

Facility Name & ID Number The Carle Arbours

0028522 Report Period Beginning: 07/01/99 Ending: 06/30/00

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	240	Skilled (SNF)	240	87,840	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	240	TOTALS	240	87,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	3,155	2,262	6,323	11,740	8
9	SNF/PED					9
10	ICF	20,814	21,779		42,593	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,969	24,041	6,323	54,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.85%

D. How many bed-hold days during this year were paid by Public Aid? 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)
N/A

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 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/84 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 43 and days of care provided 6,323

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/00 Fiscal Year: 06/30/00

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

STATE OF ILLINOIS

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/99 Ending: 06/30/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	285,312	22,104		307,416		307,416	(1,366)	306,050		1
2	Food Purchase		259,331		259,331		259,331	(973)	258,358		2
3	Housekeeping	109,350	14,829		124,179		124,179		124,179		3
4	Laundry	61,989	6,043	7,615	75,647		75,647		75,647		4
5	Heat and Other Utilities			142,179	142,179	(4,985)	137,194		137,194		5
6	Maintenance	43,250	16,309	51,215	110,774	(30,759)	80,015		80,015		6
7	Other (specify):*					37,041	37,041		37,041		7
8	TOTAL General Services	499,901	318,616	201,009	1,019,526	1,297	1,020,823	(2,339)	1,018,484		8
B. Health Care and Programs											
9	Medical Director			19,668	19,668		19,668		19,668		9
10	Nursing and Medical Records	1,443,540	288,277	1,116,976	2,848,793	41,855	2,890,648	(508)	2,890,140		10
10a	Therapy	39,800	5,920	416,200	461,920		461,920		461,920		10a
11	Activities	93,369	6,254	1,296	100,919	(127)	100,792	(8,746)	92,046		11
12	Social Services	104,516			104,516	1,198	105,714		105,714		12
13	Nurse Aide Training					9,233	9,233	28,849	38,082		13
14	Program Transportation					685	685		685		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,681,225	300,451	1,554,140	3,535,816	52,844	3,588,660	19,595	3,608,255		16
C. General Administration											
17	Administrative			13,933	13,933	61,172	75,105	562,941	638,046		17
18	Directors Fees										18
19	Professional Services			182,936	182,936	2,832	185,768	(178,896)	6,872		19
20	Dues, Fees, Subscriptions & Promotions			57,223	57,223	2,300	59,523	(27,135)	32,388		20
21	Clerical & General Office Expenses	129,446	19,565	90,960	239,971	(113,286)	126,685	22,905	149,590		21
22	Employee Benefits & Payroll Taxes			586,912	586,912		586,912		586,912		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,149	7,149	(808)	6,341	(2,832)	3,509		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,576	41,576		41,576		41,576		26
27	Other (specify):* Non-Reimbursable Expense			81	81		81	(81)			27
28	TOTAL General Administration	129,446	19,565	980,770	1,129,781	(47,790)	1,081,991	376,902	1,458,893		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,310,572	638,632	2,735,919	5,685,123	6,351	5,691,474	394,158	6,085,632		29

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

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

Facility Name & ID Number

The Carle Arbours

#0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			340,661	340,661		340,661		340,661			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			432,004	432,004		432,004	(693)	431,311			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							(827)	(827)			34
35	Rent-Equipment & Vehicles			37,244	37,244	(1,286)	35,958	(20,379)	15,579			35
36	Other (specify):*											36
37	TOTAL Ownership			809,909	809,909	(1,286)	808,623	(21,899)	786,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		637,549		637,549		637,549	178,560	816,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,743	142,743	(5,065)	137,678	(5,915)	131,763			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		637,549	142,743	780,292	(5,065)	775,227	172,645	947,872			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,310,572	1,276,181	3,688,571	7,275,324		7,275,324	544,904	7,820,228			45

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

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning: 07/01/99

Ending: 06/30/00

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,366)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(827)	34		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	(26)	21		10
11	Discounts, Allowances, Rebates & Refunds	(202)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(5,915)	42		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	23,806	21		24
25	Fund Raising, Advertising and Promotional	(27,135)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,506)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,171)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	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)	571,075		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 571,075		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 544,904		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Carle Arbours

ID# 003852

Report Period Beginning: 07/01/99

Ending: 06/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Activity Income	\$ (8,746)	11
2	Sales/Misc	(736)	21
3	Copies	(306)	10
4	Unallowable expense	(81)	27
5	Non-direct care travel	(2,832)	24
6	Food service rebate	(973)	2
7	Investment Income	(693)	32
8	Unallowable copier	(35)	21
9	Unallowable administrative	(104)	21
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(14,506)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

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	(1,366)	0	0	0	0	0	0	0	0	0	0	(1,366)	1
2	Food Purchase	(973)	0	0	0	0	0	0	0	0	0	0	(973)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,339)	0	0	0	0	0	0	0	0	0	0	(2,339)	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	(508)	0	0	0	0	0	0	0	0	0	0	(508)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,746)	0	0	0	0	0	0	0	0	0	0	(8,746)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	28,849	0	0	0	0	0	0	0	0	0	28,849	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	(9,254)	28,849	0	19,595	16								
	C. General Administration													
17	Administrative	0	562,941	0	0	0	0	0	0	0	0	0	562,941	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(178,896)	0	0	0	0	0	0	0	0	0	(178,896)	19
20	Fees, Subscriptions & Promotions	(27,135)	0	0	0	0	0	0	0	0	0	0	(27,135)	20
21	Clerical & General Office Expenses	22,905	0	0	0	0	0	0	0	0	0	0	22,905	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,832)	0	0	0	0	0	0	0	0	0	0	(2,832)	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(81)	0	0	0	0	0	0	0	0	0	0	(81)	27
28	TOTAL General Administration	(7,143)	384,045	0	376,902	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,736)	412,894	0	394,158	29								

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/99 Ending: 06/30/00

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>The Carle Foundation</u>	<u>100</u>			<u>Carle Hospital</u>	<u>Urbana</u>	<u>Hospital/DME/Rx</u>
				<u>Carle HealthCare</u>	<u>Urbana</u>	<u>Ambulance</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>17 Home Office Expenses</u>	\$	<u>Carle Foundation</u>	<u>100.00%</u>	\$ <u>562,941</u>	\$	<u>562,941</u>	1
2	V	<u>10 Supplies & Medical Transport</u>	<u>209,168</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>209,168</u>			2
3	V	<u>13 CNA Training</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>28,849</u>		<u>28,849</u>	3
4	V	<u>19 Management Fee</u>	<u>178,896</u>	<u>Carle Foundation</u>	<u>100.00%</u>			<u>(178,896)</u>	4
5	V	<u>21 Supplies</u>	<u>164</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>164</u>			5
6	V	<u>35 Rental Equipment</u>	<u>28,314</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>7,935</u>		<u>(20,379)</u>	6
7	V	<u>39 Pharmacy & Drugs</u>	<u>615,725</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>794,285</u>		<u>178,560</u>	7
8	V	<u>101 Physical & Occupational Therapy</u>	<u>391,041</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>391,041</u>			8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ <u>1,423,308</u>			\$ <u>1,994,383</u>	\$ *	<u>571,075</u>	14

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

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/99 Ending: 06/30/00

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									\$		1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11											11	
12											12	
13									TOTAL	\$		13

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

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

Facility Name & ID Number The Carle Arbours

0028522 Report Period Beginning: 07/01/99

Ending: 06/30/00

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 The Carle Foundation
 Street Address 611 W. Park St.
 City / State / Zip Code Urbana, IL 61801
 Phone Number (217) 383-4716
 Fax Number (217) 383-4588

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	17	Home Office - Administrative	Direct Costs	12	12	\$ 469,787	\$ 202,243	12	\$ 469,787	1
2	21	Home Office - Outside Service	Direct Costs	12	12	47,444		12	47,444	2
3	19	Home Office - Recruitment	Direct Costs	12	12	28,815		12	28,815	3
4	24	Home Office - Seminars	Direct Costs	12	12	6,437		12	6,437	4
5	21	Home Office - Operating Supplies	Direct Costs	12	12	6,547		12	6,547	5
6	21	Home Office - Printed Materials	Direct Costs	12	12	3,738		12	3,738	6
7	21	Home Office - Customer Service	Direct Costs	12	12	173		12	173	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	TOTALS					\$ 562,941	\$ 202,243		\$ 562,941	25

Facility Name & ID Number The Carle Arbours# 0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10										
						Name of Lender	Related**						Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES									NO	Original				Balance
	A. Directly Facility Related																				
	Long-Term																				
1	\$26.00 Million Bond Issue	X		Refinance/Remodel	N/A	06/01/96	\$ 1,086,927	\$ 1,039,687	Multiple	Variable	\$ 58,714	1									
2	\$49.99 Million Bond Issue	X		Refinance/Remodel	N/A	05/01/98	4,721,506	4,648,781	Multiple	Variable	108,586	2									
3	\$29.30 Million Bond Issue	X		Refinance/Remodel	N/A	07/01/99	253,671	249,342	Multiple	Variable	8,750	3									
4	\$70.00 Million Bond Issue	X		Refinance/Remodel	N/A	10/27/99			Multiple	Variable		4									
5												5									
	Working Capital																				
6												6									
7												7									
8												8									
9	TOTAL Facility Related						\$ 6,062,104	\$ 5,937,810			\$ 176,050	9									
	B. Non-Facility Related*																				
10												10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$	14									
15	TOTALS (line 9+line14)						\$ 6,062,104	\$ 5,937,810			\$ 176,050	15									

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number The Carle Arbours# 0028522 Report Period Beginning: 07/01/99 Ending: 06/30/00

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	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.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	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 used previously to calculate a payment rate. 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 19 _____ 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.	\$	7
Real Estate Tax History:		
Real Estate Tax Bill for Calendar Year:	1995 _____ 8	
	1996 _____ 9	
	1997 _____ 10	
	1998 _____ 11	
	1999 _____ 12	
		FOR OFF USE ONLY
	13 FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14 PLUS APPEAL COST FROM LINE 5 \$	14
	15 LESS REFUND FROM LINE 6 \$	15
	16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number The Carle Arbours# 0028522 Report Period Beginning:07/01/99 Ending:06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,382 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/AF. 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>Nursing Home</u>	<u>174,240</u>	<u>1984</u>	<u>\$ 274,934</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	174,240		\$ 274,934	3

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	240		1984	1973	\$ 2,967,466	\$ 84,785	35	\$ 84,785		\$ 1,391,883	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Renovations		1984		267,128	9,478	Various	9,478		184,828	9
10	Windows		1984		6,326		Various			6,326	10
11	Signs & A/C		1984		25,006	136	Various	136		25,006	11
12	Landscaping		1985		13,589	672	Various	672		12,477	12
13	Plumbing		1985		34,747	1,390	Various	1,390		21,173	13
14	Roof & Electrical		1985		23,658	931	Various	931		20,037	14
15	Kitchen Remodeling		1985		24,371	852	Various	852		17,814	15
16	Landscaping		1986		7,325	247	Various	247		7,181	16
17	Renovations		1986		31,097	1,512	Various	1,512		22,071	17
18	Landscaping		1987		2,032	135	Various	135		1,750	18
19	Roof Repair		1987		749	50	Various	50		649	19
20	Carpet		1987		6,689	446	Various	446		5,871	20
21	Renovations		1987		28,041	1,869	Various	1,869		24,600	21
22	Carpet & Flooring		1988		21,483	1,432	Various	1,432		17,664	22
23	Alzheimers Addition		1988		1,400	47	Various	47		564	23
24	Generator		1988		11,693	275	Various	275		9,470	24
25	Insulation		1988		3,650	183	Various	183		2,205	25
26	Renovations		1988		6,774	87	Various	87		6,398	26
27	Alzheimers/2nd Floor Renovation		1990		6,214	301	Various	301		3,307	27
28	Emergency Power Distribution		1990		27,115	1,334	Various	1,334		13,460	28
29	Doors		1990		1,388	93	Various	93		956	29
30	Remodeling		1990		2,838	142	Various	142		1,372	30
31	Remodeling		1991		472,549	20,391	Various	20,391		185,765	31
32	Flooring		1991		87,008	6,154	Various	6,154		53,118	32
33	Renovations		1991		1,981	149	Various	149		1,317	33
34	Renovations		1992		5,150	343	Various	343		2,732	34
35	Roof Repair		1992		22,257	2,226	Various	2,226		18,918	35
36	TOTAL (lines 4 thru 35)				\$ 4,109,724	\$ 135,660		\$ 135,660		\$ 2,058,912	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.

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

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	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Flooring		1992	14,427	702	Various	702		9,278	9
10	Landscaping		1992	4,734	473	Various	473		3,669	10
11	Outdoor Lighting		1993	8,352	557	Various	557		3,990	11
12	Elevator		1993	10,788	561	Various	561		4,033	12
13	Remodeling		1993	48,830	2,384	Various	2,384		17,099	13
14	Parking Lot Improvements		1993	4,300	430	Various	430		2,938	14
15	Elevator		1994	3,368	168	Various	168		1,095	15
16	Renovations		1994	57,905	3,174	Various	3,174		19,717	16
17	Parking Lot Improvements		1995	11,934	1,151	Various	1,151		5,952	17
18	Remodeling		1994	55,764	2,839	Various	2,839		16,110	18
19	Doors		1994	4,684	255	Various	255		1,790	19
20	Remodeling (per FY99 audit)		1994	2,320	116	Various	116		609	20
21	Remodeling (per FY99 audit)		1995	12,720	669	Various	669		3,403	21
22	Roof Repair		1995	20,660	1,065	Various	1,065		5,419	22
23	Roof Air Conditioning		1995	40,354	3,558	Various	3,558		16,762	23
24	Roof Air Conditioning		1996	2,950	295	Various	295		1,303	24
25	Renovations - Kitchen/Dining		1995	264,018	14,668	Various	14,668		68,449	25
26	Renovations - Kitchen/Dining		1996	5,613	312	Various	312		1,325	26
27	Renovations - Bathrooms		1995	79,899	3,995	Various	3,995		16,646	27
28	Nurse Station (per FY99 audit)		1995	69,094	3,839	Various	3,839		18,553	28
29	Flooring		1996	15,511	1,551	Various	1,551		6,334	29
30	Windows		1996	3,028	151	Various	151		568	30
31	Entrance Canopy		1996	1,580	158	Various	158		579	31
32	Electric Doors		1996	5,072	437	Various	437		1,598	32
33	Roofing		1996	22,900	2,290	Various	2,290		8,397	33
34	Repair Boiler Room		1996	3,300	330	Various	330		1,210	34
35	Refurbish Sign		1996	1,200	120	Various	120		440	35
36	TOTAL (lines 4 thru 35)			\$ 775,305	\$ 46,248		\$ 46,248	\$	\$ 237,266	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.

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/99

Ending:

06/30/00

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Entrance Canopy	1997		3,693	369	Various	369		1,262	9
10		Nurse Stations (per FY99 audit)	1997		34,011	2,126	Various	2,126		5,491	10
11		Fence	1998		3,885	259	Various	259		583	11
12		Doors	1998		945	63	Various	63		105	12
13		Nurse Stations (per FY99 audit)	1998		10,001	667	Various	667		1,111	13
14		Chain Link Fence	1998		4,544	303	Various	303		530	14
15		Baths (per FY99 audit)	1999		623,242	31,162	Various	31,162		38,953	15
16		Wall Architectural	1999		1,491	75	Various	75		81	16
17		Subacute Improvements	2000		75,624	1,675	Various	1,675		1,675	17
18		Renovations-Bathrooms	2000		36,055	791	Various	791		791	18
19		Handrails	2000		11,693	325	Various	325		325	19
20		Hall Floor	2000		30,472	668	Various	668		668	20
21		Rounding			(2)					(1)	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		TOTAL (lines 4 thru 35)			\$ 835,654	\$ 38,482		\$ 38,482	\$	\$ 51,574	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 Date of Lease	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. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

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: \$ 15,612 Description: Copy Machine \$7,677; DME \$7,935

(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.

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>48</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	3,234	\$	\$ 3,234
2	Books and Supplies		440		440
3	Classroom Wages (a)		5,552		5,552
4	Clinical Wages (b)		3,296		3,296
5	In-House Trainer Wages (c)		28,849		28,849
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	\$	41,921	\$	\$ 41,921
10	SUM OF line 9, col. 1 and 2 (e)	\$	41,921		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10a Col. 3	hrs	\$	5,499	\$ 163,759	\$	5,499	\$ 163,759	1
2	Licensed Speech and Language Development Therapist	Line 10a Col. 3	hrs		646	26,227		646	26,227	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col. 3	hrs		6,882	226,209		6,882	226,209	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39 Col. 2	# of prescripts				816,109		816,109	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	13,026	\$ 416,195	\$ 816,109	13,026	\$ 1,232,304	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Carle Arbours
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0028522
 As of 06/30/00

Report Period Beginning: 07/01/99
 (last day of reporting year)

Ending: 06/30/00

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 40,465	\$	1
2 Cash-Patient Deposits	15,713		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 248,076)	1,082,254		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	478,813		5
6 Prepaid Insurance	9,991		6
7 Other Prepaid Expenses	7,483		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):	(3,027,643)		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,392,924)	\$	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			15
16 Equipment, at Historical Cost			16
17 Accumulated Depreciation (book methods)			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)	\$	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,392,924)	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 292,471	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	15,713		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	287,509		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 595,693	\$	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)	\$ 595,693	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (1,988,617)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,392,924)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,959,446)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,959,446)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(115,440)	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) Rounding	(3)	15
16	Other (describe) Partnership Revenue	86,272	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (29,171)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,988,617)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning: 07/01/99

Ending:

06/30/00

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	\$ 7,817,138	1
2	Discounts and Allowances for all Levels	(2,645,168)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,171,970	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,277,305	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,277,305	8
C. Other Operating Revenue			
9	Payments for Education	17,195	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	827	13
14	Non-Patient Meals	1,366	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	40,000	16
17	Sale of Drugs	639,539	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)	\$ 698,927	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	693	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 693	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	10,989	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,989	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,159,884	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,019,526	31
32	Health Care	3,535,816	32
33	General Administration	1,129,781	33
B. Capital Expense			
34	Ownership	809,909	34
C. Ancillary Expense			
35	Special Cost Centers	637,549	35
36	Provider Participation Fee	142,743	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,275,324	40
41	Income before Income Taxes (line 30 minus line 40)**	(115,440)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (115,440)	43

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

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

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

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

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning: 07/01/99

Ending:

06/30/00

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	
2	Assistant Director of Nursing	1,466	1,592	40,028	25.14	2
3	Registered Nurses	19,041	20,468	348,708	17.04	3
4	Licensed Practical Nurses	34,158	36,448	509,930	13.99	4
5	Nurse Aides & Orderlies	45,842	50,100	448,429	8.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,606	4,097	39,801	9.71	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,902	2,213	27,364	12.37	9
10	Activity Assistants	6,925	7,603	66,006	8.68	10
11	Social Service Workers	5,512	6,150	104,511	16.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,292	2,489	41,596	16.71	14
15	Cook Helpers/Assistants	26,245	27,707	243,716	8.80	15
16	Dishwashers					16
17	Maintenance Workers	3,380	3,677	43,249	11.76	17
18	Housekeepers	11,766	13,498	109,349	8.10	18
19	Laundry	7,915	8,579	61,990	7.23	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,590	1,800	32,171	17.87	22
23	Office Manager					23
24	Clerical	8,154	9,037	97,275	10.76	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	5,994	6,406	64,270	10.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,788	201,864	\$ 2,278,393 *	\$ 11.29	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	\$		35	
36	Medical Director	N/A	19,668	Line 9 Col. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	19,668		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,183	\$ 94,164	Ln 10 Col. 3	50
51	Licensed Practical Nurses	14,218	478,336	Ln 10 Col. 3	51
52	Nurse Aides	23,334	443,220	Ln 10 Col. 3	52
53	TOTAL (lines 50 - 52)	39,735	\$ 1,015,720		53

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	
K. Kopenski	Administrator	0.00	\$ 72,000	Workers' Compensation Insurance	\$ 121,648	IDPH License Fee	\$ 4,700	
S. Lowney				Unemployment Compensation Insurance	36,940	Advertising: Employee Recruitment	18,995	
(per Heritage contract)				FICA Taxes	172,116	Health Care Worker Background Check		
				Employee Health Insurance	157,348	(Indicate # of checks performed <u>20</u>)	240	
				Employee Meals		Fees	368	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	25,939	
				Life Insurance	1,878	P/R & Entertainment	821	
				Long Term Disability	5,629	Dues - IHCA	7,877	
				Pension	71,797	Other Dues & Fees	150	
				Tuition Reimbursement	1,200	Subscriptions	58	
				Pre-Employment Physicals	16,439	Less: Public Relations Expense	(821)	
				Employee Incentive	1,917	Non-allowable advertising	(23,055)	
						Yellow page advertising	(2,884)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 72,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 586,912	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,388	
(List each licensed administrator separately.)								
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
Heritage Management Fee			\$ 3,103				Out-of-State Travel	\$ 0
Rx Consulting (reclassified to Line 10)			10,700					
Healthcare Consulting (reclassified to Line 10)			130				In-State Travel	811
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 13,933				Seminar Expense	2,698
(Attach a copy of any management service agreement)								
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,509
Carle Hospital	Related Party		\$ 178,896					
Carle Clinic Assoc.	Data Processing		4,040					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 182,936	TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/99Ending: 06/30/00**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. IHCA \$7,877
- (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? _____
- (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? _____
- (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? 8.58
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,956 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. _____
- (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 of Public Aid during this cost report period. \$ 131,760
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 of Public Aid, 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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,366
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
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? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.