

Facility Name & ID Number Imboden Creek Living Center# 0036574 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>34,770</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>34,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,067</u>	<u>17,696</u>	<u>5,045</u>	<u>31,808</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,067</u>	<u>17,696</u>	<u>5,045</u>	<u>31,808</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.48%

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 4,725Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	256,063	27,288	23,005	306,356		306,356		306,356			1
2	Food Purchase		246,945		246,945	(79,935)	167,010		167,010			2
3	Housekeeping	132,643	48,462		181,105		181,105		181,105			3
4	Laundry	77,280	36,414	40	113,734		113,734		113,734			4
5	Heat and Other Utilities			113,942	113,942		113,942	3,785	117,727			5
6	Maintenance	53,547	39,200	67,434	160,181		160,181	8,157	168,338			6
7	Other (specify):*											7
8	TOTAL General Services	519,533	398,309	204,421	1,122,263	(79,935)	1,042,328	11,942	1,054,270			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,608,555	82,642	8,729	1,699,926		1,699,926		1,699,926			10
10a	Therapy											10a
11	Activities	50,032	1,303	3,277	54,612		54,612		54,612			11
12	Social Services	26,671		1,201	27,872		27,872		27,872			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,685,258	83,945	36,007	1,805,210		1,805,210		1,805,210			16
	C. General Administration											
17	Administrative	93,741			93,741		93,741	126,707	220,448			17
18	Directors Fees											18
19	Professional Services			4,853	4,853		4,853	15,317	20,170			19
20	Dues, Fees, Subscriptions & Promotions			14,491	14,491		14,491	324	14,815			20
21	Clerical & General Office Expenses	33,999	13,042	23,509	70,550		70,550	82,420	152,970			21
22	Employee Benefits & Payroll Taxes			393,012	393,012	79,935	472,947	25,017	497,964			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,366	4,366		4,366	481	4,847			24
25	Other Admin. Staff Transportation			908	908		908	2,072	2,980			25
26	Insurance-Prop.Liab.Malpractice			62,664	62,664		62,664	2,404	65,068			26
27	Other (specify):* Nondeductible Exp			54,324	54,324		54,324	(54,324)				27
28	TOTAL General Administration	127,740	13,042	558,127	698,909	79,935	778,844	200,418	979,262			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,332,531	495,296	798,555	3,626,382		3,626,382	212,360	3,838,742			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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			65,379	65,379	65,379	86,737	152,116				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						144,345	144,345				32
33	Real Estate Taxes			81,533	81,533	81,533	5,769	87,302				33
34	Rent-Facility & Grounds			498,000	498,000	498,000	(498,000)					34
35	Rent-Equipment & Vehicles			1,195	1,195	1,195		1,195				35
36	Other (specify):*											36
37	TOTAL Ownership			646,107	646,107	646,107	(261,149)	384,958				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		397,281	397,181	794,462	794,462		794,462				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,156	52,156	52,156		52,156				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		397,281	449,337	846,618	846,618		846,618				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,332,531	892,577	1,893,999	5,119,107	5,119,107	(48,789)	5,070,318				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: 01/01/08

Ending: 12/31/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,296)	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	(6,814)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,996)	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	(648)	27		18
19	Entertainment	(418)	27		19
20	Contributions	(9,135)	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	(29,862)	27		24
25	Fund Raising, Advertising and Promotional	(11,840)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Gifts	(425)	27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,684)		\$	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)	(284,249)		34
35	Other- Attach Schedule	305,144		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,895		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (48,789)		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						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: 01/01/08

Ending: 12/31/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Gifts	\$ (425)	27
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(425)	49

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Utilities	\$ 3,785	5	1
2	Supplies-Repairs	178	6	2
3	Repairs & Maintenance	7,979	6	3
4	Wages-Administrative	126,707	17	4
5	Professional Services	15,317	19	5
6	Licenses & Fees	175	20	6
7	Dues & Subscriptions	149	20	7
8	Wages-Clerical	84,518	21	8
9	Office Supplies	2,927	21	9
10	Telephone	2,351	21	10
11	Miscellaneous Office	1,920	21	11
12	Payroll Taxes	16,250	22	12
13	Workers' Comp Insurance	1,669	22	13
14	Employee Insurance	6,890	22	14
15	Employee Incentives	208	22	15
16	Travel & Seminar	481	24	16
17	Other Admin. Staff Transportation	2,072	25	17
18	Insurance	2,404	26	18
19	Depreciation	2,748	30	19
20	Interest	20,647	32	20
21	Real Estate Taxes	5,769	33	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	305,144		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/08

Ending:

12/31/08**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	3,785	0	0	0	0	0	0	0	0	0	0	3,785	5
6	Maintenance	8,157	0	0	0	0	0	0	0	0	0	0	8,157	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	11,942	0	0	0	0	0	0	0	0	0	0	11,942	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	126,707	0	0	0	0	0	0	0	0	0	0	126,707	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	15,317	0	0	0	0	0	0	0	0	0	0	15,317	19
20	Fees, Subscriptions & Promotions	324	0	0	0	0	0	0	0	0	0	0	324	20
21	Clerical & General Office Expenses	82,420	0	0	0	0	0	0	0	0	0	0	82,420	21
22	Employee Benefits & Payroll Taxes	25,017	0	0	0	0	0	0	0	0	0	0	25,017	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	481	0	0	0	0	0	0	0	0	0	0	481	24
25	Other Admin. Staff Transportation	2,072	0	0	0	0	0	0	0	0	0	0	2,072	25
26	Insurance-Prop.Liab.Malpractice	2,404	0	0	0	0	0	0	0	0	0	0	2,404	26
27	Other (specify):*	(54,324)	0	0	0	0	0	0	0	0	0	0	(54,324)	27
28	TOTAL General Administration	200,418	0	0	0	0	0	0	0	0	0	0	200,418	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	212,360	0	0	0	0	0	0	0	0	0	0	212,360	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	3,498	83,239	0	0	0	0	0	0	0	0	0	86,737	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	13,833	130,512	0	0	0	0	0	0	0	0	0	144,345	32
33	Real Estate Taxes	5,769	0	0	0	0	0	0	0	0	0	0	5,769	33
34	Rent-Facility & Grounds	0	(498,000)	0	0	0	0	0	0	0	0	0	(498,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	23,100	(284,249)	0	(261,149)	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)	235,460	(284,249)	0	(48,789)	45								

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/08

Ending:

12/31/08

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$	John & Martha Brinkoetter	100.00%	\$	\$(498,000)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	83,239	83,239	2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	130,512	130,512	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		\$			\$ 213,751	\$ * (284,249)	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: 01/01/08 Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Days 48,955	2	\$ 5,826	\$	31,808	\$ 3,785	1
2	6	Supplies-Repairs	Days 48,955	2	274		31,808	178	2
3	6	Repairs & Maintenance	Days 48,955	2	12,281		31,808	7,979	3
4	17	Wages-Administrative	Days 48,955	2	195,012	195,012	31,808	126,707	4
5	19	Professional Services	Days 48,955	2	23,574		31,808	15,317	5
6	20	License & Fees	Days 48,955	2	270		31,808	175	6
7	20	Dues & Subscription	Days 48,955	2	230		31,808	149	7
8	21	Wages-Clerical	Days 48,955	2	130,080	130,080	31,808	84,518	8
9	21	Office Supplies	Days 48,955	2	4,505		31,808	2,927	9
10	21	Telephone	Days 48,955	2	3,619		31,808	2,351	10
11	21	Miscellaneous Office	Days 48,955	2	2,955		31,808	1,920	11
12	22	Payroll Taxes	Days 48,955	2	25,010		31,808	16,250	12
13	22	Workers' Comp Insurance	Days 48,955	2	2,568		31,808	1,669	13
14	22	Employee Insurance	Days 48,955	2	10,604		31,808	6,890	14
15	22	Employee Incentives	Days 48,955	2	320		31,808	208	15
16	24	Travel & Seminar	Days 48,955	2	740		31,808	481	16
17	25	Other Admin Staff Trans	Days 48,955	2	3,188		31,808	2,072	17
18	26	Insurance	Days 48,955	2	3,700		31,808	2,404	18
19	30	Deprecation	Days 48,955	2	4,229		31,808	2,748	19
20	32	Interest	Days 48,955	2	31,778		31,808	20,647	20
21	33	Real Estate Taxes	Days 48,955	2	8,879		31,808	5,769	21
22									22
23									23
24									24
25	TOTALS				\$ 469,642	\$ 325,092		\$ 305,144	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Regions Bank		X	Real Estate Loan	\$17,632.00	04/27/01	\$ 3,302,473	\$ 2,565,982	04/05/09	5.0000	\$ 130,512	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Regions Bank		X	Line of Credit	Interest Only	12/21/07	500,000	375,000	03/21/09	3.2500	20,647	6								
7												7								
8												8								
9	TOTAL Facility Related				\$17,632.00		\$ 3,802,473	\$ 2,940,982			\$ 151,159	9								
B. Non-Facility Related*																				
10				Interest Income							(6,814)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(6,814)	14								
15	TOTALS (line 9+line14)						\$ 3,802,473	\$ 2,940,982			\$ 144,345	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 0001 B 00 South Franklin Estates</u>	\$ <u>86,261.36</u>	\$ <u>86,261.36</u>
2. <u>04-12-27-278-010</u>	<u>N1/2 NE1/4 SE1/4 NE1/4 EXC N100</u>	\$ <u>8,815.30</u>	\$ <u>5,727.65</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>95,076.66</u>	\$ <u>91,989.01</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? 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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>	<u>1</u>
2					<u>2</u>
3	TOTALS	143,748		\$ 111,846	3

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

0036574

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 1,268,961	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sewer Improvements		1991	15,000		20	750	750	13,688	9
10		Landscaping		1992	2,460		10			2,460	10
11		Landscaping-Yard Pad		1992	1,000		10			1,000	11
12		Carpeting		1992	584		10			584	12
13		Decorate Activity Room		1992	852		10			852	13
14		Electrical		1993	2,550		10			2,550	14
15		Carpeting		1993	791		10			791	15
16		Carpeting		1993	747		10			747	16
17		Door		1993	657		10			657	17
18		Rose Garden Fence		1995	2,495		10			2,495	18
19		Carpeting		1996	1,121		10			1,121	19
20		Drive & Parking Lot		1996	2,065		10			2,065	20
21		Concrete Drive Service Doors		1995	2,100		10			2,100	21
22		Carpeting		1997	29,333		10			29,333	22
23		Landscaping		1998	2,387	119	10	119		2,387	23
24		Carpeting		1999	2,258	225	10	225		2,182	24
25		Carpeting		1999	937	94	10	94		844	25
26		Landscaping		2000	877	88	10	88		790	26
27		Carpeting		2000	2,321	232	10	232		1,992	27
28		Carpeting		2000	3,981	398	10	398		3,384	28
29		Baseboards for Bathrooms		2000	720	72	10	72		612	29
30		Shower Room Tile		2000	2,954	295	10	295		2,510	30
31		Baseboards for Bathrooms		2000	466	47	10	47		393	31
32		Floor Covering		2000	1,032	103	10	103		851	32
33		New Roof		2000	51,000	5,100	10	5,100		42,500	33
34		Roof Drains		2000	3,691	369	10	369		3,045	34
35		Deck		2000	2,668	267	10	267		2,201	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:

01/01/08

Ending:

12/31/08**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	<u>Tile Installation</u>	2000	\$ 1,380	\$ 138	10	\$ 138	\$	\$ 1,173	37
38	<u>Floor Covering</u>	2000	532	53	10	53		439	38
39	<u>Deck & Handrails</u>	2001	27,848	2,785	10	2,785		22,279	39
40	<u>Siding</u>	2000	1,475	148	10	148		1,217	40
41	<u>Kitchen Floor/Baseboards</u>	2001	8,244	825	10	825		6,115	41
42	<u>Carpeting</u>	2002	1,972		10	128	128	1,006	42
43	<u>Security System</u>	2002	8,338		10	677	677	5,155	43
44	<u>Outside Door</u>	2002	912		10	59	59	428	44
45	<u>Underground Cable System</u>	2002	9,178		10	596	596	4,768	45
46	<u>Glass Door</u>	2002	1,321		10	86	86	697	46
47	<u>Carpeting</u>	2002	2,732	273	10	273		1,844	47
48	<u>Dining Room Carpeting</u>	2002	11,734	1,174	10	1,174		7,627	48
49	<u>Fire Alarm System</u>	2002	17,894	1,789	10	1,789		11,184	49
50	<u>Roof</u>	2003	5,250		10	341	341	2,159	50
51	<u>Sprinklers</u>	2003	5,970	597	10	597		3,134	51
52	<u>New Water Guard System</u>	2003	2,044	204	10	204		1,073	52
53	<u>Step by Step Floors</u>	2004	2,723	272	10	272		1,180	53
54	<u>Nurses Station</u>	2005	21,300	2,130	10	2,130		7,455	54
55	<u>Carpeting-Nurse's Station</u>	2006	3,579	358	10	358		984	55
56	<u>Bathroom Fixture</u>	2007	3,540	354	10	354		649	56
57	<u>Bathroom Flooring</u>	2007	296	30	10	30		50	57
58	<u>Building Awning</u>	2007	2,675	267	10	267		490	58
59	<u>Therapy Room Fixture</u>	2007	1,072	107	10	107		143	59
60	<u>All Body Rebound</u>	2007	643	64	10	64		85	60
61	<u>Powermatic Mat Platform</u>	2007	3,767	377	10	377		502	61
62	<u>Upper and Lower Cabinets</u>	2007	425	43	10	43		57	62
63	<u>Activity Room</u>	2007	2,665	266	10	266		333	63
64	<u>Vinyl Flooring</u>	2007	2,694	269	10	269		359	64
65	<u>Wallcovering</u>	2007	21,358	2,136	10	2,136		2,226	65
66	<u>Bathroom Flooring</u>	2007	451	45	10	45		75	66
67	<u>Ceiling Light Fixture</u>	2007	432	43	10	43		47	67
68	<u>Deck & Breakfast</u>	2007	500	50	10	50		79	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,084,938	\$ 22,206		\$ 94,167	\$ 71,961	\$ 1,478,107	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:

01/01/08

Ending:

12/31/08

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	Remodeling - Wallpaper	2008	\$ 6,280	\$ 576	10	\$ 576	\$	\$ 576	37
38	Remodeling - Bathrooms	2008	1,170	107	10	107		107	38
39	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		185	39
40	Cornices and Cascades - Front Living	2008	1,503	138	10	138		138	40
41	Fixtures - HD Supply	2008	1,589	146	10	146		146	41
42	Lighting	2008	620	57	10	57		57	42
43	Cascades	2008	9,935	828	10	828		828	43
44	Remodeling - HD Facilities Maintenance	2008	296	22	10	22		22	44
45	Remodeling - Lowe's	2008	535	45	10	45		45	45
46	Signage	2008	6,650	443	10	443		443	46
47	Light Fixtures	2008	2,183	164	10	164		164	47
48	Light Fixtures	2008	730	55	10	55		55	48
49	Carpeting - Aimee and Andrew Hall	2008	25,198	1,890	10	1,890		1,890	49
50	Flooring - VCT	2008	1,866	140	10	140		140	50
51	Carpeting	2008	113,974	8,548	10	8,548		8,548	51
52	Carpeting - Flooring America	2008	10,576	617	10	617		617	52
53	Signage	2008	534	36	10	36		36	53
54	Plumbing and Toilet Fixtures	2008	469	31	10	31		31	54
55	Painting and Wallcovering	2008	4,350	218	10	218		218	55
56	Carpeting	2008	7,184	419	10	419		419	56
57	Light Fixtures	2008	303	20	10	20		20	57
58	Coves, Base Cabinets and Hardware	2008	725	30	10	30		30	58
59	Bathroom Fixtures	2008	521	13	10	13		13	59
60		2008	694	6	10	6		6	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)		\$ 3,284,672	\$ 36,940		\$ 108,901	\$ 71,961	\$ 1,492,841	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: 01/01/08 Ending: 12/31/08

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	\$ 451,276	\$ 20,601	\$ 35,223	\$ 14,622	5	\$ 334,489	71
72	Current Year Purchases	113,097	7,838	7,992	154	5	7,991	72
73	Fully Depreciated Assets	329,559				5	322,215	73
74								74
75	TOTALS	\$ 893,932	\$ 28,439	\$ 43,215	\$ 14,776		\$ 664,695	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,402,398	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,379	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,116	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 86,737	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,269,483	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 1,195 Description: Dishwasher \$1,195

(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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39,3	hrs	\$	2,932	\$ 150,325	\$	2,932	\$ 150,325	1
2	Licensed Speech and Language Development Therapist	39,3	hrs		1,606	100,948		1,606	100,948	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3	hrs		2,673	145,908		2,673	145,908	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):									12
13	Other (specify): Med Supplies, Lab IV	39,2					397,281		397,281	13
14	TOTAL			\$	7,211	\$ 397,181	\$ 397,281	7,211	\$ 794,462	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 9,284	\$ 52,626	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,080,227	1,166,538	3
4	Supply Inventory (priced at <u>cost</u>)	20,112	26,795	4
5	Short-Term Investments			5
6	Prepaid Insurance	48,582	65,446	6
7	Other Prepaid Expenses	7,377	82,079	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	1,987,092		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,152,674	\$ 1,393,484	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	469,755	506,751	15
16	Equipment, at Historical Cost	445,336	799,416	16
17	Accumulated Depreciation (book methods)	(448,263)	(742,475)	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>Deposit</u>		53,627	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 466,828	\$ 617,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,619,502	\$ 2,010,803	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 129,206	\$ 168,538	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		64,560	28
29	Short-Term Notes Payable		375,000	29
30	Accrued Salaries Payable	70,821	96,692	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,561	3,220	31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,124	232,954	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Advanced Billing</u>	274,390	406,014	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 564,102	\$ 1,346,978	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)	\$ 564,102	\$ 1,346,978	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,055,400	\$ 663,825	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,619,502	\$ 2,010,803	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,560,225	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,560,225	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	495,175	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)	\$ 495,175	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)	\$ 3,055,400	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 5,595,695	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,595,695	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	9,296	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)	\$ 9,296	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>	9,275	28
28a	<u>Miscellaneous Income</u>	16	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,291	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,614,282	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,122,263	31
32	Health Care	1,805,210	32
33	General Administration	698,909	33
B. Capital Expense			
34	Ownership	646,107	34
C. Ancillary Expense			
35	Special Cost Centers	794,462	35
36	Provider Participation Fee	52,156	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,119,107	40
41	Income before Income Taxes (line 30 minus line 40)**	495,175	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 495,175	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:

01/01/08

Ending:

12/31/08

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	1,960	2,003	\$ 62,435	\$ 31.17	1
2	Assistant Director of Nursing	2,080	2,082	39,493	18.97	2
3	Registered Nurses	4,764	5,137	80,190	15.61	3
4	Licensed Practical Nurses	21,014	23,903	368,635	15.42	4
5	CNAs & Orderlies	89,234	98,602	871,422	8.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,081	24,771	11.90	9
10	Activity Assistants	2,883	3,102	25,261	8.14	10
11	Social Service Workers	2,080	2,081	26,671	12.82	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,082	34,549	16.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,318	25,953	221,514	8.54	15
16	Dishwashers					16
17	Maintenance Workers	3,519	3,961	53,547	13.52	17
18	Housekeepers	14,342	15,225	132,643	8.71	18
19	Laundry	8,294	8,815	77,280	8.77	19
20	Administrator	2,080	2,081	54,131	26.01	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,081	39,610	19.03	22
23	Office Manager					23
24	Clerical	2,711	2,717	33,999	12.51	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	1,939	2,098	23,814	11.35	31
32	Other Health Care Restorative	5,950	6,363	81,152	12.75	32
33	Other(specify) Care Plan Coord	3,960	3,964	81,414	20.54	33
34	TOTAL (lines 1 - 33)	197,368	214,331	\$ 2,332,531 *	\$ 10.88	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	498	\$ 23,005	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	6	1,200	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10,3	39
40	Physical Therapy Consultant	104	6,163	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	1,311	11,3	44
45	Social Service Consultant	6	1,201	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	668	\$ 56,280		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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Health Care Assoc. \$5,438
- (3) Did the nursing home make political contributions or payments to a political action organization? 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. \$ 41,778 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. \$ 52,156
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. \$ 79,935 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? .4%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.