

Facility Name & ID Number Imboden Creek Living Center

0036574 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	95	34,675	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	9,112	16,576	5,690	31,378	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,112	16,576	5,690	31,378	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.49%

D. How many bed-hold days during this year were paid by the Department? 42 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 5,498

Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	254,875	29,220	22,671	306,766		306,766		306,766		1
2	Food Purchase		228,920		228,920	(139,686)	89,234		89,234		2
3	Housekeeping	141,132	33,159	851	175,142		175,142		175,142		3
4	Laundry	79,720	22,887		102,607		102,607		102,607		4
5	Heat and Other Utilities			99,449	99,449		99,449	3,888	103,337		5
6	Maintenance	54,865	39,355	64,885	159,105		159,105	9,048	168,153		6
7	Other (specify):*										7
8	TOTAL General Services	530,592	353,541	187,856	1,071,989	(139,686)	932,303	12,936	945,239		8
	B. Health Care and Programs										
9	Medical Director			22,800	22,800		22,800		22,800		9
10	Nursing and Medical Records	1,809,185	94,384	6,343	1,909,912		1,909,912		1,909,912		10
10a	Therapy										10a
11	Activities	52,340	2,689	2,644	57,673		57,673		57,673		11
12	Social Services	41,611		1,297	42,908		42,908		42,908		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,903,136	97,073	33,084	2,033,293		2,033,293		2,033,293		16
	C. General Administration										
17	Administrative	72,376			72,376		72,376	131,778	204,154		17
18	Directors Fees										18
19	Professional Services			18,819	18,819		18,819	29,715	48,534		19
20	Dues, Fees, Subscriptions & Promotions			14,530	14,530		14,530	743	15,273		20
21	Clerical & General Office Expenses	46,513	14,136	23,439	84,088		84,088	85,683	169,771		21
22	Employee Benefits & Payroll Taxes			471,878	471,878	139,686	611,564	21,027	632,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,284	14,284		14,284	367	14,651		24
25	Other Admin. Staff Transportation			619	619		619	227	846		25
26	Insurance-Prop.Liab.Malpractice			40,818	40,818		40,818	2,300	43,118		26
27	Other (specify):* Nondeductible Exp			131,742	131,742		131,742	(131,742)			27
28	TOTAL General Administration	118,889	14,136	716,129	849,154	139,686	988,840	140,098	1,128,938		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,552,617	464,750	937,069	3,954,436		3,954,436	153,034	4,107,470		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Imboden Creek Living Center

#0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			87,530	87,530		87,530	87,494	175,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							131,553	131,553			32
33	Real Estate Taxes			87,931	87,931		87,931	5,463	93,394			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(498,000)				34
35	Rent-Equipment & Vehicles			480	480		480		480			35
36	Other (specify):*											36
37	TOTAL Ownership			673,941	673,941		673,941	(273,490)	400,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		809,307	270,069	1,079,376		1,079,376		1,079,376			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,013	52,013		52,013		52,013			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		809,307	322,082	1,131,389		1,131,389		1,131,389			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,552,617	1,274,057	1,933,092	5,759,766		5,759,766	(120,456)	5,639,310			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1	Gifts		(349)	27
2				
3				
4				
5				
6				
7				
8				
9				
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11				
12				
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47				
48				
49	Total		(349)	

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Utilities	\$ 3,888	5	1
2	Supplies-Repairs	950	6	2
3	Repairs & Maintenance	8,098	6	3
4	Wages-Administrative	131,778	17	4
5	Professional Fees	29,715	19	5
6	License & Fees	1,161	20	6
7	Wages-Clerical	85,612	21	7
8	Office Supplies	3,962	21	8
9	Telephone	2,006	21	9
10	Miscellaneous Office	2,644	21	10
11	Payroll Taxes	16,549	22	11
12	Workers' Comp Insurance	640	22	12
13	Employee Insurance	3,216	22	13
14	Uniforms	6	22	14
15	Employee Incentives	616	22	15
16	Travel & Seminar	367	24	16
17	Other Admin. Staff Transportation	227	25	17
18	Insurance	2,300	26	18
19	Depreciation	3,505	30	19
20	Interest	5,303	32	20
21	Real Estate Taxes	5,463	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	308,006		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	3,888	0	0	0	0	0	0	0	0	0	0	3,888	5
6	Maintenance	9,048	0	0	0	0	0	0	0	0	0	0	9,048	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	12,936	0	12,936	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	131,778	0	0	0	0	0	0	0	0	0	0	131,778	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	29,715	0	0	0	0	0	0	0	0	0	0	29,715	19
20	Fees, Subscriptions & Promotions	743	0	0	0	0	0	0	0	0	0	0	743	20
21	Clerical & General Office Expenses	85,683	0	0	0	0	0	0	0	0	0	0	85,683	21
22	Employee Benefits & Payroll Taxes	21,027	0	0	0	0	0	0	0	0	0	0	21,027	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	367	0	0	0	0	0	0	0	0	0	0	367	24
25	Other Admin. Staff Transportation	227	0	0	0	0	0	0	0	0	0	0	227	25
26	Insurance-Prop.Liab.Malpractice	2,300	0	0	0	0	0	0	0	0	0	0	2,300	26
27	Other (specify):*	(131,742)	0	0	0	0	0	0	0	0	0	0	(131,742)	27
28	TOTAL General Administration	140,098	0	140,098	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	153,034	0	153,034	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	4,255	83,239	0	0	0	0	0	0	0	0	0	87,494	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	5,189	126,364	0	0	0	0	0	0	0	0	0	131,553	32
33	Real Estate Taxes	5,463	0	0	0	0	0	0	0	0	0	0	5,463	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	14,907	(288,397)	0	(273,490)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	167,941	(288,397)	0	0	0	0	0	0	0	0	0	(120,456)	45

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
<u>John & Martha Brinkoetter</u>	<u>100</u>			<u>Imboden Gardens</u>	<u>Decatur</u>	<u>Assisted Living</u>

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	<u>34 Rent</u>	\$	<u>John & Martha Brinkoetter</u>	<u>100.00%</u>	\$	<u>(498,000)</u>	1
2	V	<u>30 Depreciation</u>		<u>John & Martha Brinkoetter</u>	<u>100.00%</u>	<u>83,239</u>	<u>83,239</u>	2
3	V	<u>32 Interest</u>		<u>John & Martha Brinkoetter</u>	<u>100.00%</u>	<u>126,364</u>	<u>126,364</u>	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		\$			\$ <u>209,603</u>	\$ * <u>(288,397)</u>	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:

01/01/09

Ending:

12/31/09

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	\$ 64,908	17,7	1
2	Martha Brinkoetter	Clerical	Clerical	100.00		26	66.00	Salary	31,147	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	\$ 96,055		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Imboden Creek Gardens
 Street Address 185 W. Imboden Drive
 City / State / Zip Code Decatur, IL 62521
 Phone Number (217) 233-1425
 Fax Number (217) 233-1777

1	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	47,978	2	\$ 5,937	\$ 31,420	\$ 3,888	1
2	6	Supplies-Repairs	Days	47,978	2	1,451	31,420	950	2
3	6	Repairs & Maintenance	Days	47,978	2	12,366	31,420	8,098	3
4	17	Wages-Administrative	Days	47,978	2	201,223	201,223	131,778	4
5	19	Professional Services	Days	47,978	2	45,374	31,420	29,715	5
6	20	License & Fees	Days	47,978	2	1,773	31,420	1,161	6
7	20	Dues & Subscription	Days	47,978	2		31,420	0	7
8	21	Wages-Clerical	Days	47,978	2	130,729	130,729	85,612	8
9	21	Office Supplies	Days	47,978	2	6,050	31,420	3,962	9
10	21	Telephone	Days	47,978	2	3,063	31,420	2,006	10
11	21	Miscellaneous Office	Days	47,978	2	4,038	31,420	2,644	11
12	22	Payroll Taxes	Days	47,978	2	25,270	31,420	16,549	12
13	22	Workers' Comp Insurance	Days	47,978	2	977	31,420	640	13
14	22	Employee Insurance	Days	47,978	2	4,911	31,420	3,216	14
15	22	Employee Incentives	Days	47,978	2	941	31,420	616	15
16	24	Travel & Seminar	Days	47,978	2	560	31,420	367	16
17	25	Other Admin Staff Trans	Days	47,978	2	347	31,420	227	17
18	26	Insurance	Days	47,978	2	3,512	31,420	2,300	18
19	30	Depreciation	Days	47,978	2	5,352	31,420	3,505	19
20	32	Interest	Days	47,978	2	8,098	31,420	5,303	20
21	33	Real Estate Taxes	Days	47,978	2	8,342	31,420	5,463	21
22	22	Uniforms	Days	47,978	2	9	31,420	6	22
23									23
24									24
25	TOTALS					\$ 470,323	\$ 331,952	\$ 308,006	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										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	\$54,300.00	10/13/09	\$ 7,583,621	\$ 7,545,726	10/13/12	5.5100	\$ 126,364	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Regions Bank		X	Line of Credit	Interest Only	10/13/09	500,000	108,346	10/13/10	3.2500	5,303	6							
7												7							
8												8							
9	TOTAL Facility Related				\$54,300.00		\$ 8,083,621	\$ 7,654,072			\$ 131,667	9							
B. Non-Facility Related*																			
10				Interest Income							(114)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (114)	14							
15	TOTALS (line 9+line14)						\$ 8,083,621	\$ 7,654,072			\$ 131,553	15							

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	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

SEE ACCOUNTANTS' COMPILATION REPORT

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	95	1990	1990	\$ 2,772,947	\$	40	\$ 69,324	\$ 69,324	\$ 1,338,285	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sewer Improvements		1991	15,000		20	750	750	14,438	9
10	Landscaping		1992	2,460		10			2,460	10
11	Landscaping-Yard Pad		1992	1,000		10			1,000	11
12	Carpeting		1992	584		10			584	12
13	Decorate Activity Room		1992	852		10			852	13
14	Electrical		1993	2,550		10			2,550	14
15	Carpeting		1993	791		10			791	15
16	Carpeting		1993	747		10			747	16
17	Door		1993	657		10			657	17
18	Rose Garden Fence		1995	2,495		10			2,495	18
19	Carpeting		1996	1,121		10			1,121	19
20	Drive & Parking Lot		1996	2,065		10			2,065	20
21	Concrete Drive Service Doors		1995	2,100		10			2,100	21
22	Carpeting		1997	29,333		10			29,333	22
23	Landscaping		1998	2,387		10			2,387	23
24	Carpeting		1999	2,258	76	10	76		2,258	24
25	Carpeting		1999	937	94	10	94		937	25
26	Landscaping		2000	877	88	10	88		877	26
27	Carpeting		2000	2,321	232	10	232		2,224	27
28	Carpeting		2000	3,981	398	10	398		3,782	28
29	Baseboards for Bathrooms		2000	720	72	10	72		684	29
30	Shower Room Tile		2000	2,954	296	10	296		2,806	30
31	Baseboards for Bathrooms		2000	466	47	10	47		440	31
32	Floor Covering		2000	1,032	103	10	103		954	32
33	New Roof		2000	51,000	5,100	10	5,100		47,600	33
34	Roof Drains		2000	3,691	369	10	369		3,414	34
35	Deck		2000	2,668	267	10	267		2,468	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09**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		\$ 1,311	37
38	<u>Floor Covering</u>	2000	532	53	10	53		492	38
39	<u>Deck & Handrails</u>	2001	27,848	2,785	10	2,785		25,064	39
40	<u>Siding</u>	2000	1,475	147	10	147		1,364	40
41	<u>Kitchen Floor/Baseboards</u>	2001	8,244	824	10	824		6,939	41
42	<u>Carpeting</u>	2002	1,972		10	129	129	1,135	42
43	<u>Security System</u>	2002	8,338		10	683	683	5,838	43
44	<u>Outside Door</u>	2002	912		10	60	60	488	44
45	<u>Underground Cable System</u>	2002	9,178		10	601	601	5,369	45
46	<u>Glass Door</u>	2002	1,321		10	87	87	784	46
47	<u>Carpeting</u>	2002	2,732	273	10	273		2,117	47
48	<u>Dining Room Carpeting</u>	2002	11,734	1,173	10	1,173		8,800	48
49	<u>Fire Alarm System</u>	2002	17,894	1,789	10	1,789		12,973	49
50	<u>Roof</u>	2003	5,250		10	343	343	2,502	50
51	<u>Sprinklers</u>	2003	5,970	597	10	597		3,731	51
52	<u>New Water Guard System</u>	2003	2,044	204	10	204		1,277	52
53	<u>Step by Step Floors</u>	2004	2,723	272	10	272		1,452	53
54	<u>Nurses Station</u>	2005	21,300	2,130	10	2,130		9,585	54
55	<u>Carpeting-Nurse's Station</u>	2006	3,579	358	10	358		1,342	55
56	<u>Bathroom Fixture</u>	2007	3,540	354	10	354		1,003	56
57	<u>Bathroom Flooring</u>	2007	296	30	10	30		79	57
58	<u>Building Awning</u>	2007	2,675	268	10	268		758	58
59	<u>Therapy Room Fixture</u>	2007	1,072	107	10	107		250	59
60	<u>All Body Rebound</u>	2007	643	65	10	65		150	60
61	<u>Powermatic Mat Platform</u>	2007	3,767	377	10	377		879	61
62	<u>Upper and Lower Cabinets</u>	2007	425	42	10	42		99	62
63	<u>Activity Room</u>	2007	2,665	267	10	267		600	63
64	<u>Vinyl Flooring</u>	2007	2,694	269	10	269		628	64
65	<u>Wallcovering</u>	2007	21,358	2,136	10	2,136		4,362	65
66	<u>Bathroom Flooring</u>	2007	451	45	10	45		120	66
67	<u>Ceiling Light Fixture</u>	2007	432	43	10	43		90	67
68	<u>Deck & Breakfast</u>	2007	500	50	10	50		129	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,084,938	\$ 21,938		\$ 93,915	\$ 71,977	\$ 1,572,019	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09**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	
1	Totals from Page 12A, Carried Forward		\$ 3,084,938	\$ 21,938		\$ 93,915	\$ 71,977	\$ 1,572,019	1
2	Remodeling - Wallpaper	2008	6,280	628	10	628		1,204	2
3	Remodeling - Bathrooms	2008	1,170	117	10	117		224	3
4	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		370	4
5	Cornices and Cascades - Front Living	2008	1,503	150	10	150		288	5
6	Fixtures - HD Supply	2008	1,589	159	10	159		305	6
7	Lighting	2008	620	62	10	62		119	7
8	Cascades	2008	9,935	993	10	993		1,821	8
9	Remodeling - HD Facilities Maintenance	2008	296	30	10	30		52	9
10	Remodeling - Lowe's	2008	535	53	10	53		98	10
11	Signage	2008	6,650	665	10	665		1,108	11
12	Light Fixtures	2008	2,183	218	10	218		382	12
13	Light Fixtures	2008	730	73	10	73		128	13
14	Carpeting - Aimee and Andy Hall	2008	25,198	2,520	10	2,520		4,410	14
15	Flooring - VCT	2008	1,866	186	10	186		326	15
16	Carpeting	2008	113,974	11,397	10	11,397		19,945	16
17	Carpeting - Flooring America	2008	10,576	1,058	10	1,058		1,675	17
18	Signage	2008	534	53	10	53		89	18
19	Plumbing and Toilet Fixtures	2008	469	47	10	47		78	19
20	Painting and Wallcovering	2008	4,350	435	10	435		653	20
21	Carpeting	2008	7,184	719	10	719		1,138	21
22	Light Fixtures	2008	303	30	10	30		50	22
23	Coves, Base Cabinets and Hardware	2008	725	73	10	73		103	23
24	Bathroom Fixtures	2008	521	52	10	52		65	24
25	Indoor Signs	2008	694	69	10	69		75	25
26	Cabling	2009	961	88	10	88		88	26
27	Vanities	2009	551	46	10	46		46	27
28	HVAC Rooftop Unit	2009	10,150	508	10	508		508	28
29	Cornices	2009	2,343	117	10	117		117	29
30	8 Vanities/Faucets	2009	986	41	10	41		41	30
31	Flooring	2009	364	18	10	18		18	31
32	Sidewalks, stairs	2009	20,060		10	876	876	876	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,320,087	\$ 42,728		\$ 115,581	\$ 72,853	\$ 1,608,419	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 557,532	\$ 34,777	\$ 49,392	\$ 14,615	5	\$ 387,457	71
72	Current Year Purchases	182,134	10,024	10,051	27	5	10,051	72
73	Fully Depreciated Assets	336,400				5	326,630	73
74								74
75	TOTALS	\$ 1,076,066	\$ 44,801	\$ 59,443	\$ 14,642		\$ 724,138	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	Saff	1992 Toyota 4 X 4	1996	\$ 10,201	\$	\$	\$	5	\$ 10,201	76
77	Saff	2001 Ford F150 Truck	2000	35,174				5	35,173	77
78	Saff	2001 Lexus LS340	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)	\$ 4,619,947	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,529	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,024	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,495	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,444,504	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: \$ 480 Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	39,3	hrs	\$		3,830	\$ 312,699	\$	3,830	\$ 312,699						1
2	Licensed Speech and Language Development Therapist	39,3	hrs			1,341	80,587		1,341	80,587						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39,3	hrs			5,764	416,021		5,764	416,021						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	Other (specify):															12
13	Other (specify): <u>Med Supplies, Lab IV</u>	39,2								270,069					270,069	13
14	TOTAL			\$		10,935	\$ 809,307	\$	10,935	\$ 270,069			10,935	\$ 1,079,376		14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 8,590	\$ 74,305	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	887,051	989,570	3
4	Supply Inventory (priced at <u>cost</u>)	20,449	28,093	4
5	Short-Term Investments			5
6	Prepaid Insurance	37,552	54,689	6
7	Other Prepaid Expenses	6,056	12,714	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	2,816,476		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,776,174	\$ 1,159,371	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	485,110	543,150	15
16	Equipment, at Historical Cost	693,544	1,054,545	16
17	Accumulated Depreciation (book methods)	(603,104)	(926,615)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 575,550	\$ 671,080	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,351,724	\$ 1,830,451	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 155,707	\$ 250,220	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		47,245	28
29	Short-Term Notes Payable		108,346	29
30	Accrued Salaries Payable	30,853	41,045	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,850	40,311	31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,527	230,723	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		5,311	35
Other Current Liabilities(specify):				
36	<u>Advanced Billing</u>	255,800	381,634	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 553,737	\$ 1,104,835	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)	\$ 553,737	\$ 1,104,835	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,797,987	\$ 725,616	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,351,724	\$ 1,830,451	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,055,400	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,055,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	742,587	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)	\$ 742,587	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)	\$ 3,797,987	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 6,491,624	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,491,624	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	100	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	8,541	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,641	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	114	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 114	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Memorial Income</u>	1,925	28
28a	<u>Miscellaneous Income</u>	49	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,974	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,502,353	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,071,989	31
32	Health Care	2,033,293	32
33	General Administration	849,154	33
B. Capital Expense			
34	Ownership	673,941	34
C. Ancillary Expense			
35	Special Cost Centers	1,079,376	35
36	Provider Participation Fee	52,013	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,759,766	40
41	Income before Income Taxes (line 30 minus line 40)**	742,587	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 742,587	43

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

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

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

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

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,963	\$ 71,555	\$ 36.45	1
2	Assistant Director of Nursing	1,600	1,600	32,592	20.37	2
3	Registered Nurses	4,552	4,645	85,071	18.31	3
4	Licensed Practical Nurses	22,240	23,378	382,877	16.38	4
5	CNAs & Orderlies	89,027	93,382	1,004,627	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,081	28,127	13.52	9
10	Activity Assistants	2,846	2,885	24,213	8.39	10
11	Social Service Workers	2,009	2,010	41,611	20.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,082	36,490	17.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,165	25,348	218,385	8.62	15
16	Dishwashers					16
17	Maintenance Workers	3,904	4,135	54,865	13.27	17
18	Housekeepers	14,573	15,471	141,132	9.12	18
19	Laundry	8,530	9,118	79,720	8.74	19
20	Administrator	2,080	2,081	57,262	27.52	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,081	15,114	7.26	22
23	Office Manager					23
24	Clerical	3,562	3,611	46,513	12.88	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	2,035	2,136	25,432	11.91	31
32	Other Health Care Restorative	7,882	8,296	107,991	13.02	32
33	Other(specify) Care Plan Coord	6,416	6,525	99,040	15.18	33
34	TOTAL (lines 1 - 33)	203,621	212,828	\$ 2,552,617 *	\$ 11.99	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	537	\$ 22,671	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	45	2,496	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	3,847	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,529	11,3	44
45	Social Service Consultant	18	1,297	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	685	\$ 54,640		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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Molly Carpenter	Administrative		\$ 57,262	Workers' Compensation Insurance	\$ 84,515	IDPH License Fee	\$			
Diane Hunt	Human Resources		15,114	Unemployment Compensation Insurance	16,464	Advertising: Employee Recruitment		1,920		
				FICA Taxes	212,072	Health Care Worker Background Check (Indicate # of checks performed _____)		2,297		
				Employee Health Insurance	165,337	Patient Background Checks				
				Employee Meals	139,686	Licenses		1,288		
				Illinois Municipal Retirement Fund (IMRF)*		IL Health Care Association		8,613		
				Incentives	8,972	Internet Subscription		587		
				Uniforms	(865)	Dues & Subscriptions		568		
				Other	6,471					
				Innoculations	(61)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,376	TOTAL (agree to Schedule V, line 22, col.8)			\$ 632,591	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,273
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		\$	
							In-State Travel		3,912	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		10,739	
C. Professional Services				TOTAL			\$	Entertainment Expense		()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)			
BKD, LLP	Medicare Consultants		\$ 4,950				TOTAL		\$ 14,651	
Brinkoetter Law Office	Legal		450							
Polsinelli Shughart PC	Legal		8,414							
MPRO Administration			3,335							
Farnsworth Group Architects	Architects		1,395							
Mature Resource Network	Marketing Group		275							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,819							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center# 0036574Report Period Beginning: 01/01/09Ending: 12/31/09**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 Accoc. \$8,613
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,951 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,013
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 139,686 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? .4%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT