

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036574

Facility Name: Imboden Creek Living Center

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

County: Macon

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

HFS ID Number: 37-1122149

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) <u>Thomas K. Leach</u> <u>Member</u>	
	(Firm Name & Address) <u>Sleeper, Disbrow, Morrison, Tarro & Lively, LLC</u> <u>P.O. Box 1460, Decatur, IL 62525-1460</u>	
	(Telephone) <u>(217)423-6000</u> Fax # <u>(217)423-6100</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	Phone # (217) 782-1630

Facility Name & ID Number Imboden Creek Living Center# 0036574 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,553</u>	<u>17,497</u>	<u>6,081</u>	<u>31,131</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,553</u>	<u>17,497</u>	<u>6,081</u>	<u>31,131</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.78%

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)

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

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

YES NO

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

YES NO

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

Date started 09/08/1990

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 95 and days of care provided 6,081Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	234,991	24,975	18,953	278,919		278,919		278,919			1
2	Food Purchase		250,339		250,339	(71,358)	178,981		178,981			2
3	Housekeeping	114,096	35,178	16	149,290		149,290		149,290			3
4	Laundry	67,891	24,203	40	92,134		92,134		92,134			4
5	Heat and Other Utilities			90,336	90,336		90,336	3,868	94,204			5
6	Maintenance	48,365	45,214	54,611	148,190		148,190	6,768	154,958			6
7	Other (specify):*											7
8	TOTAL General Services	465,343	379,909	163,956	1,009,208	(71,358)	937,850	10,636	948,486			8
	B. Health Care and Programs											
9	Medical Director			22,400	22,400		22,400		22,400			9
10	Nursing and Medical Records	1,386,868	85,908	10,638	1,483,414		1,483,414		1,483,414			10
10a	Therapy											10a
11	Activities	47,860	2,131	3,150	53,141		53,141		53,141			11
12	Social Services	24,705		1,469	26,174		26,174		26,174			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,459,433	88,039	37,657	1,585,129		1,585,129		1,585,129			16
	C. General Administration											
17	Administrative	180,438			180,438		180,438	41,213	221,651			17
18	Directors Fees											18
19	Professional Services			16,090	16,090		16,090	15,458	31,548			19
20	Dues, Fees, Subscriptions & Promotions			17,434	17,434		17,434	500	17,934			20
21	Clerical & General Office Expenses	27,520	20,756	18,817	67,093		67,093	52,438	119,531			21
22	Employee Benefits & Payroll Taxes			330,427	330,427	71,358	401,785	10,272	412,057			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,077	2,077		2,077	380	2,457			24
25	Other Admin. Staff Transportation			1,460	1,460		1,460	1,232	2,692			25
26	Insurance-Prop.Liab.Malpractice			81,890	81,890		81,890	2,902	84,792			26
27	Other (specify):* Nondeductible exp			27,256	27,256		27,256	(27,256)				27
28	TOTAL General Administration	207,958	20,756	495,451	724,165	71,358	795,523	97,139	892,662			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,132,734	488,704	697,064	3,318,502		3,318,502	107,775	3,426,277			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Imboden Creek Living Center #0036574 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,994	36,994		36,994	89,495	126,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							154,597	154,597			32
33	Real Estate Taxes			91,976	91,976		91,976	6,615	98,591			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(486,176)	11,824			34
35	Rent-Equipment & Vehicles			2,130	2,130		2,130		2,130			35
36	Other (specify):*											36
37	TOTAL Ownership			629,100	629,100		629,100	(235,469)	393,631			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,616	528,564	731,180		731,180		731,180			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,669	52,669		52,669		52,669			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		202,616	581,233	783,849		783,849		783,849			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,132,734	691,320	1,907,397	4,731,451		4,731,451	(127,694)	4,603,757			45

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,349)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	750	30		9
10	Interest and Other Investment Income	(31,871)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,683)	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	(656)	27		18
19	Entertainment	(1,137)	27		19
20	Contributions	(3,018)	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	(5,287)	27		24
25	Fund Raising, Advertising and Promotional	(14,632)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(843)	27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,726)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(276,549)		34
35	Other- Attach Schedule Page 5B	220,581		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (55,968)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (127,694)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Gifts	\$ (843)	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	(843)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/06

Ending:

12/31/06**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	3,868	0	0	0	0	0	0	0	0	3,868	5
6	Maintenance	0	0	6,768	0	0	0	0	0	0	0	0	6,768	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	10,636	0	0	0	0	0	0	0	0	10,636	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	41,213	0	0	0	0	0	0	0	0	41,213	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	15,458	0	0	0	0	0	0	0	0	15,458	19
20	Fees, Subscriptions & Promotions	0	0	500	0	0	0	0	0	0	0	0	500	20
21	Clerical & General Office Expenses	(13,349)	0	65,787	0	0	0	0	0	0	0	0	52,438	21
22	Employee Benefits & Payroll Taxes	0	0	10,272	0	0	0	0	0	0	0	0	10,272	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	380	0	0	0	0	0	0	0	0	380	24
25	Other Admin. Staff Transportation	0	0	1,232	0	0	0	0	0	0	0	0	1,232	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,902	0	0	0	0	0	0	0	0	2,902	26
27	Other (specify):*	(27,256)	0	0	0	0	0	0	0	0	0	0	(27,256)	27
28	TOTAL General Administration	(40,605)	0	137,744	0	0	0	0	0	0	0	0	97,139	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,605)	0	148,380	0	0	0	0	0	0	0	0	107,775	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	750	83,239	5,506	0	0	0	0	0	0	0	0	89,495	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,871)	138,212	48,256	0	0	0	0	0	0	0	0	154,597	32
33	Real Estate Taxes	0	0	6,615	0	0	0	0	0	0	0	0	6,615	33
34	Rent-Facility & Grounds	0	(498,000)	11,824	0	0	0	0	0	0	0	0	(486,176)	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	(31,121)	(276,549)	72,201	0	(235,469)	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)	(71,726)	(276,549)	220,581	0	(127,694)	45							

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John & Martha Brinkoetter	100			Imboden Gardens	Decatur	Assisted Living

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$	John & Martha Brinkoetter	100.00%	\$	\$(498,000)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	83,239	83,239	2
3	V	32 Interst		John & Martha Brinkoetter	100.00%	138,212	138,212	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		\$			\$ 221,451	\$ * (276,549)	14

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Brinkoetter	President	Administrative	100.00		26	66.00	Salary	\$ 62,504	17,7	1
2	Martha Brinkoetter	Clerical	Clerical	100.00		26	66.00	Salary	29,994	21,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,498		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.

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Days 47,393	2	\$ 5,888	\$	31,131	\$ 3,868	1
2	6	Supplies-Repairs	Days 47,393	2	826		31,131	543	2
3	6	Repairs & Maintenance	Days 47,393	2	9,477		31,131	6,225	3
4	17	Wages-Administrative	Days 47,393	2	62,741	62,741	31,131	41,213	4
5	19	Professional Services	Days 47,393	2	23,533		31,131	15,458	5
6	20	License & Fees	Days 47,393	2	170		31,131	112	6
7	20	Dues & Subscriptions	Days 47,393	2	590		31,131	388	7
8	21	Wages-Clerical	Days 47,393	2	88,703	88,703	31,131	58,266	8
9	21	Office Supplies	Days 47,393	2	4,429		31,131	2,909	9
10	21	Telephone	Days 47,393	2	6,752		31,131	4,435	10
11	21	Miscellaneous Office	Days 47,393	2	270		31,131	177	11
12	22	Payroll Taxes	Days 47,393	2	14,486		31,131	9,515	12
13	22	Workers' Comp Insurance	Days 47,393	2	1,157		31,131	760	13
14	22	Employee Insurance	Days 47,393	2	84		31,131	55	14
15	22	Uniforms	Days 47,393	2	(88)		31,131	(58)	15
16	24	Travel & Seminar	Days 47,393	2	578		31,131	380	16
17	25	Auto Expense	Days 47,393	2	1,875		31,131	1,232	17
18	26	Insurance	Days 47,393	2	4,418		31,131	2,902	18
19	30	Depreciation	Days 47,393	2	8,382		31,131	5,506	19
20	32	Interest	Days 47,393	2	73,464		31,131	48,256	20
21	33	Real Estate Taxes	Days 47,393	2	10,070		31,131	6,615	21
22	34	Rent	Days 47,393	2	18,000		31,131	11,824	22
23									23
24									24
25	TOTALS				\$ 335,805	\$ 151,444		\$ 220,581	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Regions Bank		X	Real Estate Loan	\$17,632.00	04/27/01	\$ 3,302,473	\$ 2,724,197	04/05/09	5.0000	\$ 138,212	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank		X	Line of Credit		10/12/06	1,000,000	997,000	10/12/07	8.2500	40,213	6
7	Regions Bank		X	Line of Credit		10/01/06	200,000	200,000	01/23/07	8.2500	8,043	7
8												8
9	TOTAL Facility Related				\$17,632.00		\$ 4,502,473	\$ 3,921,197			\$ 186,468	9
	B. Non-Facility Related*											
10				Interest Income							(31,871)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			(31,871)	14
15	TOTALS (line 9+line14)						\$ 4,502,473	\$ 3,921,197			\$ 154,597	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Imboden Creek Living Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036574

CONTACT PERSON REGARDING THIS REPORT Martha Brinkoetter

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-12-27-231-008</u>	<u>L 001 D 00 South Franklin Estates</u>	\$ <u>89,396.54</u>	\$ <u>89,396.54</u>
2. <u>04-12-27-278-010</u>	<u>00000105 W. Imboden Drive</u>	\$ <u>8,602.56</u>	\$ <u>5,650.76</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>97,999.10</u>	\$ <u>95,047.30</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

0036574

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1990	1990	\$ 2,772,947	\$	40	\$ 69,324	\$ 69,324	\$ 1,130,313	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sewer Improvements		1991	15,000		20	750	750	12,188	9
10		Landscaping		1992	2,460		10			2,460	10
11		Landscaping - Yard Pad		1992	1,000		10			1,000	11
12		Carpeting		1992	584		10			584	12
13		Decorate Activity Room		1992	852		10			852	13
14		Electrical		1993	2,550		10			2,550	14
15		Carpeting		1993	791		10			791	15
16		Carpeting		1993	747		10			747	16
17		Door		1993	657		10			657	17
18		Rose Garden Fence		1995	2,495		10			2,495	18
19		Carpeting		1996	1,121	9	10	9		1,121	19
20		Drive & Parking Lot		1996	2,065	86	10	86		2,065	20
21		Concrete Drive Service Doors		1995	2,100		10			2,100	21
22		Carpeting		1997	29,333	2,933	10	2,933		26,889	22
23		Landscaping		1998	2,387	239	10	239		2,029	23
24		Carpeting		1999	2,258	226	10	226		1,731	24
25		Curtains		1999	937	94	10	94		656	25
26		Landscaping		2000	877	88	10	88		614	26
27		Carpeting		2000	2,321	232	10	232		1,528	27
28		Carpeting		2000	3,981	398	10	398		2,588	28
29		Baseboards for Bathrooms		2000	720	72	10	72		468	29
30		Shower Room Tile		2000	2,954	295	10	295		1,920	30
31		Baseboards for Bathrooms		2000	466	47	10	47		299	31
32		Floor Covering		2000	1,032	103	10	103		645	32
33		New Roof		2000	51,000	5,100	10	5,100		32,300	33
34		Roof Drains		2000	3,691	369	10	369		2,307	34
35		Deck		2000	2,668	267	10	267		1,667	35
36											36

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

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

See Page 12A, Line 70 for total

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

0036574

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tile Installation	2000	\$ 1,380	\$ 138	10	\$ 138	\$	\$ 897	37
38	Floor Covering	2000	532	53	10	53		333	38
39	Deck & Handrails	2001	27,848	2,785	10	2,785		16,709	39
40	Siding	2000	1,475	148	10	148		922	40
41	Kitchen Floor/Baseboards	2001	8,244	825	10	825		4,466	41
42	Carpeting	2002	1,972		10	129	129	750	42
43	Security System	2002	8,338		8	685	685	3,800	43
44	Outside Door	2002	912		10	60	60	310	44
45	Underground Cable System	2002	9,178		10	603	603	3,575	45
46	Glass Door	2002	1,321		10	87	87	525	46
47	Carpeting	2002	2,732	273	10	273		1,298	47
48	Dining Room Carpeting	2002	11,734	1,173	10	1,173		5,280	48
49	Fire Alarm System	2002	17,894	1,790	10	1,790		7,605	49
50	Roof	2003	5,250		10	345	345	1,477	50
51	Sprinklers	2003	5,970	597	10	597		1,940	51
52	New Wander Guard System	2003	2,044	204	10	204		664	52
53	Step by Step Floors	2004	2,723	272	10	272		635	53
54	Bathroom	2005	7,245	725	10	725		1,087	54
55	Carpeting - Nurse's Station	2006	3,579	268	10	268		268	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,030,365	\$ 19,809		\$ 91,792	\$ 71,983	\$ 1,288,105	70

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 426,933	\$ 14,906	\$ 32,418	\$ 17,512	5	\$ 298,796	71
72	Current Year Purchases	13,675	2,279	2,279		5	2,279	72
73	Fully Depreciated Assets	284,779				5	284,779	73
74								74
75	TOTALS	\$ 725,387	\$ 17,185	\$ 34,697	\$ 17,512		\$ 585,854	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1992 Toyota 4 X 4	1996	\$ 10,201	\$	\$	\$	5	\$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174				5	35,173	77
78	Staff	2001 Lexus LS430	2000	66,573				5	66,573	78
79										79
80	TOTALS			\$ 111,948	\$	\$	\$		\$ 111,947	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 3,979,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 36,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 126,489	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 89,495	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,985,906	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,130 Description: Ice Machine \$ 1,650 & Dishwasher \$480

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39,3 & 39,2	hrs	\$	327	\$ 194,778	\$ 15	327	\$ 194,793	1						
2	Licensed Speech and Language Development Therapist	39,3 & 39,2	hrs		1,666	95,511		1,666	95,511	2						
3	Licensed Recreational Therapist		hrs							3						
4	Licensed Physical Therapist	39,3 & 39,2	hrs		4,788	234,159	137	4,788	234,296	4						
5	Physician Care		visits							5						
6	Dental Care		visits							6						
7	Work Related Program		hrs							7						
8	Habilitation		hrs							8						
9	Pharmacy		# of prescripts							9						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10						
11	Academic Education		hrs							11						
12	Exceptional Care Program									12						
13	Other (specify): <u>Med Supplies, Lab, IV</u>	<u>39,2</u>					<u>206,580</u>		<u>206,580</u>	13						
14	TOTAL			\$	6,781	\$ 524,448	\$ 206,732	6,781	\$ 731,180	14						

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

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 11,514	\$ (22,837)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,668,311	1,781,166	3
4	Supply Inventory (priced at <u>cost</u>)	16,108	24,043	4
5	Short-Term Investments			5
6	Prepaid Insurance	36,162	49,782	6
7	Other Prepaid Expenses		687	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	759,926		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,492,021	\$ 1,832,841	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	215,448	263,719	15
16	Equipment, at Historical Cost	346,992	659,423	16
17	Accumulated Depreciation (book methods)	(407,109)	(666,265)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Note Receivable Stockholder</u>		718,438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 155,331	\$ 975,315	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,647,352	\$ 2,808,156	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 272,454	\$ 568,722	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		60,054	28
29	Short-Term Notes Payable		1,197,000	29
30	Accrued Salaries Payable	86,893	112,681	30
31	Accrued Taxes Payable (excluding real estate taxes)		(42)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,184	231,784	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Advance Billing</u>	219,637	339,661	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 670,168	\$ 2,509,860	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)	\$ 670,168	\$ 2,509,860	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,977,184	\$ 298,296	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,647,352	\$ 2,808,156	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,208,697	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,208,697	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	768,487	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)	\$ 768,487	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,977,184	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,487,960	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,487,960	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	3	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	10,968	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)	\$ 10,971	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	<u>Memorial Income</u>	945	28
28a	<u>Miscellaneous Income</u>	62	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,007	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,499,938	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,009,208	31
32	Health Care	1,585,129	32
33	General Administration	724,165	33
B. Capital Expense			
34	Ownership	629,100	34
C. Ancillary Expense			
35	Special Cost Centers	731,180	35
36	Provider Participation Fee	52,669	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,731,451	40
41	Income before Income Taxes (line 30 minus line 40)**	768,487	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 768,487	43

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

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

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

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/06

Ending:

12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,081	\$ 61,279	\$ 29.45	1
2	Assistant Director of Nursing	2,080	2,081	36,327	17.46	2
3	Registered Nurses	4,300	4,981	81,162	16.29	3
4	Licensed Practical Nurses	20,659	23,990	350,851	14.62	4
5	CNAs & Orderlies	78,304	95,400	711,947	7.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,273	2,274	24,206	10.64	9
10	Activity Assistants	3,287	3,287	23,654	7.20	10
11	Social Service Workers	2,080	2,081	24,705	11.87	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,081	32,210	15.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,002	26,016	202,781	7.79	15
16	Dishwashers					16
17	Maintenance Workers	3,881	3,884	48,365	12.45	17
18	Housekeepers	14,570	14,575	114,096	7.83	18
19	Laundry	8,070	8,074	67,891	8.41	19
20	Administrator	2,080	2,081	115,281	55.40	20
21	Assistant Administrator	1,808	1,808	26,850	14.85	21
22	Other Administrative	2,080	2,080	38,307	18.42	22
23	Office Manager					23
24	Clerical	2,081	2,080	27,520	13.23	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	2,070	2,072	21,729	10.49	31
32	Other Health Care Restorative	6,012	6,281	81,358	12.95	32
33	Other(specify) Care Plan Coordin	2,081	2,080	42,215	20.30	33
34	TOTAL (lines 1 - 33)	187,878	209,287	\$ 2,132,734 *	\$ 10.19	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	557	\$ 18,953	1,3	35
36	Medical Director	144	22,400	9,3	36
37	Medical Records Consultant	24	3,300	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10,3	39
40	Physical Therapy Consultant	107	5,992	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,737	11,3	44
45	Social Service Consultant	24	1,469	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	928	\$ 54,451		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Luther	Administrative		\$ 115,281	Workers' Compensation Insurance	\$ 57,765	IDPH License Fee	\$ 2,140	
Cindy See	Asst Admin		26,850	Unemployment Compensation Insurance	33,534	Advertising: Employee Recruitment	2,525	
Diane Hunt	Human Resources		38,307	FICA Taxes	168,356	Health Care Worker Background Check (Indicate # of checks performed _____)	3,638	
				Employee Health Insurance	67,516	Patient Background Checks		
				Employee Meals	71,358	Licenses	247	
				Illinois Municipal Retirement Fund (IMRF)*		IL Health Care Association	4,982	
				Innoculations		Internet Subscription	2,444	
				Incentives	12,141	Dues & Subscriptions	1,958	
				Other	324			
				Uniforms	1,063	Less: Public Relations Expense (_____)		
						Non-allowable advertising (_____)		
						Yellow page advertising (_____)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 180,438				\$ 412,057			\$ 17,934	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$ _____					\$ _____	Out-of-State Travel	\$ 75
	_____					_____		
	_____					_____	In-State Travel	589
	_____					_____		
	_____					_____	Seminar Expense	1,793
	_____					_____		
	_____					_____	Entertainment Expense (_____)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ _____				\$ _____			\$ 2,457	
C. Professional Services								
Vendor/Payee	Type	Amount						
BKD. LLP	Medicare Consultants	\$ 11,740						
BKD. LLP	Medicare Cost Report Fee	4,350						

TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 16,090								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. II Health Care Assoc. \$4,982
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,283 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,669
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 71,358 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? .4%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/06

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Utilities	\$ 3,868	5	1
2	Supplies-Repairs	543	6	2
3	Repairs & Maintenance	6,225	6	3
4	Wages-Administrative	41,213	17	4
5	Professional Services	15,458	19	5
6	License & Fees	112	20	6
7	Dues & Subscriptions	388	20	7
8	Wages-Clerical	58,266	21	8
9	Office Supplies	2,909	21	9
10	Telephone	4,435	21	10
11	Miscellaneous Office	177	21	11
12	Payroll Taxes	9,515	22	12
13	Workers' Comp Insurance	760	22	13
14	Employee Insurance	55	22	14
15	Uniforms	(58)	22	15
16	Travel & Seminar	380	24	16
17	Auto Expense	1,232	25	17
18	Insurance	2,902	26	18
19	Depreciation	5,506	30	19
20	Interest	48,256	32	20
21	Real Estate Taxes	6,615	33	21
22	Rent	11,824	34	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	220,581		49