

Facility Name & ID Number Imboden Creek Living Center

0036574 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,125	15,447	5,505	30,077	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,125	15,447	5,505	30,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.74%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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 4,990

Medicare Intermediary AdminStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	267,950	25,694	25,616	319,260		319,260		319,260		1
2	Food Purchase		256,181		256,181	(123,166)	133,015		133,015		2
3	Housekeeping	133,860	40,576		174,436		174,436		174,436		3
4	Laundry	57,205	13,175		70,380		70,380		70,380		4
5	Heat and Other Utilities			95,409	95,409		95,409	3,260	98,669		5
6	Maintenance	90,376	32,578	88,430	211,384		211,384	1,353	212,737		6
7	Other (specify):* Trash & Waste			11,240	11,240		11,240		11,240		7
8	TOTAL General Services	549,391	368,204	220,695	1,138,290	(123,166)	1,015,124	4,613	1,019,737		8
	B. Health Care and Programs										
9	Medical Director			22,800	22,800		22,800		22,800		9
10	Nursing and Medical Records	1,880,089	143,032	7,570	2,030,691		2,030,691	1,520	2,032,211		10
10a	Therapy										10a
11	Activities	75,159	2,141	4,198	81,498		81,498		81,498		11
12	Social Services	61,479		1,911	63,390		63,390		63,390		12
13	CNA Training										13
14	Program Transportation			1,050	1,050		1,050		1,050		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,016,727	145,173	37,529	2,199,429		2,199,429	1,520	2,200,949		16
	C. General Administration										
17	Administrative	125,394			125,394		125,394	180,677	306,071		17
18	Directors Fees										18
19	Professional Services			17,427	17,427		17,427	29,082	46,509		19
20	Dues, Fees, Subscriptions & Promotions			17,575	17,575		17,575	70	17,645		20
21	Clerical & General Office Expenses	23,364	8,972	32,108	64,444		64,444	78,651	143,095		21
22	Employee Benefits & Payroll Taxes			433,471	433,471	123,166	556,637	36,749	593,386		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,253	9,253		9,253	542	9,795		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,045	40,045		40,045	1,642	41,687		26
27	Other (specify):* Nondeductible			53,746	53,746		53,746	(53,746)			27
28	TOTAL General Administration	148,758	8,972	603,625	761,355	123,166	884,521	273,667	1,158,188		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,714,876	522,349	861,849	4,099,074		4,099,074	279,800	4,378,874		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:

01/01/14

Ending:

12/31/14

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			96,883	96,883	96,883	72,247	169,130				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						110,528	110,528				32
33	Real Estate Taxes			91,972	91,972	91,972	8,239	100,211				33
34	Rent-Facility & Grounds			534,000	534,000	534,000	(534,000)					34
35	Rent-Equipment & Vehicles			400	400	400		400				35
36	Other (specify):*											36
37	TOTAL Ownership			723,255	723,255	723,255	(342,986)	380,269				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		564,004	162,146	726,150	726,150		726,150				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			202,476	202,476	202,476		202,476				42
43	Other (specify):* Radiology & Lab			22,385	22,385	22,385		22,385				43
44	TOTAL Special Cost Centers		564,004	387,007	951,011	951,011		951,011				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,714,876	1,086,353	1,972,111	5,773,340	5,773,340	(63,186)	5,710,154				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	(4,877)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(293)	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	(7,280)	27		18
19	Entertainment	(243)	27		19
20	Contributions	(2,931)	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	(22,639)	27		24
25	Fund Raising, Advertising and Promotional	(19,748)	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 See Pg 5A	(1,573)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,859)		\$	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)	(362,463)		34
35	Other- Attach Schedule	360,136		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,327)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (63,186)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Gifts	\$ (612)	27	1
2	Adjust out depreciation on P/Y expensed items.	(961)	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(1,573)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,260	0	0	0	0	0	0	0	0	3,260	5
6	Maintenance	0	0	1,353	0	0	0	0	0	0	0	0	1,353	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	4,613	0	4,613	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	1,520	0	0	0	0	0	0	0	0	1,520	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	1,520	0	1,520	16							
	C. General Administration													
17	Administrative	0	0	180,677	0	0	0	0	0	0	0	0	180,677	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	29,082	0	0	0	0	0	0	0	0	29,082	19
20	Fees, Subscriptions & Promotions	0	0	70	0	0	0	0	0	0	0	0	70	20
21	Clerical & General Office Expenses	(4,877)	0	83,528	0	0	0	0	0	0	0	0	78,651	21
22	Employee Benefits & Payroll Taxes	0	0	36,749	0	0	0	0	0	0	0	0	36,749	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	542	0	0	0	0	0	0	0	0	542	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,642	0	0	0	0	0	0	0	0	1,642	26
27	Other (specify):*	(53,746)	0	0	0	0	0	0	0	0	0	0	(53,746)	27
28	TOTAL General Administration	(58,623)	0	332,290	0	273,667	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,623)	0	338,423	0	279,800	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(961)	69,324	3,884	0	0	0	0	0	0	0	0	72,247	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,275)	102,213	9,590	0	0	0	0	0	0	0	0	110,528	32
33	Real Estate Taxes	0	0	8,239	0	0	0	0	0	0	0	0	8,239	33
34	Rent-Facility & Grounds	0	(534,000)	0	0	0	0	0	0	0	0	0	(534,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,236)	(362,463)	21,713	0	(342,986)	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)	(60,859)	(362,463)	360,136	0	0	0	0	0	0	0	0	(63,186)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John & Martha Brinkoetter	100			Imboden Gardents	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	\$ 534,000	John & Martha Brinkoetter	100.00%	\$	\$ (534,000)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	69,324	69,324	2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	102,213	102,213	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 534,000			\$ 171,537	\$ * (362,463)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>5</u> Utilities	\$	Corporate Center		\$ 3,260	\$	3,260	15
16	V	<u>6</u> Supplies-Repairs		Corporate Center		941		941	16
17	V	<u>6</u> Repairs & Maintenance		Corporate Center		412		412	17
18	V	<u>17</u> Wages-Administrative		Corporate Center		180,677		180,677	18
19	V	<u>19</u> Professional Fees		Corporate Center		29,082		29,082	19
20	V	<u>20</u> License & Fees		Corporate Center		70		70	20
21	V	<u>10</u> Nursing & Medical Records		Corporate Center		1,520		1,520	21
22	V	<u>21</u> Wages-Clerical		Corporate Center		76,159		76,159	22
23	V	<u>21</u> Office Supplies		Corporate Center		2,022		2,022	23
24	V	<u>21</u> Telephone		Corporate Center		1,799		1,799	24
25	V	<u>21</u> Miscellaneous Office		Corporate Center		3,548		3,548	25
26	V	<u>22</u> Payroll Taxes		Corporate Center		18,359		18,359	26
27	V	<u>22</u> Workers' Comp Insurance		Corporate Center		1,876		1,876	27
28	V	<u>22</u> Employee Insurance		Corporate Center		16,307		16,307	28
29	V	<u>22</u> Uniforms		Corporate Center		34		34	29
30	V	<u>22</u> Employee Incentives		Corporate Center		173		173	30
31	V	<u>24</u> Travel & Seminar		Corporate Center		542		542	31
32	V	<u>26</u> Insurance		Corporate Center		1,642		1,642	32
33	V	<u>30</u> Depreciaton		Corporate Center		3,884		3,884	33
34	V	<u>32</u> Interest		Corporate Center		9,590		9,590	34
35	V	<u>33</u> Real Estate Taxes		Corporate Center		8,239		8,239	35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 360,136	\$ *	360,136	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	17,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,498		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 (217) 233-1777

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	46,546	2	\$ 5,045	\$ 30,077	\$ 3,260	1
2	6	Supplies-Repairs	Days	46,546	2	1,457	30,077	941	2
3	6	Repairs & Maintenance	Days	46,546	2	637	30,077	412	3
4	17	Wages-Administrative	Days	46,546	2	279,609	279,609	180,677	4
5	19	Professional Fees	Days	46,546	2	45,006	30,077	29,082	5
6	20	License & Fees	Days	46,546	2	108	30,077	70	6
7	10	Nursing & Medical Records	Days	46,546	2	2,352	30,077	1,520	7
8	21	Wages-Clerical	Days	46,546	2	117,860	117,860	76,159	8
9	21	Office Supplies	Days	46,546	2	3,129	30,077	2,022	9
10	21	Telephone	Days	46,546	2	2,784	30,077	1,799	10
11	21	Miscellaneous Office	Days	46,546	2	5,491	30,077	3,548	11
12	22	Payroll Taxes	Days	46,546	2	28,412	30,077	18,359	12
13	22	Workers' Comp Insurance	Days	46,546	2	2,903	30,077	1,876	13
14	22	Employee Insurance	Days	46,546	2	25,236	30,077	16,307	14
15	22	Uniforms	Days	46,546	2	52	30,077	34	15
16	22	Employee Incentives	Days	46,546	2	267	30,077	173	16
17	24	Travel & Seminar	Days	46,546	2	839	30,077	542	17
18	26	Insurance	Days	46,546	2	2,541	30,077	1,642	18
19	30	Depreciation	Days	46,546	2	6,010	30,077	3,884	19
20	32	Interest	Days	46,546	2	14,841	30,077	9,590	20
21	33	Real Estate Taxes	Days	46,546	2	12,750	30,077	8,239	21
22									22
23									23
24									24
25	TOTALS					\$ 557,329	\$ 397,469	\$ 360,136	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Imboden Creek Living Center

0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	10/21/11	\$ 7,583,621	\$ 6,241,179	10/21/16	7.9600	\$ 102,213	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Regions Bank		X	Line of Credit	Interest Only	4/28/14	500,000	223,000	6/15/15	4.2500	9,590	6						
7												7						
8												8						
9	TOTAL Facility Related				\$54,300.00		\$ 8,083,621	\$ 6,464,179			\$ 111,803	9						
B. Non-Facility Related*																		
10	Interest Income										(1,275)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(1,275)	14						
15	TOTALS (line 9+line14)						\$ 8,083,621	\$ 6,464,179			\$ 110,528	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	96,948		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	98,410		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,462		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	98,749		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	100,211		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	98,030	8	FOR BHF USE ONLY	
	2010	94,939	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	93,873	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	96,868	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	102,966	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Nursing Home \$90,510					
Corp Office-allocated \$12,750 x .646177 = \$8,239					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2013 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 2013 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 2013.

(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>04-12-27-231-013</u>	<u>South Franklin Estates Second Add Lt</u>	\$ <u>90,225.04</u>	\$ <u>90,225.04</u>
2. <u>04-12-27-278-010</u>	<u>N1/2 NE 1/4 SE1/4 NE1/4 EXC N 10</u>	\$ <u>12,741.29</u>	\$ <u>8,238.75</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>102,966.33</u></u>	\$ <u><u>98,463.79</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 1,684,905	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Sewer Improvements	1991		15,000		20			15,000	9
10		Landscaping	1992		2,460		10			2,460	10
11		Landscaping - Yard Pad	1992		1,000		10			1,000	11
12		Carpeting	1992		584		10			584	12
13		Decorate Activity Room	1992		852		10			852	13
14		Electrical	1992		2,550		10			2,550	14
15		Carpeting	1993		791		10			791	15
16		Carpeting	1993		747		10			747	16
17		Door	1993		657		10			657	17
18		Rose Garden Fence	1993		2,495		10			2,495	18
19		Carpeting	1995		1,121		10			1,121	19
20		Drive & Parking Lot	1996		2,065		10			2,065	20
21		Concrete Drive Service Doors	1996		2,100		10			2,100	21
22		Carpeting	1995		29,333		10			29,333	22
23		Landscaping	1997		2,387		10			2,387	23
24		Carpeting	1998		2,258		10			2,258	24
25		Carpeting	1999		937		10			937	25
26		Landscaping	1999		877		10			877	26
27		Carpeting	2000		2,321		10			2,321	27
28		Carpeting	2000		3,981		10			3,981	28
29		Baseboards for Bathrooms	2000		720		10			720	29
30		Shower Room Tile	2000		2,954		10			2,954	30
31		Baseboards for Bathrooms	2000		466		10			466	31
32		Floor Covering	2000		1,032		10			1,032	32
33		New Roof	2000		51,000		10			51,000	33
34		Roof Drains	2000		3,691		10			3,691	34
35		Deck	2000		2,668		10			2,668	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tile Installation	2000	\$ 1,380	\$	10	\$	\$	\$ 1,380	37
38	Floor Covering	2000	532		10			532	38
39	Deck & Handrails	2001	27,848		10			27,848	39
40	Siding	2000	1,475		10			1,475	40
41	Kitchen Floor/Baseboards	2001	8,244		10			8,244	41
42	Carpeting	2002	1,972		10			1,422	42
43	Security System	2002	8,338		10			6,119	43
44	Outside Doors	2002	912		10			645	44
45	Underground Cable System	2002	9,178		10			6,658	45
46	Glass Door	2002	1,321		10			963	46
47	Carpeting	2002	2,732		10			2,732	47
48	Dining Room Carpeting	2002	11,734		10			11,734	48
49	Fire Alarm System	2002	17,894		10			17,894	49
50	Roof	2003	5,250		10			3,605	50
51	Sprinklers	2003	5,970		10			5,970	51
52	New Water Guard System	2003	2,044		10			2,044	52
53	Step by Step Floors	2004	2,723	182	10	182		2,723	53
54	Nurses Station	2005	21,300	2,130	10	2,130		20,235	54
55	Carpeting-Nurse's Station	2006	3,579	358	10	358		3,132	55
56	Bathroom Fixture	2007	3,540	354	10	354		2,773	56
57	Bathroom Flooring	2007	296	30	10	30		227	57
58	Building Awning	2007	2,675	268	10	268		2,095	58
59	Therapy Room Fixture	2007	1,072	107	10	107		786	59
60	All Body Rebound	2007	643	64	10	64		471	60
61	Powermate Mat Platform	2007	3,767	377	10	377		2,762	61
62	Upper and Lower Cabinets	2007	425	43	10	43		312	62
63	Activity Room	2007	2,665	267	10	267		1,932	63
64	Vinyl Flooring	2007	2,694	269	10	269		1,975	64
65	Wallcovering	2007	21,358	2,136	10	2,136		15,041	65
66	Bathroom Flooring	2007	451	45	10	45		345	66
67	Ceiling Light Fixture	2007	432	43	10	43		306	67
68	Deck & Breakfast	2007	500	50	10	50		379	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,084,938	\$ 6,723		\$ 76,047	\$ 69,324	\$ 1,976,711	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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 6,723		\$ 76,047	\$ 69,324	\$ 1,976,711	1
2	Remodeling - Wallpaper	2008	6,280	628	10	628		4,344	2
3	Remodeling - Bathrooms	2008	1,170	117	10	117		809	3
4	Cornices - Activity and Adjoining Office	2008	1,849	185	10	185		1,295	4
5	Cornices and Cascades - Front Living	2008	1,503	150	10	150		1,040	5
6	Fixtures - HD Facilities Maintenance	2008	1,589	159	10	159		1,099	6
7	Lighting	2008	620	62	10	62		429	7
8	Cascades	2008	9,935	994	10	994		6,789	8
9	Remodeling - HD Facilities Maintenance	2008	296	30	10	30		200	9
10	Remodeling - Lowe's	2008	535	53	10	53		366	10
11	Signage	2008	6,650	665	10	665		4,433	11
12	Light Fixtures	2008	2,183	218	10	218		1,473	12
13	Light Fixtures	2008	730	73	10	73		493	13
14	Carpeting - Aimee and Andy Hall	2008	25,198	2,520	10	2,520		17,009	14
15	Flooring - VCI	2008	1,866	187	10	187		1,259	15
16	Carpeting	2008	113,974	11,397	10	11,397		76,932	16
17	Carpeting - Flooring America	2008	10,576	1,058	10	1,058		6,963	17
18	Signage	2008	534	53	10	53		356	18
19	Plumbing and Toilet Fixtures	2008	469	47	10	47		313	19
20	Painting and Wallcovering	2008	4,350	435	10	435		2,828	20
21	Carpeting	2008	7,184	718	10	718		4,730	21
22	Light Fixtures	2008	303	30	10	30		202	22
23	Coves, Base Cabinets and Hardware	2008	725	72	10	72		465	23
24	Bathroom Fixtures	2008	521	52	10	52		325	24
25	Indoor Signs	2008	694	69	10	69		422	25
26	Cabling	2009	961	96	10	96		569	26
27	Vanities	2009	551	55	10	55		322	27
28	HVAC Rooftop Unit	2009	10,150	1,015	10	1,015		5,583	28
29	Cornices	2009	2,343	234	10	234		1,289	29
30	8 Vanities Faucets	2009	986	99	10	99		534	30
31	Flooring - Bathroom	2009	364	36	10	36		200	31
32	Sidewalks, Stairs	2009	20,060		10	1,296	1,296	7,360	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,320,087	\$ 28,230		\$ 98,850	\$ 70,620	\$ 2,127,142	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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		\$ 3,320,087	\$ 28,230		\$ 98,850	\$ 70,620	\$ 2,127,142	1
2	Windsor Collection	2010	798	71	10	71		512	2
3	5 Easycare Beds	2010	4,894	413	10	413		3,240	3
4	2 PTAC P-410A Model	2010	1,245	112	10	112		799	4
5	Awning	2010	18,602	1,860	10	1,860		7,596	5
6	3 Easycard Beds	2011	3,793	379	10	379		1,296	6
7	6 Windsor Footboard/Headboard	2011	1,214	121	10	121		405	7
8	8 Pendant Lights	2011	2,641	264	10	264		792	8
9	Fireplace and Stone	2012	2,493	249	10	249		727	9
10	Electrical for Fireplace	2012	862	86	10	86		237	10
11	Fireplace Framing	2012	1,479	148	10	148		419	11
12	Compressor	2012	6,876	688	10	688		1,891	12
13	Flooring - Hall and Resident Room	2012	5,345	534	10	534		1,470	13
14	Door Restrictors	2013	3,350	335	10	335		391	14
15	Steel Door	2013	3,371	337	10	337		393	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,377,050	\$ 33,827		\$ 104,447	\$ 70,620	\$ 2,147,310	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 832,250	\$ 61,797	\$ 62,012	\$ 215	5	\$ 608,064	71
72	Current Year Purchases	3,996	299	299		5	299	72
73	Fully Depreciated Assets	435,937				5	422,637	73
74								74
75	TOTALS	\$ 1,272,183	\$ 62,096	\$ 62,311	\$ 215		\$ 1,031,000	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1992 Toyota 4 x 4	1996	\$ 10,201	\$	\$	\$	5	\$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174				5	35,174	77
78	Staff	2001 Lexus LX3240	2000	66,573				5	66,573	78
79	Staff	2012 Dodge Caravan	2013	18,353		2,372	2,372	5	3,749	79
80	TOTALS			\$ 130,301	\$	\$ 2,372	\$ 2,372		\$ 115,697	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)	\$ 4,891,380	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,923	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,130	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,294,007	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 400

Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 01/01/14 Ending: 12/31/14
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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39,3	hrs	\$	3,288	\$ 181,682	\$	3,288	\$ 181,682	1	
2	Licensed Speech and Language Development Therapist	39,3	hrs		1,936	110,081		1,936	110,081	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39,3	hrs		5,182	272,241		5,182	272,241	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): <u>Med Supplies, Lab IV</u>	39,2 & 43,2					184,531		184,531	12	
13	Other (specify):									13	
14	TOTAL			\$	10,406	\$ 564,004	\$ 184,531	10,406	\$ 748,535	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: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	\$ 15,956	\$ 111,964	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	662,414	679,580	3
4	Supply Inventory (priced at <u>Cost</u>)	18,864	29,508	4
5	Short-Term Investments			5
6	Prepaid Insurance	38,085	49,142	6
7	Other Prepaid Expenses	12,620	18,179	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 747,939	\$ 888,373	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	546,254	619,693	15
16	Equipment, at Historical Cost	891,738	1,337,935	16
17	Accumulated Depreciation (book methods)	(1,081,471)	(1,537,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,335	29,335	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,335)	(29,335)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 356,521	\$ 419,923	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,104,460	\$ 1,308,296	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 168,794	\$ 237,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		47,500	28
29	Short-Term Notes Payable		223,000	29
30	Accrued Salaries Payable	79,701	141,109	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,342	69,061	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,510	223,075	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,946	35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 406,347	\$ 944,320	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)	\$ 406,347	\$ 944,320	46
47	TOTAL EQUITY(page 18, line 24)	\$ 698,113	\$ 363,976	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,104,460	\$ 1,308,296	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,188,002	1
2	Restatements (describe):		2
3	Restatement of beginning equity to remove intercompany		3
4	balances	(5,341,467)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 846,535	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	775,341	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) C/Y Intercompany Activity	(923,763)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (148,422)	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)	\$ 698,113	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,541,323	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,541,323	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	4,877	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,878	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,275	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,275	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Memorial Income</u>	708	28
28a	<u>Miscellaneous Income</u>	497	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,205	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,548,681	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,138,290	31
32	Health Care	2,199,429	32
33	General Administration	761,355	33
B. Capital Expense			
34	Ownership	723,255	34
C. Ancillary Expense			
35	Special Cost Centers	748,535	35
36	Provider Participation Fee	202,476	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,773,340	40
41	Income before Income Taxes (line 30 minus line 40)**	775,341	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 775,341	43

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 75,805	\$ 36.44	1
2	Assistant Director of Nursing	1,232	1,232	24,884	20.20	2
3	Registered Nurses	3,250	3,402	101,808	29.93	3
4	Licensed Practical Nurses	23,848	25,032	471,833	18.85	4
5	CNAs & Orderlies	68,514	70,836	738,404	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	31,297	15.05	9
10	Activity Assistants	4,497	4,631	43,862	9.47	10
11	Social Service Workers	3,480	3,536	61,479	17.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,054	2,054	39,138	19.05	14
15	Cook Helpers/Assistants	25,021	26,246	228,812	8.72	15
16	Dishwashers					16
17	Maintenance Workers	5,445	5,604	90,376	16.13	17
18	Housekeepers	14,024	14,652	133,860	9.14	18
19	Laundry	6,626	6,998	57,205	8.17	19
20	Administrator	2,080	2,080	87,617	42.12	20
21	Assistant Administrator	2,080	2,080	37,777	18.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,531	2,623	23,364	8.91	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	1,994	2,131	27,637	12.97	31
32	Other Health C: Restorative Aide	27,778	28,246	329,559	11.67	32
33	Other(specify) <u>Care Plan Coor</u>	4,160	4,160	110,159	26.48	33
34	TOTAL (lines 1 - 33)	202,774	209,703	\$ 2,714,876 *	\$ 12.95	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	505	\$ 25,616	1,3	35
36	Medical Director	36	22,800	9,3	36
37	Medical Records Consultant	24	1,760	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	5,810	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	45	1,911	11,3	44
45	Social Service Consultant	45	1,911	12,3	45
46	Other(specify)				46
47	<u>Medicare Consultant</u>	2	425	19,3	47
48					48
49	TOTAL (lines 35 - 48)	669	\$ 60,233		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

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

0036574

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Molly carpenter	Administrator	0	\$ 87,617	Workers' Compensation Insurance	\$ 71,114	IDPH License Fee	\$	
Pam Richards	Admin Asst	0	37,777	Unemployment Compensation Insurance	24,840	Advertising: Employee Recruitment	1,967	
				FICA Taxes	218,296	Health Care Worker Background Check		
				Employee Health Insurance	154,072	(Indicate # of checks performed <u>31</u>)	1,212	
				Employee Meals	123,166	Patient Background Checks	133	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	1,170	
				Innoculations	2,121	Dues & Subscriptions	3,722	
				Incentives	3,699	Internet Subscriptions	1,470	
				Uniforms	(415)	IL Health Care Association	5,244	
				Other	(3,507)	IPAC Dues	600	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 125,394	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,645
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$	
C. Professional Services								
Vendor/Payee	Type		Amount					
Sandbery Pheonix & Von Gontard	Legal		\$ 521				Out-of-State Travel	
Duane Morris	Legal		2,935				\$ 2,024	
FR&R Healthcare Consulting	Medicare CR Consulting		425					
FR&R Healthcare Consulting	Medicare Cost Report		4,200				In-State Travel	
Sikich LLP	Medicaid Cost Report		4,200				31	
AHCA	Bronze Award Fee		425					
QBE North America	Legal		2,500				Seminar Expense	
E-Health Data Solutions	Carewatch		913				7,740	
National Research Corporation	Satisfaction Survey		1,308					
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							TOTAL	
\$ 17,427				\$			\$ 9,795	

* 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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

01/01/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. II Health Care Assoc. \$5,244
- (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. \$ 36,285 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 202,476
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 123,166 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation. See travel and seminar spreadsheet
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? .4%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.