
16	V	6	Supplies-Repairs		Corporate Center		434	434	16
17	V	6	Repairs & Maintenance		Corporate Center		686	686	17
18	V	17	Wages-Administrative		Corporate Center		188,746	188,746	18
19	V	19	Professsional Fees		Corporate Center		31,965	31,965	19
20	V	20	License & Fees		Corporate Center		142	142	20
21	V	25	Auto Expense		Corporate Center		72	72	21
22	V	21	Wages-Clerical		Corporate Center		81,412	81,412	22
23	V	21	Office Supplies		Corporate Center		2,431	2,431	23
24	V	21	Telephone		Corporate Center		2,264	2,264	24
25	V	21	Miscellaneous Office		Corporate Center		4,216	4,216	25
26	V	22	Payroll Taxes		Corporate Center		18,609	18,609	26
27	V	22	Workers' Comp Insurance		Corporate Center		2,015	2,015	27
28	V	22	Employee Insurance		Corporate Center		15,950	15,950	28
29	V	22	Uniforms		Corporate Center		53	53	29
30	V	22	Employee Incentives		Corporate Center		36	36	30
31	V	24	Travel & Seminar		Corporate Center		457	457	31
32	V	26	Insurance		Corporate Center		1,698	1,698	32
33	V	30	Depreciation		Corporate Center		4,452	4,452	33
34	V	32	Interest		Corporate Center		1,862	1,862	34
35	V	33	Real Estate Taxes		Corporate Center		9,461	9,461	35
36	V	22	Education		Corporate Center		67	67	36
37	V	10	Nursing and Medical Records		Corporate Center		379	379	37
38	V								38
39	Total			$			$ 370,551	$ * 370,551	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: 01/01/05 Ending: 12/31/15

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	94.39		26	66.00	Salary	$ 62,504	17,7	1
2	Martah Brinkoetter	Clerical	Clerical	94.39		26	66.00	Salary	29,994	17,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 92,498		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: 01/01/05 Ending: 12/31/15

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	45,289	2	$ 4,774	$	29,825	$ 3,144	1
2	6	Supplies-Repairs	Days	45,289	2	659		29,825	434	2
3	6	Repairs & Maintenance	Days	45,289	2	1,041		29,825	686	3
4	17	Wages-Administrative	Days	45,289	2	286,609	286,609	29,825	188,746	4
5	19	Professional Fees	Days	45,289	2	48,539		29,825	31,965	5
6	20	License & Fees	Days	45,289	2	216		29,825	142	6
7	25	Auto Expense	Days	45,289	2	109		29,825	72	7
8	21	Wages-Clercial	Days	45,289	2	123,624	123,624	29,825	81,412	8
9	21	Office Supplies	Days	45,289	2	3,692		29,825	2,431	9
10	21	Telephone	Days	45,289	2	3,438		29,825	2,264	10
11	21	Miscellaneous Office	Days	45,289	2	6,402		29,825	4,216	11
12	22	Payroll Taxes	Days	45,289	2	28,258		29,825	18,609	12
13	22	Workers' Comp Insurance	Days	45,289	2	3,060		29,825	2,015	13
14	22	Employee Insurance	Days	45,289	2	24,220		29,825	15,950	14
15	22	Uniforms	Days	45,289	2	80		29,825	53	15
16	22	Employee Incentives	Days	45,289	2	54		29,825	36	16
17	24	Travel & Seminar	Days	45,289	2	694		29,825	457	17
18	26	Insurance	Days	45,289	2	2,579		29,825	1,698	18
19	30	Depreciation	Days	45,289	2	6,761		29,825	4,452	19
20	32	Interest	Days	45,289	2	2,828		29,825	1,862	20
21	33	Real Estate Taxes	Days	45,289	2	14,366		29,825	9,461	21
22	22	Education	Days	45,289	2	102		29,825	67	22
23	10	Nursing and Medical Records	Days	45,289	2	575		29,825	379	23
24										24
25	TOTALS					$ 562,680	$ 410,233		$ 370,551	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/05 Ending: 12/31/15

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	9/29/15	$ 7,583,621	$ 5,971,510	10/01/20	6.7500	$ 96,617	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank		X	Line of Credit	Interest Only	6/9/15	500,000	935	6/9/16	4.5000	1,862	6
7												7
8												8
9	TOTAL Facility Related				$54,300.00		$ 8,083,621	$ 5,972,445			$ 98,479	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,083,621	$ 5,972,445			$ 98,479	15

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

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

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: 01/01/05 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 98,749	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.)		$ 97,277	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,472)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 97,761	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.		$ 96,289	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	94,939	8
	2011	93,873	9
	2012	96,868	10
	2013	102,966	11
	2014	103,005	12

Nursing Home $88,669
Corp Office-allocated $13,806 6 .6585484 = $9,092

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-27-231-013	South Franklin Estates Second Add Lt	$ 88,669.00	$ 88,669.00
2.	04-12-27-278-010	N1/2 NE1/4 SE1/4 NE1/4 EXC N 10	$ 13,290.00	$ 9,092.45
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,959.00	$ 97,761.45

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/05 Ending: 12/31/15

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).

Imboden Creek Gardens, Assisted Living

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: 01/01/05 Ending: 12/31/15

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	$ 1,754,229	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Improvments			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	Electrical			1992	2,550		10			2,550	12
13	Door			1993	657		10			657	13
14	Rose Garden Fence			1993	2,495		10			2,495	14
15	Drive & Parking Lot			1996	2,065		10			2,065	15
16	Concrete Drive Service Doors			1996	2,100		10			2,100	16
17	Landscaping			1997	2,387		10			2,387	17
18	Landscaping			1999	877		10			877	18
19	Baseboards for Bathrooms			2000	720		10			720	19
20	Shower Room Tile			2000	2,954		10			2,954	20
21	Baseboards for Bathrooms			2000	466		10			466	21
22	New Roof			2000	51,000		10			51,000	22
23	Roof Drains			2000	3,691		10			3,691	23
24	Deck			2000	2,668		10			2,668	24
25	Tile Installation			2000	1,380		10			1,380	25
26	Deck & Handrails			2001	27,848		10			27,848	26
27	Siding			2000	1,475		10			1,475	27
28	Security System			2002	8,338		10			6,119	28
29	Underground Cable System			2002	9,178		10			6,658	29
30	Dining Room Carpeting			2002	11,734		10			11,734	30
31	Fire Alarm System			2002	17,894		10			17,894	31
32	Roof			2003	5,250		10			3,605	32
33	Sprinklers			2003	5,970		10			5,970	33
34	Wander Guard System			2003	2,044		10			2,044	34
35	Nurses Station			2005	21,300	1,065	10	1,065		21,300	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: 01/01/05 Ending: 12/31/15

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	Bathroom Fixtures	2007	$ 3,540	$ 354	10	$ 354	$	$ 3,127	37
38	Bathroom Flooring	2007	296	30	10	30		257	38
39	All Body Rebound	2007	643	64	10	64		536	39
40	Powermate Mat Platform	2007	3,767	377	10	377		3,139	40
41	Upper and Lower Cabinets	2007	425	43	10	43		354	41
42	Activity Room	2007	2,665	267	10	267		2,199	42
43	Vinyl Flooring	2007	2,694	269	10	269		2,244	43
44	Wallcovering	2007	21,358	2,136	10	2,136		17,177	44
45	Bathroom Flooring	2007	451	45	10	45		390	45
46	Ceiling Light Fixture	2007	432	43	10	43		349	46
47	Deck & Breakfast	2007	500	50	10	50		429	47
48	Remodeling - Wallpaper	2008	6,280	628	10	628		4,972	48
49	Remodeling - Bathrooms	2008	1,170	117	10	117		926	49
50	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		1,480	50
51	Cornices and Cascades - Front Living	2008	1,503	150	10	150		1,190	51
52	Fixtures - HD Facilities Maintenance	2008	1,589	159	10	159		1,258	52
53	Lighting	2008	620	62	10	62		491	53
54	Cascades	2008	9,935	994	10	994		7,783	54
55	Remodeling - HD Facilities Maintenance	2008	296	30	10	30		230	55
56	Remodeling - Lowe's	2008	535	54	10	54		419	56
57	Signage	2008	6,650	665	10	665		5,098	57
58	Light Fixtures	2008	2,183	218	10	218		1,691	58
59	Light Fixtures	2008	730	73	10	73		566	59
60	Carpeting - Aimee and Andy Hall	2008	25,198	2,520	10	2,520		19,529	60
61	Flooring - VCI	2008	1,866	187	10	187		1,446	61
62	Carpeting	2008	113,974	11,397	10	11,397		88,329	62
63	Signage	2008	534	53	10	53		409	63
64	Plumbing and Toilet Fixtures	2008	469	47	10	47		360	64
65	Painting and Wallcovering	2008	4,350	435	10	435		3,263	65
66	Carpeting	2008	7,184	718	10	718		5,448	66
67	Light Fixtures	2008	303	30	10	30		232	67
68	Coves, Base Cabinets and Hardware	2008	725	73	10	73		537	68
69	Bathroom Fixtures	2008	521	52	10	52		378	69
70	TOTAL (lines 4 thru 69)		$ 3,203,683	$ 23,590		$ 92,914	$ 69,324	$ 2,129,582	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: 01/01/05 Ending: 12/31/15

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		$ 3,203,683	$ 23,590		$ 92,914	$ 69,324	$ 2,129,582	1
2	Indoor Signs	2008	694	69	10	69		491	2
3	Cabling	2009	961	96	10	96		665	3
4	Vanities	2009	551	55	10	55		377	4
5	HVAC Rooftop Unit	2009	10,150	1,015	10	1,015		6,598	5
6	Cornices	2009	2,343	234	10	234		1,523	6
7	8 Vanities Faucets	2009	986	99	10	99		633	7
8	Flooring - Bathroom	2009	364	36	10	36		236	8
9	Sidewalks, Stairs	2009	20,060		10	1,321	1,321	8,681	9
10	Windsor Collection	2010	798	57	10	57		569	10
11	5 Easycare Beds	2010	4,894	331	10	331		3,571	11
12	2 PTACP-410A Model	2010	1,245	89	10	89		888	12
13	Awning	2010	18,602	1,860	10	1,860		9,456	13
14	3 Easycare Beds	2011	3,793	379	10	379		1,675	14
15	6 Windsor Footboard/Headboard	2011	1,214	122	10	122		526	15
16	8 Pendant Lights	2011	2,641	264	10	264		1,056	16
17	Fireplace and Stone	2012	2,493	249	10	249		976	17
18	Elcetric for Fireplace	2012	862	86	10	86		323	18
19	Fireplace Framing	2012	1,479	148	10	148		567	19
20	Compressor	2012	6,876	688	10	688		2,579	20
21	Flooring - Hall and Resident Room	2012	5,345	535	10	535		2,004	21
22	Door Restrictors	2013	3,350	335	10	335		726	22
23	Steel Door	2013	3,371	337	10	337		730	23
24	Parking Lot	2015	213,774	1,811	10	1,811		1,751	24
25	Flooring-Resident Dining Room	2015	14,019	1,051	10	1,051		1,051	25
26	Shower Room Tile, Plumbing & Electric-Resident Wing Jodi	2015	8,190	273	10	273		485	26
27	Shower Wall Tile-Resident Wing Jodi	2015	9,925	248	10	248		248	27
28	Shower Wall Tile-Resident Wing Jodi	2015	7,065	59	10	59		59	28
29	Shower Room Cabinets & Plumbing-Resident Wing Jodi	2015	7,820	66	10	66		72	29
30	Kitchen Convection Oven & Labor	2015	5,155	172	10	172		94	30
31	Generator Upgrades	2015	9,635	80	10	80		359	31
32	Siding	2015	21,830		10	359	359		32
33	Assets Removed			1,790		1,790			33
34	TOTAL (lines 1 thru 33)		$ 3,594,168	$ 36,224		$ 107,228	$ 71,004	$ 2,178,551	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: 01/01/05 Ending: 12/31/15

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	$ 836,246	$ 52,678	$ 52,762	$ 84	5	$ 661,123	71
72	Current Year Purchases	5,754	267	538	271	5	538	72
73	Fully Depreciated Assets	56,660				5	54,868	73
74								74
75	TOTALS	$ 898,660	$ 52,945	$ 53,300	$ 355		$ 716,529	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	2001 Ford F150 Truck	2000	$ 35,174	$	$	$	5	$ 35,174	76
77	Staff	2001 Lexus LX3240	2000	66,573				5	66,573	77
78	Staff	2012 Dodge Caravan	2013	18,353		2,417	2,417	5	6,166	78
79										79
80	TOTALS			$ 120,100	$	$ 2,417	$ 2,417		$ 107,913	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)	$ 4,724,774	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 89,169	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 162,945	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 73,776	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,002,993	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: 01/01/05 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 480 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: 01/01/05 Ending: 12/31/15

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: 01/01/05 Ending: 12/31/15

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	$	4,240	$ 211,177	$	4,240	$ 211,177	1
2	Licensed Speech and Language Development Therapist	39,3	hrs		1,637	88,518		1,637	88,518	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3	hrs		5,956	280,271		5,956	280,271	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	39,2 & 43,2					112,392		112,392	12
13	Other (specify):									13
14	TOTAL			$	11,833	$ 579,966	$ 112,392	11,833	$ 692,358	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: 01/01/05 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 17,462	$ (30,257)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	463,004	489,870	3
4	Supply Inventory (priced at Cost)	15,300	24,556	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,591	53,336	6
7	Other Prepaid Expenses	2,463	6,394	7
8	Accounts Receivable (owners or related parties)		145,124	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 539,820	$ 689,023	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	745,748	855,251	15
16	Equipment, at Historical Cost	651,497	956,388	16
17	Accumulated Depreciation (book methods)	(855,245)	(1,184,339)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 542,000	$ 627,300	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,081,820	$ 1,316,323	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 325,412	$ 384,474	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		45,500	28
29	Short-Term Notes Payable		935	29
30	Accrued Salaries Payable	93,112	155,142	30
31	Accrued Taxes Payable (excluding real estate taxes)	62,643	62,643	31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,669	216,376	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		8,112	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 569,836	$ 873,182	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)**	$ 569,836	$ 873,182	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 511,984	$ 443,141	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,081,820	$ 1,316,323	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/05 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 698,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 698,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	501,273	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) C/Y Intercompany Activity	(687,402)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (186,129)	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)**	$ 511,984	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: 01/01/05 Ending: 12/31/15

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	$ 6,435,743	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,435,743	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	1	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	5,672	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)**	$ 5,673	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Memorial Income	980	28
28a	Miscellaneous Loss	(2,913)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,933)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,439,483	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,149,312	31
32	Health Care	2,326,485	32
33	General Administration	849,168	33
	B. Capital Expense		
34	Ownership	711,613	34
	C. Ancillary Expense		
35	Special Cost Centers	692,358	35
36	Provider Participation Fee	209,274	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,938,210	40
41	**Income before Income Taxes (line 30 minus line 40)****	501,273	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 501,273	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,261,696	44
45	Private Pay - Net Inpatient Revenue	3,505,032	45
46	Medicare - Net Inpatient Revenue	1,669,015	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,435,743	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: 01/01/05 Ending: 12/31/15

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	1,120	1,204	$ 42,610	$ 35.39	1
2	Assistant Director of Nursing	1,520	1,520	60,315	39.68	2
3	Registered Nurses	5,562	5,562	139,303	25.05	3
4	Licensed Practical Nurses	23,059	23,653	476,161	20.13	4
5	CNAs & Orderlies	65,621	67,148	744,005	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	32,645	15.69	9
10	Activity Assistants	7,412	7,544	71,170	9.43	10
11	Social Service Workers	3,710	3,710	63,408	17.09	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,103	15.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,843	24,495	235,250	9.60	15
16	Dishwashers					16
17	Maintenance Workers	5,396	5,424	93,876	17.31	17
18	Housekeepers	13,601	14,098	135,430	9.61	18
19	Laundry	6,985	7,181	69,325	9.65	19
20	Administrator	2,080	2,080	87,687	42.16	20
21	Assistant Administrator	2,080	2,080	39,230	18.86	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,413	2,429	22,585	9.30	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	1,958	2,069	27,761	13.42	31
32	Other Health C: Restorative Aide	28,096	28,517	354,666	12.44	32
33	Other(specify) Care Plan Coor	4,160	4,160	113,637	27.32	33
34	TOTAL (lines 1 - 33)	202,776	207,034	$ 2,842,167 *	$ 13.73	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	407	$ 18,290	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	43	2,953	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	984	4,918	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	34	2,014	11,3	44
45	Social Service Consultant	28	1,673	12,3	45
46	Other(specify)				46
47	Medicare Consultant	14	4,370	19,3	47
48					48
49	TOTAL (lines 35 - 48)	1,546	$ 57,018		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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/05 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Molly Carpenter	Administrator	0	$ 87,687
Pam Richards	Admin Asst	0	39,230
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 126,917

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	Legal	$ 40,611
FR&R Healthcare Consulting	Medicare Consulting	170
FR&R Healthcare Consulting	Medicare CR Consulting	4,200
Sikich	Medicaid Cost Report	5,950
5Star Consulting	CMS 5 Star Rating Consult	500
Silver Award App	Quality Fee Consultant	200
Katherine Smith	Market Survey	333
National Research Corporation	Satisfaction Survey	3,077
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 55,041

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,024
Unemployment Compensation Insurance	23,133
FICA Taxes	228,748
Employee Health Insurance	154,107
Employee Meals	144,540
Illinois Municipal Retirement Fund (IMRF)*	
Innoculations	1,705
Incentives	5,453
Uniforms	129
Other	7,430
TOTAL (agree to Schedule V, line 22, col.8)	$ 639,269

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	$ 2,797
Advertising: Employee Recruitment	6,601
Health Care Worker Background Check	
(Indicate # of checks performed 39)	1,521
Patient Background Checks 101	1,616
Licenses	1,482
Dues & Subscriptions	1,223
Internet Subscriptions	2,713
IL Health Care Association	5,300
IPAC Dues	456
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,034
Seminar Expense	16,393
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,427

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/05 Ending: 12/31/15

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: 01/01/05 Ending: 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Assoc. $5,300**

(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. $ **32,332** 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. $ **209,274**
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. $ **144,540** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number **Imboden Creek Living Center** **# 0036574** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/15**

Legal Fees

Law Firm	Date	Description of Services	Amount
Duane Morris	01/22/15	Review for prehearing conference and IDPH files	3,360
Duane Morris	02/09/15	Reschedule prehearing conference draft settlement proposal	7,029
Duane Morris	03/11/15	Prehearing conference and analysis proposed settlement	6,771
Duane Morris	04/14/15	Settlement analysis and propsed settlement terms	4,896
Duane Morris	05/19/15	Draft consent agreement and request for final offer	1,020
Duane Morris	05/19/15	Review correspondence from client re: summary of timeline of events	5,960
Duane Morris	06/11/15	Telephone conference with opposing counsel regarding possible resolution	4,408
Duane Morris	06/23/15	Fee retainer	299
Duane Morris	07/28/15	Review correspondence from opposing counsel and draft order	3,448
Duane Morris	08/12/15	Review status	1,130
Duane Morris	09/23/15	Fee retainer	200
Duane Morris	10/26/15	Review correspondence from opposing counsel	508
Duane Morris	11/17/15	Review correspondence from opposing counsel	1,582
		Total	40,611