

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0005462

Facility Name: The Arthur Home

Address: 423 Eberhardt Drive Arthur 61911
 Number City Zip Code

County: Moultrie

Telephone Number: 217-543-2103 **Fax #** 217-543-2278

HFS ID Number: 370794402001

Date of Initial License for Current Owners: 1/1/1958

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501(c)(3)</u>	<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: David Eversole **Telephone Number:** 217-543-2103

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2006 to 8/31/2007 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.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) David Eversole

(Title) Administrator

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Chad Kunze, CPA
Principal

(Firm Name & Address) LarsonAllen LLP
12801 Flushing Meadows Dr., St. Louis, MO 63131

(Telephone) 314-336-3721 Fax # 314-336-3650

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number The Arthur Home# 0005462 Report Period Beginning: 9/1/2006 Ending: 8/31/2007

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 bedsN/A

	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>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</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>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,782</u>	<u>9,981</u>	<u>3,251</u>	<u>23,014</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,782</u>	<u>9,981</u>	<u>3,251</u>	<u>23,014</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.38%

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

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

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

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

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

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/1/1958

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 69 and days of care provided 3,251Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 8/31/07 Fiscal Year: 8/31/07

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2006 Ending: 8/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	249,002	8,046	11,190	268,238		268,238		268,238		1
2	Food Purchase		143,234		143,234		143,234	(4,137)	139,097		2
3	Housekeeping	86,114	14,494	592	101,200		101,200		101,200		3
4	Laundry	67,547	12,366		79,913		79,913		79,913		4
5	Heat and Other Utilities			93,697	93,697		93,697		93,697		5
6	Maintenance	71,639		80,402	152,041		152,041		152,041		6
7	Other (specify):*										7
8	TOTAL General Services	474,302	178,140	185,881	838,323		838,323	(4,137)	834,186		8
	B. Health Care and Programs										
9	Medical Director			4,310	4,310		4,310		4,310		9
10	Nursing and Medical Records	1,105,918	115,411	8,019	1,229,348		1,229,348		1,229,348		10
10a	Therapy			176,214	176,214		176,214		176,214		10a
11	Activities	68,085	5,731	4,790	78,606		78,606	(22,027)	56,579		11
12	Social Services	18,626	4		18,630		18,630		18,630		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,192,629	121,146	193,333	1,507,108		1,507,108	(22,027)	1,485,081		16
	C. General Administration										
17	Administrative	76,200			76,200		76,200		76,200		17
18	Directors Fees										18
19	Professional Services			32,357	32,357		32,357		32,357		19
20	Dues, Fees, Subscriptions & Promotions			21,697	21,697		21,697	(2,614)	19,083		20
21	Clerical & General Office Expenses	122,208	26,511	27,814	176,533		176,533	(18,912)	157,621		21
22	Employee Benefits & Payroll Taxes			301,570	301,570		301,570		301,570		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,358	12,358		12,358		12,358		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,467	47,467		47,467		47,467		26
27	Other (specify):*										27
28	TOTAL General Administration	198,408	26,511	443,263	668,182		668,182	(21,526)	646,656		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,865,339	325,797	822,477	3,013,613		3,013,613	(47,690)	2,965,923		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 Arthur Home #0005462 Report Period Beginning: 9/1/2006 Ending: 8/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			76,474	76,474	76,474		76,474			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			6,626	6,626	6,626	(6,626)				32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			83,100	83,100	83,100	(6,626)	76,474			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		89,949		89,949	89,949		89,949			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			37,778	37,778	37,778		37,778			42
43	Other (specify):*			117,628	117,628	117,628	(117,628)				43
44	TOTAL Special Cost Centers		89,949	155,406	245,355	245,355	(117,628)	127,727			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,865,339	415,746	1,060,983	3,342,068	3,342,068	(171,944)	3,170,124			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 Arthur Home

0005462

Report Period Beginning: 9/1/2006

Ending: 8/31/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,125)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,459)	43		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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(501)	43		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				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	(68,863)	43		24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,948)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (78,948)		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

BHF USE ONLY					
48		49		50	
				51	
					52

The Arthur Home

ID# 0005462

Report Period Beginning: 9/1/2006

Ending: 8/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow X-Ray - Medicare	\$ (6,237)	43	1
2	Disallow Lab - Medicare	(3,472)	43	2
3	Disallow House & Farm Prop. Maintenance	(5,800)	43	3
4	Disallow Social Dues	(424)	20	4
5	Offset Interest Income Against Related Expense	(6,626)	32	5
6	Offset Vending Income Against Related Expense	(12)	2	6
7	Offset Activity Income Against Related Expense	(712)	11	7
8	Offset Transportation Income Against Expense	(21,315)	11	8
9	Offset Other Income Against Related Expense	(18,912)	21	9
10	Disallow Advertising	(2,190)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(65,700)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,137)	0	0	0	0	0	0	0	0	0	0	(4,137)	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	(4,137)	0	0	0	0	0	0	0	0	0	0	(4,137)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(22,027)	0	0	0	0	0	0	0	0	0	0	(22,027)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(22,027)	0	0	0	0	0	0	0	0	0	0	(22,027)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,614)	0	0	0	0	0	0	0	0	0	0	(2,614)	20
21	Clerical & General Office Expenses	(18,912)	0	0	0	0	0	0	0	0	0	0	(18,912)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL General Administration	(21,526)	0	0	0	0	0	0	0	0	0	0	(21,526)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,690)	0	0	0	0	0	0	0	0	0	0	(47,690)	29

STATE OF ILLINOIS

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006 Ending:

Summary B

8/31/2007

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,626)	0	0	0	0	0	0	0	0	0	0	(6,626)	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	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,626)	0	0	0	0	0	0	0	0	0	0	(6,626)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(90,332)	(27,296)	0	0	0	0	0	0	0	0	0	(117,628)	43
44	TOTAL Special Cost Centers	(90,332)	(27,296)	0	(117,628)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(144,648)	(27,296)	0	(171,944)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Eberhardt Village	Arthur			

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	43 Maintenance	\$ 5,203	Eberhardt Village	100.00%	\$	\$ (5,203)	1
2	V	43 Advertising	284	Eberhardt Village	100.00%		(284)	2
3	V	43 Office Supplies	4,079	Eberhardt Village	100.00%		(4,079)	3
4	V	43 Administrative Expense	2,211	Eberhardt Village	100.00%		(2,211)	4
5	V	43 Real Estate Taxes	9,930	Eberhardt Village	100.00%		(9,930)	5
6	V	43 Utilities	3,742	Eberhardt Village	100.00%		(3,742)	6
7	V	43 Travel	59	Eberhardt Village	100.00%		(59)	7
8	V	43 Insurance Expense	1,438	Eberhardt Village	100.00%		(1,438)	8
9	V	43 Professional Fees	350	Eberhardt Village	100.00%		(350)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 27,296			\$	\$ * (27,296)	14

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2006 Ending: 8/31/2007

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	See attached listing of board members. No board members receive compensation.								\$		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 Arthur Home

0005462 Report Period Beginning: 9/1/2006 Ending: 3/31/2007

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	USDA		X	Construction	\$24,886.35	3/1/2007	\$ 1,701,791	\$ 1,701,791	3/1/2047	4.1250	\$	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	State Bank of Arthur		X	Working Capital	none	8/30/06	300,000		2/23/08	7.7500	6,626	6								
7												7								
8												8								
9	TOTAL Facility Related				\$24,886.35		\$ 2,001,791	\$ 1,701,791			\$ 6,626	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 2,001,791	\$ 1,701,791			\$ 6,626	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT David Eversole, Administrator

TELEPHONE 217-543-2103 FAX #: 217-543-2278

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>Facility pays real estate taxes on</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>non-care assets. All costs are</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>adjusted out of the cost report.</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>03-03-25-425-007</u>	<u>415 S. Oak</u>	\$ <u>2,762.80</u>	\$ <u>_____</u>
6. <u>03-03-25-406-009</u>	<u>PT S 1/2 SW 1/4 SE 1/4</u>	\$ <u>759.68</u>	\$ <u>_____</u>
7. <u>03-03-25-406-003</u>	<u>423 Eberhardt Dr.</u>	\$ <u>569.22</u>	\$ <u>_____</u>
8. <u>0303-25-406-007</u>	<u>PT SW 1/4 SE 1/4</u>	\$ <u>6,655.24</u>	\$ <u>_____</u>
9. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
TOTALS		\$ <u>10,746.94</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Arthur Home

0005462 Report Period Beginning:

9/1/2006 Ending:

8/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,236 B. General Construction Type: Exterior brick veneer Frame concrete, steel, wood Number of Stories 1

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).

Eberhardt Village - supportive living facility - construction of building was still in progress as of 8/31/07, 8.8 acres, 16-bed skilled nursing facility and 36-apartment assisted living unit

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>Resident Care</u>	<u>152,469</u>	<u>1959</u>	<u>\$ 2,085</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	152,469		\$ 2,085	3

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	40		1959	1959	\$ 124,966	\$	33	\$	\$	\$ 124,966	4
5	29		1975	1975	308,251	9,341	33	9,341		303,323	5
6											6
7											7
8											8
	Improvement Type**										
9	New Roof		1972		1,988		10			1,988	9
10	Fire Sprinkler System		1973		20,020		10			20,020	10
11	Fire Door		1973		2,400		10			2,400	11
12	Building Improvements		1973		2,646		10			2,646	12
13	Front Step and Ramp		1974		204		10			204	13
14	Heat Ducts		1974		942		10			942	14
15	Electric Breaker and Box		1974		30		10			30	15
16	Night Lights		1974		1,499		10			1,499	16
17	Heater for Ramp		1974		465		10			465	17
18	Concrete On Step & Ramp		1974		3,398		10			3,398	18
19	Pip Insulation		1975		89		10			89	19
20	Field Tile		1975		54		10			54	20
21	Door Holder		1975		78		10			78	21
22	Water Heater		1975		1,461		10			1,461	22
23	Ward Door		1975		275		10			275	23
24	Concrete		1975		83		10			83	24
25	Plumbing		1975		57		10			57	25
26	Electrical		1976		677		10			677	26
27	Concrete		1976		2,884		10			2,884	27
28	Lights in Parking Lot		1976		327		10			327	28
29	Doors		1976		1,011		10			1,011	29
30	Insulation		1977		3,094		10			3,094	30
31	Roof Fan and Cooler		1978		2,252		10			2,252	31
32	Building Improvements		1978		1,316		10			1,316	32
33	Building Improvements		1978		451		10			451	33
34	Seamless Floors		1979		9,036		10			9,036	34
35	Building Improvements		1979		4,228		10			4,228	35
36	Remodeling Kitchen		1980		12,772		10			12,772	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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	Building Improvements	1980	\$ 552	\$	10	\$	\$	\$ 552	37
38	Roof	1981	23,816		10			23,816	38
39	Water Heater	1982	769		10			769	39
40	Parking Lot Addition	1982	4,577		10			4,577	40
41	Wood Folding Doors/Shade	1982	1,728		10			1,728	41
42	Remodeling Heating System	1982	22,500		10			22,500	42
43	Sewerage Improvements	1983	2,604		10			2,604	43
44	New Overhang	1983	4,120		10			4,120	44
45	Over Hang	1983	2,210		10			2,210	45
46	New Roof	1984	11,137		10			11,137	46
47	Firecode Paintroom	1985	1,214		10			1,214	47
48	New Front Doors	1985	2,333		10			2,333	48
49	New Bath & Beauty Shop	1986	13,969		10			13,969	49
50	Remodel Medicine Room	1986	1,886		10			1,886	50
51	Sprinkler System-Boiler Room	1987	1,971	79	25	79		1,603	51
52	Fire Doors	1987	1,097		10			1,097	52
53	Garage	1987	6,834	313	20	313		6,834	53
54	Boiler & Furnace Room	1987	96,626	3,865	25	3,865		78,267	54
55	Points on Construction Loan	1987	1,300	52	25	52		1,053	55
56	Floor Replacement	1987	1,016	51	20	51		1,008	56
57	New Water Heater	1987	3,238		15			3,238	57
58	Gargage Wiring	1987	916	46	20	46		905	58
59	Floor Replacement	1988	900	45	20	45		855	59
60	Replacement Windows	1988	2,100	105	20	105		1,978	60
61	Doorways-Widening	1989	401	20	20	20		373	61
62	Sprinkler System-Kitchen	1989	2,523	101	25	101		1,876	62
63	Patio	1989	2,384	119	20	119		2,185	63
64	Kitchen Fire System	1989	1,005	40	25	40		717	64
65	New Flooring	1990	35,477	1,774	20	1,774		31,190	65
66	Shower Room Remodeling	1990	2,111	106	20	106		1,848	66
67	Basement Remodeling	1990	5,913	296	20	296		5,150	67
68	Patient Alarm System	1990	3,172		10			3,172	68
69	Curtain Tracks	1991	679		10			679	69
70	TOTAL (lines 4 thru 69)		\$ 770,032	\$ 16,353		\$ 16,353	\$	\$ 739,470	70

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

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 770,032	\$ 16,353		\$ 16,353	\$	\$ 739,470	1
2	Door	1992	2,056		10			2,056	2
3	Ramp	1992	6,007	240	25	240		3,724	3
4	Gazebo	1992	10,636	532	20	532		8,199	4
5	Sprinkler System	1992	22,385	895	25	895		13,729	5
6	Building Improvements	1992	1,560	78	20	78		1,183	6
7	Electrical Heat Mats	1992	2,450	123	20	123		1,818	7
8	Roof	1992	1,569	78	20	78		1,150	8
9	Guttering	1993	1,362	68	20	68		999	9
10	Free Air Vents	1992	814	41	20	41		601	10
11	Remodel/D.O.N. Office	1993	3,970	199	20	199		2,846	11
12	Air Conditioner-Vent Work	1993	4,679		10			4,679	12
13	Fans & Lights	1993	802	40	20	40		555	13
14	Ramp, Rail & Heater	1993	8,030	401	20	401		5,520	14
15	Roof Work	1994	3,150	158	20	158		2,127	15
16	Curtains	1994	382	19	20	19		256	16
17	Kitchen Windows	1994	300	15	20	15		199	17
18	Water Heater	1994	1,958		10			1,958	18
19	Bed Lights	1994	2,707		10			2,707	19
20	Windows	1995	39,488	1,974	20	1,974		24,021	20
21	Flooring	1995	454	23	20	23		286	21
22	Nurse Call System	1995	10,082		10			10,082	22
23	Doors	1995	2,733	137	20	137		1,663	23
24	Hot Water Pipes	1996	2,576	129	20	129		1,482	24
25	Shower Room Remodeling	1996	1,707	85	20	85		952	25
26	Lights	1996	1,366	68	20	68		745	26
27	Air Conditioner	1996	4,730	39	10	39		4,730	27
28	Lavatory	1996	1,778	89	20	89		963	28
29	Flooring	1997	15,671	784	20	784		8,294	29
30	Recover Walls	1997	27,143	2,036	10	2,036		27,143	30
31	Miscellaneous Improvements	1997	2,679	134	20	134		1,406	31
32	Insulation	1998	3,600	180	20	180		1,620	32
33	Basement Steel Posts	1998	4,639	232	20	232		2,184	33
34	TOTAL (lines 1 thru 33)		\$ 963,495	\$ 25,150		\$ 25,150	\$	\$ 879,347	34

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

Facility Name & ID Number The Arthur Home

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		\$ 963,495	\$ 25,150		\$ 25,150	\$	\$ 879,347	1
2	Architectural Fees-Addition	1998	10,950	548	20	548		5,156	2
3	Air Conditioner	1997	6,752	675	10	675		6,639	3
4	Miscellaneous Bldg Improvements	1998	2,802	140	20	140		1,331	4
5	Parking Spaces	1998	1,596	64	25	64		554	5
6	Exhaust Fans	1999	221	11	20	11		95	6
7	Install Steel Plates Over Gutters	1999	484	24	20	24		191	7
8	Sink & Faucet	2000	1,401	93	15	93		716	8
9	Ducts	2000	404	20	20	20		153	9
10	Basement Door	2001	1,058	53	20	53		353	10
11	Back Doors	2001	2,687	134	20	134		840	11
12	Alarm System	2001	2,075	208	10	208		1,349	12
13	Ceiling Imp	2001	500	25	20	25		152	13
14	Grease Trap	2001	2,531	127	20	127		759	14
15	New Roof	2002	27,023	1,354	20	1,354		6,812	15
16	Miscellaneous Improvements	2002	1,489	74	20	74		410	16
17	Fire Sprinkler	2003	2,653	177	15	177		663	17
18	Cabinet	2004	748	75	10	75		275	18
19	Cabinet	2004	748	75	10	75		275	19
20	Draperies	2004	1,672	167	10	167		571	20
21	Draperies	2004	1,806	181	10	181		557	21
22	Sewer Line	2004	4,200	280	15	280		863	22
23	Shower Room Tile	2005	3,675	368	10	368		1,133	23
24	Draperies	2005	632	63	10	63		195	24
25	Counter Top	2005	980	98	10	98		302	25
26	Kitchen Tile Floor	2005	1,560	156	10	156		481	26
27	Cabinet	2005	755	76	10	76		233	27
28	Cabinet	2005	695	70	10	70		214	28
29	Exhaust Fan	2004	1,782	178	10	178		423	29
30	Back Step	2004	2,545	170	15	170		530	30
31	Basement Work	2005	10,465	523	20	523		1,309	31
32	Handrails	2005	7,045	470	15	470		1,135	32
33	Doors	2005	557	56	10	56		130	33
34	TOTAL (lines 1 thru 33)		\$ 1,067,985	\$ 31,881		\$ 31,881	\$	\$ 914,146	34

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

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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 12C, Carried Forward		\$ 1,067,985	\$ 31,881		\$ 31,881	\$	\$ 914,146	1
2	Carpet	2005	1,550	155	10	155		349	2
3	Ramps	2005	1,827	122	15	122		290	3
4	Doors	2005	1,174	117	10	117		255	4
5	Roof	2005	8,000	400	20	400		933	5
6	Roof	2005	8,000	400	20	400		933	6
7	Roof	2005	16,103	805	20	805		1,878	7
8	Smoke Detectors	2006	4,785	479	10	479		798	8
9	Concrete Patio	2006	733	37	20	37		40	9
10	Doors	2007	4,076	119	20	119		119	10
11	Fire Doors	2007	3,163	66	20	66		66	11
12	Concrete	2007	595	20	10	20		20	12
13	Concrete	2007	2,285	76	10	76		76	13
14	Ramp Railing	2007	1,325	33	10	33		33	14
15	Bathroom Remodeling	2007	1,080	5	20	5		5	15
16	Doors	2006	2,280	9	20	9		9	16
17	Prinsco-Tile Work	2007	2,772	23	10	23		23	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)		\$ 1,127,733	\$ 34,747		\$ 34,747	\$	\$ 919,973	34

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

Facility Name & ID Number The Arthur Home # 0005462 Report Period Beginning: 9/1/2006 Ending: 8/31/2007

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	\$ 359,927	\$ 37,852	\$ 37,852	\$		\$ 172,377	71
72	Current Year Purchases	52,902	3,234	3,234			3,234	72
73	Fully Depreciated Assets	447,851	641	641			447,851	73
74								74
75	TOTALS	\$ 860,680	\$ 41,727	\$ 41,727	\$		\$ 623,462	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	Resident Care	Van	1986	\$ 7,000	\$	\$	\$	4	\$ 7,000	76
77	Resident Care	1991 Aerostar Van	1991	15,110				4	15,110	77
78	Resident Care	Handicap Bus	2001	45,103				4	45,103	78
79										79
80	TOTALS			\$ 67,213	\$	\$	\$		\$ 67,213	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)		\$ 2,057,711	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 76,474	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 76,474	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)		\$ 1,610,648	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	8 Acres Donated Farm Land	\$ 22,500	\$	\$	86
87	8.8 Acres - Lutheran Church Distri	81,771			87
88	Funeral Home Land & Building	290,363			88
89	Parking Lot Roadpack	6,015			89
90	Lot 415 S. Oak	18,000			90
91	TOTALS	\$ 418,649	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Eberhardt Village - various	\$ 2,251,911	92
93			93
94			94
95		\$ 2,251,911	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 Arthur Home

0005462

Report Period Beginning: 9/1/2006

Ending: 8/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ 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	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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	TOTAL			\$		\$	\$		\$	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 Arthur Home# 0005462Report Period Beginning: 9/1/2006

Ending:

8/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2007

(last day of reporting year)

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	\$ 43,629	\$ 720,199	1
2	Cash-Patient Deposits	7,785	7,785	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	309,763	309,763	3
4	Supply Inventory (priced at)	5,743	5,743	4
5	Short-Term Investments	153,022	153,022	5
6	Prepaid Insurance	5,018	6,629	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	327,311	327,311	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 852,271	\$ 1,530,452	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,067	274,067	13
14	Buildings, at Historical Cost	819,491	966,168	14
15	Leasehold Improvements, at Historical Cost	308,252	308,252	15
16	Equipment, at Historical Cost	927,893	927,893	16
17	Accumulated Depreciation (book methods)	(1,610,730)	(1,610,730)	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 (spe CIP		2,251,911	22
23	Other(specify): Due from Eberhardt Village	664,734		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,169,707	\$ 3,117,561	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,021,978	\$ 4,648,013	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 37,800	\$ 829,708	26
27	Officer's Accounts Payable	7,785	7,785	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1	1	29
30	Accrued Salaries Payable	56,385	56,385	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,456	18,456	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		12,856	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Accrued Expenses	7,015	7,015	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 127,442	\$ 932,206	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,701,791	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)	\$	\$ 1,701,791	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 127,442	\$ 2,633,997	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,894,536	\$ 2,014,016	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,021,978	\$ 4,648,013	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,027,886	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,027,886	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(13,840)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (13,840)	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)	\$ 2,014,046	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Arthur Home# 0005462Report Period Beginning: 9/1/2006Ending: 8/31/2007**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	\$ 2,950,723	1
2	Discounts and Allowances for all Levels	(74,216)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,876,507	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	192,551	6
7	Oxygen	37,114	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 229,665	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,125	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133,463	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,859	19
20	Radiology and X-Ray	6,128	20
21	Other Medical Services	35,077	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 182,652	23
D. Non-Operating Revenue			
24	Contributions	12,971	24
25	Interest and Other Investment Income***	26,265	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,236	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See attached schedule</u>	168	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 168	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,328,228	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	838,323	31
32	Health Care	1,507,108	32
33	General Administration	668,182	33
B. Capital Expense			
34	Ownership	83,100	34
C. Ancillary Expense			
35	Special Cost Centers	207,577	35
36	Provider Participation Fee	37,778	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,342,068	40
41	Income before Income Taxes (line 30 minus line 40)**	(13,840)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (13,840)	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 Arthur Home

0005462

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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	6,188	6,660	\$ 143,723	\$ 21.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,840	4,002	82,198	20.54	3
4	Licensed Practical Nurses	16,465	17,441	298,957	17.14	4
5	CNAs & Orderlies	48,029	50,347	508,338	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,067	6,602	72,702	11.01	8
9	Activity Director	1,186	1,298	19,828	15.28	9
10	Activity Assistants	5,367	5,613	48,257	8.60	10
11	Social Service Workers	943	1,015	18,626	18.35	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,010	31,297	15.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,355	24,604	217,705	8.85	15
16	Dishwashers					16
17	Maintenance Workers	4,624	4,798	71,639	14.93	17
18	Housekeepers	8,332	8,756	86,114	9.83	18
19	Laundry	6,852	7,396	67,547	9.13	19
20	Administrator	2,072	2,160	76,200	35.28	20
21	Assistant Administrator					21
22	Other Administrative	7,585	8,414	122,208	14.52	22
23	Office Manager					23
24	Clerical					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,875	151,116	\$ 1,865,339 *	\$ 12.34	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	144	\$ 7,144	1-3	35
36	Medical Director	monthly	4,310	9-3	36
37	Medical Records Consultant	24	1,625	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	600	10-3	39
40	Physical Therapy Consultant	1,178	63,072	10A-3	40
41	Occupational Therapy Consultant	1,038	53,353	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	852	59,789	10A-3	43
44	Activity Consultant	48	1,542	11-3	44
45	Social Service Consultant	48	1,542	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,392	\$ 192,977		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number The Arthur Home

0005462

Report Period Beginning: 9/1/2006

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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			
David Eversole	Administrator	0	\$ 76,200	Workers' Compensation Insurance	\$ 44,129	IDPH License Fee	\$			
				Unemployment Compensation Insurance	156	Advertising: Employee Recruitment	12,337			
				FICA Taxes	141,818	Health Care Worker Background Check				
				Employee Health Insurance	97,735	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks	51 510			
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Subscriptions	358			
				Employee Physicals	1,162	Other Taxes & Licenses	5,366			
				Benefit Plan Match	16,570	Dues	3,126			
				Vacation & Holiday Expense	104,332					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 76,200	TOTAL (agree to Schedule V, line 22, col.8)			\$ 405,902	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,143
(List each licensed administrator separately.)								Less: Public Relations Expense		(424)
B. Administrative - Other							Non-allowable advertising		1,680	
Description			Amount				Yellow page advertising		2,190	
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
LarsonAllen	Accounting		\$ 29,620			\$	Out-of-State Travel	\$		
Samuels, Miller, Schroeder	Legal		940							
CNet of Champaign	Computers		340				In-State Travel	8,261		
Life Services Network	NH Association		997							
MPRO	Consulting		460				Seminar Expense	4,097		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 32,357	TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)								TOTAL		\$ 12,358

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Il. Health Care Assoc.- \$635; Life Services Network - \$1000
- (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? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,706 Line 10-2
- (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 during this cost report period. \$ 37,778
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,125
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 21,315
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? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: LarsonAllen LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Will forward copy when audit is finish
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.