

		FOR BHF USE				

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

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

**I. IDPH Facility ID Number:** 0028522

**Facility Name:** The Carle Arbours

**Address:** 302 West Burwash Savoy 61874  
 Number City Zip Code

**County:** Champaign

**Telephone Number:** 217-383-3098 **Fax #** 217-383-3194

**HFS ID Number:** 371155535001

**Date of Initial License for Current Owners:** 02/01/84

**Type of Ownership:**

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

**In the event there are further questions about this report, please contact:**  
**Name:** Kerry G. Frerichs **Telephone Number:** 217-383-4784

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Tom Mullins</u>	
	(Title) <u>Administrator</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number The Carle Arbours# 0028522 Report Period Beginning: 07/01/05 Ending: 06/30/06

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>231</u>	Skilled (SNF)	<u>231</u>	<u>84,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,315</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,256</u>	<u>3,456</u>	<u>10,425</u>	<u>17,137</u>	8
9	SNF/PED					9
10	ICF	<u>22,411</u>	<u>27,246</u>		<u>49,657</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,667</u>	<u>30,702</u>	<u>10,425</u>	<u>66,794</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 79.22%

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

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

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

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

NoneF. Does the facility maintain a daily midnight census? YesG. 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 53 and days of care provided 10,425Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 06/30/06 Fiscal Year: 06/30/06

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

Facility Name & ID Number      The Carle Arbours      #      0028522      Report Period Beginning:      07/01/05      Ending:      06/30/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	488,932	55,027	341	544,300		544,300	(685)	543,615		1
2	Food Purchase		412,526		412,526		412,526		412,526		2
3	Housekeeping	125,955	29,597	99,722	255,274		255,274		255,274		3
4	Laundry	54,419	5,083	78,372	137,874		137,874		137,874		4
5	Heat and Other Utilities			245,702	245,702	(14,521)	231,181		231,181		5
6	Maintenance	66,593	59,616	60,095	186,304	(1,792)	184,512		184,512		6
7	Other (specify):* Waste/security					35,454	35,454		35,454		7
8	<b>TOTAL General Services</b>	<b>735,899</b>	<b>561,849</b>	<b>484,232</b>	<b>1,781,980</b>	<b>19,141</b>	<b>1,801,121</b>	<b>(685)</b>	<b>1,800,436</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,950	6,950		6,950		6,950		9
10	Nursing and Medical Records	2,948,374	318,976	1,269,010	4,536,360	61,281	4,597,641	(2,799)	4,594,842		10
10a	Therapy	47,754	(116)	1,190,606	1,238,244		1,238,244		1,238,244		10a
11	Activities	100,721	10,627	2,213	113,561	(26,002)	87,559	(8,502)	79,057		11
12	Social Services	120,086			120,086		120,086		120,086		12
13	CNA Training										13
14	Program Transportation			10,536	10,536	1,110	11,646		11,646		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,216,935</b>	<b>329,487</b>	<b>2,479,315</b>	<b>6,025,737</b>	<b>36,389</b>	<b>6,062,126</b>	<b>(11,301)</b>	<b>6,050,825</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			328,440	328,440	(600)	327,840	759,856	1,087,696		17
18	Directors Fees										18
19	Professional Services			271,600	271,600		271,600	(267,527)	4,073		19
20	Dues, Fees, Subscriptions & Promotions			34,706	34,706	978	35,684	(17,330)	18,354		20
21	Clerical & General Office Expenses	235,179	35,087	197,699	467,965	(54,423)	413,542	(99,229)	314,313		21
22	Employee Benefits & Payroll Taxes			1,187,043	1,187,043		1,187,043		1,187,043		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,944	15,944	(1,485)	14,459	(7,873)	6,586		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			168,162	168,162		168,162		168,162		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>235,179</b>	<b>35,087</b>	<b>2,203,594</b>	<b>2,473,860</b>	<b>(55,530)</b>	<b>2,418,330</b>	<b>367,897</b>	<b>2,786,227</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,188,013</b>	<b>926,423</b>	<b>5,167,141</b>	<b>10,281,577</b>		<b>10,281,577</b>	<b>355,911</b>	<b>10,637,488</b>		<b>29</b>

\*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: 07/01/05 Ending: 06/30/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			391,192	391,192	391,192	(5,562)	385,630				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			534,969	534,969	534,969	(1,395)	533,574				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			717	717	717		717				35
36	Other (specify):*						30,306	30,306				36
37	<b>TOTAL Ownership</b>			926,878	926,878	926,878	23,349	950,227				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,249,089		1,249,089	1,249,089	387,672	1,636,761				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,480	126,480	126,480		126,480				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,249,089	126,480	1,375,569	1,375,569	387,672	1,763,241				44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,188,013	2,175,512	6,220,499	12,584,024	12,584,024	766,932	13,350,956				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: 07/01/05

Ending: 06/30/06

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(685)	1		4
5	Telephone, TV & Radio in Resident Rooms				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	(1,395)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,799)	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	(5,562)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,027)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,165)	21		24
25	Fund Raising, Advertising and Promotional	(17,330)	20		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	(18,439)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (157,402)		\$	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)	924,334		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 924,334		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 766,932		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

The Carle Arbours

ID# 0028522

Report Period Beginning: 07/01/05

Ending: 06/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NON-DIRECT CARE TRAVEL	\$ (7,873)	24	1
2	MISCELLANEOUS REVENUE	(2,064)	21	2
3	ACTIVITY INCOME	(8,502)	11	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	<b>Total</b>	(18,439)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(685)	0	0	0	0	0	0	0	0	0	0	(685)	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	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	<b>TOTAL General Services</b>	<b>(685)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(685)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,799)	0	0	0	0	0	0	0	0	0	0	(2,799)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,502)	0	0	0	0	0	0	0	0	0	0	(8,502)	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	<b>TOTAL Health Care and Programs</b>	<b>(11,301)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,301)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	759,856	0	0	0	0	0	0	0	0	0	759,856	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,027)	(253,500)	0	0	0	0	0	0	0	0	0	(267,527)	19
20	Fees, Subscriptions & Promotions	(17,330)	0	0	0	0	0	0	0	0	0	0	(17,330)	20
21	Clerical & General Office Expenses	(99,229)	0	0	0	0	0	0	0	0	0	0	(99,229)	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	(7,873)	0	0	0	0	0	0	0	0	0	0	(7,873)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(138,459)</b>	<b>506,356</b>	<b>0</b>	<b>367,897</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(150,445)</b>	<b>506,356</b>	<b>0</b>	<b>355,911</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/05 Ending:

Summary B

06/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,562)	0	0	0	0	0	0	0	0	0	0	(5,562)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,395)	0	0	0	0	0	0	0	0	0	0	(1,395)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	30,306	0	0	0	0	0	0	0	0	0	30,306	36
37	<b>TOTAL Ownership</b>	<b>(6,957)</b>	<b>30,306</b>	<b>0</b>	<b>23,349</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	387,672	0	0	0	0	0	0	0	0	0	387,672	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>387,672</b>	<b>0</b>	<b>387,672</b>	<b>44</b>								
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(157,402)</b>	<b>924,334</b>	<b>0</b>	<b>766,932</b>	<b>45</b>								

**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
The Carle Foundation	100			Carle Hospital	Urbana	Hospital/DME/Rx
				Carle HealthCare	Urbana	Ambulance

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	17 Home Office-Administrative	\$	Carle Foundation	100.00%	\$ 235,274	\$ 235,274	1
2	V	36 Home Office-Loss/Gain on Disp		Carle Foundation	100.00%	2,320	2,320	2
3	V	17 Shared A & G Hosp Gen. Svcs		Carle Foundation	100.00%	524,582	524,582	3
4	V	36 Shared A & G Hosp Capital		Carle Foundation	100.00%	27,986	27,986	4
5	V	19 Management Fees	253,500	Carle Foundation	100.00%		(253,500)	5
6	V	39 Pharmacy & Drugs	1,076,868	Carle Foundation	100.00%	1,464,540	387,672	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,330,368			\$ 2,254,702	\$ * 924,334	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: 07/01/05 Ending: 06/30/06

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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: 07/01/05

Ending: 06/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization The Carle Foundation  
 Street Address 611 W. Park St.  
 City / State / Zip Code Urbana, IL 61801  
 Phone Number ( 217-383-4784  
 Fax Number ( 217-383-4588

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	\$ 235,274	\$ 123,467	12	\$ 235,274	1
2	36	Home Office-Loss/Gain on Disp	Direct Costs	12	2,320		12	2,320	2
3	17	Shared A & G Hosp Gen. Svcs	Direct Costs	12	524,582	309,503	12	524,582	3
4	36	Shared A & G Hosp Capital	Direct Costs	12	27,986		12	27,986	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	TOTALS				\$ 790,162	\$ 432,970		\$ 790,162	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	\$26.00 Million Bond Issue	x		Refinance/Remodel	n/a	06/01/96	\$ 1,086,927	\$	Multiple	Variable	\$ (417)	1								
2	\$49.99 Million Bond Issue	x		Refin/Remodel/Arbrs Ct	n/a	05/01/98	6,967,497	2,759,898	Multiple	Variable	163,017	2								
3	\$29.30 Million Bond Issue	x		Refinance/Remodel	n/a	07/01/99	253,671	221,638	Multiple	Variable	7,843	3								
4	\$190.3 Million Bond Issue	x		Refinance	n/a	11/10/04	5,741,801	5,660,299	Multiple	Variable	159,826	4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 14,049,896	\$ 8,641,835			\$ 330,269	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 14,049,896	\$ 8,641,835			\$ 330,269	15								

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

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

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



**IMPORTANT NOTICE**

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

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

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

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

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Carle Arbours COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0028522

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number The Carle Arbours

# 0028522 Report Period Beginning:

07/01/05 Ending:

06/30/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 69,118 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 2

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).

N/A

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>NURSING HOME</u>	<u>174,240</u>	<u>1984</u>	<u>\$ 274,934</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>174,240</b>		<b>\$ 274,934</b>	<b>3</b>

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/05

Ending:

06/30/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1984	1973	\$ 2,967,466	\$ 84,785	35	\$ 84,785	\$	\$ 1,900,591	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		RENOVATIONS		1984	267,128	9,152	VARIOUS	9,152		239,741	9
10		WINDOWS		1984	6,326		VARIOUS			6,326	10
11		SIGNS & A/C		1984	15,232		15			15,232	11
12		LANDSCAPING		1985	13,589		VARIOUS			13,589	12
13		PLUMBING		1985	34,747	1,390	VARIOUS	1,390		29,512	13
14		ROOF & ELECTRICAL		1985	23,658	239	VARIOUS	239		22,820	14
15		KITCHEN REMODEL		1985	23,504	655	VARIOUS	655		21,080	15
16		LANDSCAPING		1986	7,325		VARIOUS			7,325	16
17		RENOVATIONS		1986	31,097	786	VARIOUS	786		27,363	17
18		LANDSCAPING		1987	2,032		15			2,032	18
19		ROOF REPAIR		1987	749		15			749	19
20		CARPET		1987	6,689		15			6,689	20
21		RENOVATIONS		1987	28,041		15			28,041	21
22		CARPET & FLOORING		1988	21,483		15			21,483	22
23		ALZHEIMERS ADDITION		1988	1,400	47	VARIOUS	47		844	23
24		GENERATOR		1988	11,693	275	VARIOUS	275		11,120	24
25		INSULATION		1988	3,650	183	20	183		3,300	25
26		RENOVATIONS		1988	6,774	8	VARIOUS	8		6,681	26
27		ALZHEIMERS/2ND FLOOR RENOVATION		1990	6,214	169	VARIOUS	169		4,933	27
28		EMERGENCY POWER DISTRIBUTION		1990	27,115	1,334	VARIOUS	1,334		21,465	28
29		DOORS		1990	1,388		15			1,388	29
30		REMODELING		1990	2,838	142	20	142		2,223	30
31		REMODELING		1991	472,549	19,333	VARIOUS	19,333		307,053	31
32		FLOORING		1991	87,008	2,547	VARIOUS	2,547		73,210	32
33		RENOVATIONS		1991	1,981	49	VARIOUS	49		1,719	33
34		RENOVATIONS		1992	5,150	343	15	343		4,792	34
35		ROOF REPAIR		1992	22,257		10			22,257	35
36		FLOORING		1992	14,427	702	VARIOUS	702		13,491	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number    The Carle Arbours

#    0028522

Report Period Beginning:

07/01/05

Ending:

06/30/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LANDSCAPING	1992	\$ 4,734	\$	10	\$	\$	\$ 4,734	37
38	OUTDOOR LIGHTING	1993	8,352	557	15	557		7,331	38
39	ELEVATOR	1993	10,788	561	VARIOUS	561		7,401	39
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		31,404	40
41	PARKING LOT IMPROVEMENTS	1994	4,300		10			4,300	41
42	ELEVATOR	1994	3,368	168	20	168		2,105	42
43	RENOVATIONS	1994	57,905	2,701	VARIOUS	2,701		37,671	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	86	VARIOUS	86		11,613	44
45	REMODELING	1994	55,764	2,839	20	2,839		33,147	45
46	DOORS	1994	4,684	190	VARIOUS	190		3,114	46
47	REMODELING	1995	2,320		20			2,320	47
48	REMODELING	1995	12,720	785	19	785		6,405	48
49	ROOF REPAIRS	1995	20,660	1,001	VARIOUS	1,001		11,734	49
50	ROOF AIR CONDITIONER	1995	40,354	1,823	VARIOUS	1,823		36,374	50
51	ROOF AIR CONDITIONER	1995	2,950	172	10	172		2,950	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	18	14,668		156,455	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	18	312		3,196	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	20	3,995		40,615	54
55	FLOORING	1996	15,511	1,422	10	1,422		15,511	55
56	WINDOWS	1996	3,028	151	20	151		1,476	56
57	ENTRANCE CANOPY	1996	1,580	158	10	158		1,527	57
58	ELECTRIC DOORS	1996	5,072	437	VARIOUS	437		4,221	58
59	ROOFING	1996	22,900	2,290	10	2,290		22,137	59
60	REPAIR BOILER ROOM	1996	3,300	330	10	330		3,190	60
61	REFURBISH SIGN	1996	1,200	120	10	120		1,160	61
62	ENTRANCE CANOPY	1997	3,693	369	10	369		3,477	62
63	NURSE STATIONS	1997	34,011	2,107	VARIOUS	2,107		18,248	63
64	FENCE	1998	3,885	259	15	259		2,137	64
65	DOORS	1998	945	63	15	63		483	65
66	NURSE STATIONS	1998	10,000	667	15	667		5,113	66
67	CHAIN LINK FENCE	1998	4,544	303	15	303		2,348	67
68	BATHS	1999	623,243	31,162	20	31,162		225,747	68
69	WALL ARCHITECTURAL	1999	1,491	75	20	75		528	69
70	TOTAL (lines 4 thru 69)		\$ 5,487,106	\$ 194,294		\$ 194,294	\$	\$ 3,527,221	70

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

Facility Name &amp; ID Number The Carle Arbours

# 0028522

Report Period Beginning:

07/01/05

Ending:

06/30/06

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,487,106	\$ 194,294		\$ 194,294	\$	\$ 3,527,221	1
2	<u>SUBACUTE IMPROVEMENTS</u>	2000	75,624	4,020	VARIOUS	4,020		25,794	2
3	<u>RENOVATIONS- BATHROOMS</u>	2000	36,055	1,898	19	1,898		12,176	3
4	<u>HANDRAILS</u>	2000	11,693	779	15	779		5,002	4
5	<u>HALL FLOOR</u>	2000	30,472	1,604	19	1,604		10,291	5
6	<u>ROOF REPAIRS</u>	2000	7,800	433	18	433		2,564	6
7	<u>AIR CURTAIN</u>	2000	1,110	62	18	62		365	7
8	<u>BATH RENOVATION</u>	2000	2,438	128	19	128		759	8
9	<u>SECOND FLOOR AIR</u>	2000	4,829	268	18	268		1,498	9
10	<u>FACILITY IMPROVEMENTS</u>	2001	274	50	5	50		274	10
11	<u>THERAPY FLOOR</u>	2001	3,700	370	10	370		1,819	11
12	<u>THERAPY CEILING</u>	2001	3,194	639	5	639		3,141	12
13	<u>FIRST FLOOR HANDRAILS</u>	2001	12,480	2,496	5	2,496		11,440	13
14	<u>SECOND FLOOR AIR</u>	2002	86,210	5,129	VARIOUS	5,129		21,162	14
15	<u>WALL ARCHITECHURAL</u>	2002	7,032	414	17	414		1,862	15
16	<u>GIFT SHOP EXPANSION</u>	2002	16,819	1,066	VARIOUS	1,066		4,753	16
17	<u>CARPET</u>	2002	3,984	797	5	797		3,453	17
18	<u>THERAPY FLOOR</u>	2002	180	18	10	18		77	18
19	<u>VINYL FLOORING</u>	2002	5,979	598	10	598		2,441	19
20	<u>THERAPY CEILING</u>	2002	6,930	1,386	5	1,386		5,660	20
21	<u>NURSE STATIONS(PER FY99 IPA AUDIT)</u>	1995	69,094	3,839	VARIOUS	3,839		41,585	21
22	<u>RENOVATIONS-FIRE WALL</u>	2003	146,487	6,972	VARIOUS	6,972		26,405	22
23	<u>ARBRS COURT BUILDING</u>	2003	1,397,938	34,948	VARIOUS	34,948		107,758	23
24	<u>RENOVATIONS-NURSING STATION/TEMP CONTROLLERS</u>	2003	57,666	1,442	VARIOUS	1,442		4,445	24
25	<u>FLOORING</u>	2003	7,490	1,098	VARIOUS	1,098		4,101	25
26	<u>ARBRS COURT BUILDING</u>	2004	344,851	8,621	40	8,621		23,709	26
27	<u>FENCING</u>	2004	7,172	429	VARIOUS	429		1,132	27
28	<u>LANDSCAPING</u>	2004	80,580	9,985	VARIOUS	9,985		33,978	28
29	<u>ORIG BLDG RENOVATIONS</u>	2004	83,766	5,924	VARIOUS	5,924		13,092	29
30	<u>RENOVATIONS</u>	2004	74,853	1,879	VARIOUS	1,879		5,166	30
31	<u>SINAGE</u>	2004	6,427	1,229	VARIOUS	1,229		3,379	31
32	<u>2ND FLR INTERIOR UPGRADE</u>	2005	87,775	5,852	VARIOUS	5,852		8,778	32
33	<u>EXTERIOR PAINTING &amp; REPAIRS</u>	2005	71,086	5,120	VARIOUS	5,120		7,680	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,239,094	\$ 303,787		\$ 303,787	\$	\$ 3,922,960	34

\*\*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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,239,094	\$ 303,787		\$ 303,787	\$	\$ 3,922,960	1
2	SIGNS	2005	2,040	204	10	204		306	2
3	CAPITALIZED INTEREST	2004	56,570	1,479	40	1,479		2,834	3
4	RENOVATIONS	2006	20,300	481	15	481		481	4
5	ROUNDING		(2)	2		2			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	TOTAL (lines 1 thru 33)		\$ 8,318,002	\$ 305,953		\$ 305,953	\$	\$ 3,926,581	34

\*\*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: 07/01/05 Ending: 06/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,722,875	\$ 75,057	\$ 75,057	\$		\$ 1,336,908	71
72	Current Year Purchases	166,219	4,620	4,620			4,620	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,889,094	\$ 79,677	\$ 79,677	\$		\$ 1,341,528	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$	10,482,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	385,630	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	385,630	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	5,268,109	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	NURSE STATIONS-1997&1998	\$ 49,545	\$ 3,097	\$ 26,422	86
87	BATHS-1999	9,818	491	3,559	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,540	34,522	88
89	PROJECT 95-028-00-1997	6,940	434	3,724	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	\$ 106,493	\$ 5,562	\$ 69,917	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.

Facility Name & ID Number The Carle Arbours

# 0028522

Report Period Beginning: 07/01/05

Ending: 06/30/06

**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 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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

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

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

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

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a Col 3	hrs	\$	n/a	\$ 585,549	\$	n/a	\$ 585,549	1
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	hrs		n/a	109,753		n/a	109,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a Col 3	hrs		n/a	493,983		n/a	493,983	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 1,189,285	\$		\$ 1,189,285	14

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

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/05

Ending:

06/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 27,409	\$	1
2	Cash-Patient Deposits	25,975		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,722,610		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	861,606		5
6	Prepaid Insurance	56,093		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(4,969,485)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (2,275,792)	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (2,275,792)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 782,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 782,438	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 782,438	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,058,230)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (2,275,792)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,208,380)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,208,380)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	58,461	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) <u>Partnership Revenue</u>	91,694	15
16	Other (describe) <u>Rounding</u>	(5)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 150,150	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,058,230)	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/05Ending: 06/30/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,285,548	1
2	Discounts and Allowances for all Levels	(6,668,593)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,616,955	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,886,183	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,886,183	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,123,902	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,123,902	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,395	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,395	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Activities &amp; Programs</u>	8,502	28
28a	<u>Discounts &amp; Misc</u>	5,548	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,050	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,642,485	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,781,980	31
32	Health Care	6,025,737	32
33	General Administration	2,473,933	33
<b>B. Capital Expense</b>			
34	Ownership	926,805	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,249,089	35
36	Provider Participation Fee	126,480	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,584,024	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	58,461	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 58,461	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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:

07/01/05

Ending:

06/30/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,908	2,148	\$ 69,097	\$ 32.17	1
2	Assistant Director of Nursing	1,961	2,201	57,864	26.29	2
3	Registered Nurses	14,880	16,039	442,158	27.57	3
4	Licensed Practical Nurses	38,824	43,159	853,422	19.77	4
5	CNAs & Orderlies	105,326	116,350	1,254,989	10.79	5
6	CNA Trainees					6
7	Licensed Therapist	3,631	4,318	47,018	10.89	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,523	2,114	33,669	15.93	9
10	Activity Assistants	5,904	6,731	67,759	10.07	10
11	Social Service Workers	5,796	6,684	120,087	17.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,040	3,124	53,010	16.97	14
15	Cook Helpers/Assistants	38,017	40,682	435,922	10.72	15
16	Dishwashers					16
17	Maintenance Workers	5,377	6,061	66,464	10.97	17
18	Housekeepers	10,696	11,915	125,310	10.52	18
19	Laundry	5,119	5,863	55,707	9.50	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,219	7,288	170,644	23.41	22
23	Office Manager					23
24	Clerical	14,417	15,874	235,158	14.81	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	6,411	7,101	99,735	14.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	269,049	297,652	\$ 4,188,013 *	\$ 14.07	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	6,950	Ln 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)		\$ 6,950		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,163	\$ 55,495	Ln 10 Col 3	50
51	Licensed Practical Nurses	8,507	310,723	Ln 10 Col 3	51
52	Certified Nurse Assistants/Aides	42,485	797,327	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	52,155	\$ 1,163,545		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$11,418
- (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? 11.6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,469 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 No 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. \$ 126,480  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes 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. \$ \_\_\_\_\_
- (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: McGlavery & 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.