

		FOR BHF USE				

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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: 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
IRS Exemption Code _____	<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 07/01/06 to 06/30/07 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) <u>Gail Porter</u>	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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 Carle Arbours# 0028522 Report Period Beginning: 07/01/06 Ending: 06/30/07

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>3,145</u>	<u>8,895</u>	<u>9,194</u>	<u>21,234</u>	8
9	SNF/PED					9
10	ICF	<u>24,767</u>	<u>20,985</u>		<u>45,752</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,912</u>	<u>29,880</u>	<u>9,194</u>	<u>66,986</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.45%

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

None (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 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 231 and days of care provided 9,194Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

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

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	531,551	55,345		586,896		586,896	586,896			1
2	Food Purchase		420,006		420,006		420,006	420,006			2
3	Housekeeping		26,805	206,712	233,517		233,517	233,517			3
4	Laundry		178	153,329	153,507		153,507	153,507			4
5	Heat and Other Utilities			217,610	217,610	(13,438)	204,172	204,172			5
6	Maintenance	88,906	39,662	66,598	195,166	(10,254)	184,912	184,912			6
7	Other (specify):* Waste/Security					46,707	46,707	46,707			7
8	TOTAL General Services	620,457	541,996	644,249	1,806,702	23,015	1,829,717	1,829,717			8
	B. Health Care and Programs										
9	Medical Director			10,425	10,425		10,425	10,425			9
10	Nursing and Medical Records	3,141,159	352,527	1,468,450	4,962,136	55,041	5,017,177	(774)	5,016,403		10
10a	Therapy	50,915	8,365	1,378,627	1,437,907		1,437,907		1,437,907		10a
11	Activities	102,411		2,224	104,635	(30,330)	74,305	(4,164)	70,141		11
12	Social Services	110,999			110,999		110,999		110,999		12
13	CNA Training										13
14	Program Transportation			12,100	12,100	1,569	13,669		13,669		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,405,484	360,892	2,871,826	6,638,202	26,280	6,664,482	(4,938)	6,659,544		16
	C. General Administration										
17	Administrative			336,098	336,098		336,098	1,204,194	1,540,292		17
18	Directors Fees										18
19	Professional Services			275,902	275,902		275,902	(273,274)	2,628		19
20	Dues, Fees, Subscriptions & Promotions			58,084	58,084	(949)	57,135	(25,347)	31,788		20
21	Clerical & General Office Expenses	211,462	29,109	173,688	414,259	(49,987)	364,272	(61,305)	302,967		21
22	Employee Benefits & Payroll Taxes			1,148,198	1,148,198		1,148,198		1,148,198		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,936	7,936	(1,109)	6,827	(2,542)	4,285		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			183,871	183,871		183,871		183,871		26
27	Other (specify):*										27
28	TOTAL General Administration	211,462	29,109	2,183,777	2,424,348	(52,045)	2,372,303	841,726	3,214,029		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,237,403	931,997	5,699,852	10,869,252	(2,750)	10,866,502	836,788	11,703,290		29

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

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

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

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			383,178	383,178		383,178	(5,560)	377,618		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			476,305	476,305		476,305	(1,000)	475,305		32
33	Real Estate Taxes			38,000	38,000		38,000	(38,000)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			107,483	107,483	2,750	110,233		110,233		35
36	Other (specify):*							23,452	23,452		36
37	TOTAL Ownership			1,004,966	1,004,966	2,750	1,007,716	(21,108)	986,608		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,306,898	1,306,898		1,306,898	473,158	1,780,056		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	TOTAL Special Cost Centers			1,433,378	1,433,378		1,433,378	473,158	1,906,536		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,237,403	931,997	8,138,196	13,307,596		13,307,596	1,288,838	14,596,434		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: 07/01/06

Ending: 06/30/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(1,000)	32		10
11	Discounts, Allowances, Rebates & Refunds	(774)	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	(5,560)	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	(14,704)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,305)	21		24
25	Fund Raising, Advertising and Promotional	(25,347)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(38,000)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,104)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,794)		\$	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))	\$ (150,794)		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 Carle Arbours

ID# 0028522
 Report Period Beginning: 07/01/06
 Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	NON PATIENT MEALS	\$ (2,044)	11	1
2	ACTIVITY INCOME	(2,060)	11	2
3	NON DIRECT CARE TRAVEL	(2,542)	24	3
4	NON ALLOWABLE SUBSCRIPTIONS	(60)	11	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(774)	0	0	0	0	0	0	0	0	0	0	(774)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,164)	0	0	0	0	0	0	0	0	0	0	(4,164)	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	(4,938)	0	0	0	0	0	0	0	0	0	0	(4,938)	16
	C. General Administration													
17	Administrative	0	1,204,194	0	0	0	0	0	0	0	0	0	1,204,194	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,704)	(258,570)	0	0	0	0	0	0	0	0	0	(273,274)	19
20	Fees, Subscriptions & Promotions	(25,347)	0	0	0	0	0	0	0	0	0	0	(25,347)	20
21	Clerical & General Office Expenses	(61,305)	0	0	0	0	0	0	0	0	0	0	(61,305)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,542)	0	0	0	0	0	0	0	0	0	0	(2,542)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	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	(103,898)	945,624	0	841,726	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,836)	945,624	0	836,788	29								

STATE OF ILLINOIS

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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	(5,560)	0	0	0	0	0	0	0	0	0	0	(5,560)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	32
33	Real Estate Taxes	(38,000)	0	0	0	0	0	0	0	0	0	0	(38,000)	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	23,452	0	0	0	0	0	0	0	0	0	23,452	36
37	TOTAL Ownership	(44,560)	23,452	0	(21,108)	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	473,158	0	0	0	0	0	0	0	0	0	473,158	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	473,158	0	473,158	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(153,396)	1,442,234	0	1,288,838	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
The Carle Foundation	100			Carle Hospital	Urbana	Hospital/DME/Rx
				Carle Health Care	Urbana	Ambulance Svc

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Home Office-Administrative	\$	Carle Foundation	100.00%	\$ 201,670	\$ 201,670
2	V	36 Home Office-Loss/Gain on Disp		Carle Foundation	100.00%	(13,271)	(13,271)
3	V	17 Shared A & G Hosp Gen. Svcs.		Carle Foundation	100.00%	1,002,524	1,002,524
4	V	36 Shared Q & G Hosp Capital		Carle Foundation	100.00%	36,723	36,723
5	V	19 Management Fees	258,570	Carle Foundation	100.00%		(258,570)
6	V	39 Pharmacy & Drugs	1,154,043	Carle Foundation	100.00%	1,627,201	473,158
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,412,613			\$ 2,854,847	\$ * 1,442,234

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

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

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: 07/01/06

Ending: 06/30/07

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	12	\$ 201,670	\$ 143,426	12	\$ 201,670	1
2	36	Home Office-Loss/Gain on Disp	Direct Costs	12	12	(13,271)		12	(13,271)	2
3	17	Shared A & G Hosp Gen. Svcs.	Direct Costs	12	12	1,002,524	286,622	12	1,002,524	3
4	36	Shared A & G Hosp Capital	Direct Costs	12	12	36,723		12	36,723	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					\$ 1,227,646	\$ 430,048		\$ 1,227,646	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	\$26.00 Million Bond Issue	x		Refinance/remodel	n/a	06/01/96	\$ 1,086,927	\$	Multiple	Variable	\$ 213	1								
2	\$49.99 Million Bond Issue	x		Refin/remodel/Arbrs Ct	n/a	05/01/98	5,408,918	2,024,785	Multiple	Variable	108,704	2								
3	\$29.30 Million Bond Issue	x		Refinance/remodel	n/a	07/01/99	750,080	640,000	Multiple	Variable	25,668	3								
4	\$190.3 Million Bond Issue	x		Refinance	n/a	11/10/04	1,655,610	1,608,461	Multiple	Variable	53,652	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 8,901,535	\$ 4,273,246			\$ 188,237	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 8,901,535	\$ 4,273,246			\$ 188,237	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 38,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 38,000	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
This represents managements estimate of one half year's real estate tax expense IF real estate taxes are assessed. Currently NO real estate taxes have been assessed or paid.				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

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 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 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

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 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 Carle Arbours

0028522 Report Period Beginning:

07/01/06 Ending:

06/30/07

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>	1
2					2
3	TOTALS	174,240		\$ 274,934	3

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	\$	\$ 1,985,376	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		RENOVATIONS		1984	267,128	9,152	VARIOUS	9,152		248,894	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		30,902	13
14		ROOF & ELECTRICAL		1985	23,658	239	VARIOUS	239		23,059	14
15		KITCHEN REMODEL		1985	23,504	655	VARIOUS	655		21,735	15
16		LANDSCAPING		1986	7,325		VARIOUS			7,325	16
17		RENOVATIONS		1986	31,097	786	VARIOUS	786		28,149	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		890	23
24		GENERATOR		1988	11,693	275	VARIOUS	275		11,395	24
25		INSULATION		1988	3,650	183	20	183		3,483	25
26		RENOVATIONS		1988	6,774	8	VARIOUS	8		6,689	26
27		ALZHEIMERS/2ND FLOOR RENOVATION		1990	6,214	169	VARIOUS	169		5,102	27
28		EMERGENCY POWER DISTRIBUTION		1990	27,115	1,334	VARIOUS	1,334		22,799	28
29		DOORS		1990	1,388		15			1,338	29
30		REMODELING		1990	2,838	142	20	142		2,365	30
31		REMODELING		1991	472,549	16,767	VARIOUS	16,767		323,874	31
32		FLOORING		1991	87,008	2,547	VARIOUS	2,547		75,757	32
33		RENOVATIONS		1991	1,981	49	VARIOUS	49		1,768	33
34		RENOVATIONS		1992	5,150	283	15	283		5,076	34
35		ROOF REPAIR		1992	22,257		10			22,257	35
36		FLOORING		1992	14,427	702	VARIOUS	702		14,193	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 Carle Arbours

0028522

Report Period Beginning:

07/01/06

Ending:

06/30/07

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		7,888	38
39	ELEVATOR	1993	10,788	561	VARIOUS	561		7,962	39
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		33,788	40
41	PARKING LOT IMPROVEMENTS	1994	4,300		10			4,300	41
42	ELEVATOR	1994	3,368	168	20	168		2,273	42
43	RENOVATIONS	1994	57,905	2,586	VARIOUS	2,586		40,257	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	86	VARIOUS	86		11,699	44
45	REMODELING	1994	55,764	2,839	20	2,839		35,987	45
46	DOORS	1994	4,684	190	VARIOUS	190		3,304	46
47	REMODELING	1995	2,320	116	20	116		1,421	47
48	REMODELING	1995	12,720	669	19	669		8,089	48
49	ROOF REPAIRS	1995	20,660	1,001	VARIOUS	1,001		12,735	49
50	ROOF AIR CONDITIONER	1995	40,354	955	VARIOUS	955		37,329	50
51	ROOF AIR CONDITIONER	1995	2,950		10			2,950	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	18	14,668		171,123	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	18	312		3,508	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	20	3,995		44,610	54
55	FLOORING	1996	15,511		10			15,511	55
56	WINDOWS	1996	3,028	151	20	151		1,628	56
57	ENTRANCE CANOPY	1996	1,580	53	10	53		1,580	57
58	ELECTRIC DOORS	1996	5,072	192	VARIOUS	192		4,414	58
59	ROOFING	1996	22,900	763	10	763		22,900	59
60	REPAIR BOILER ROOM	1996	3,300	110	10	110		3,300	60
61	REFURBISH SIGN	1996	1,200	40	10	40		1,200	61
62	ENTRANCE CANOPY	1997	3,693	215	10	215		3,693	62
63	NURSE STATIONS	1997	34,011	2,126	VARIOUS	2,126		20,374	63
64	FENCE	1998	3,885	259	15	259		2,396	64
65	DOORS	1998	945	63	15	63		546	65
66	NURSE STATIONS	1998	10,000	667	15	667		5,780	66
67	CHAIN LINK FENCE	1998	4,544	303	15	303		2,651	67
68	BATHS	1999	623,243	31,162	20	31,162		256,909	68
69	WALL ARCHITECTURAL	1999	1,491	75	20	75		602	69
70	TOTAL (lines 4 thru 69)		\$ 5,487,106	\$ 186,779		\$ 186,779	\$	\$ 3,714,008	70

**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:

07/01/06

Ending:

06/30/07

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		\$ 5,487,106	\$ 186,779		\$ 186,779	\$	\$ 3,714,008	1
2	<u>SUBACUTE IMPROVEMENTS</u>	2000	75,624	4,020	VARIOUS	4,020		29,813	2
3	<u>RENOVATIONS- BATHROOMS</u>	2000	36,055	1,898	19	1,898		14,074	3
4	<u>HANDRAILS</u>	2000	11,693	779	15	779		5,781	4
5	<u>HALL FLOOR</u>	2000	30,472	1,604	19	1,604		11,895	5
6	<u>ROOF REPAIRS</u>	2000	7,800	433	18	433		2,997	6
7	<u>AIR CURTAIN</u>	2000	1,110	62	18	62		427	7
8	<u>BATH RENOVATION</u>	2000	2,438	128	19	128		887	8
9	<u>SECOND FLOOR AIR</u>	2000	4,829	268	18	268		1,766	9
10	<u>FACILITY IMPROVEMENTS</u>	2001	274		5			274	10
11	<u>THERAPY FLOOR</u>	2001	3,700	370	10	370		2,189	11
12	<u>THERAPY CEILING</u>	2001	3,194	53	5	53		3,194	12
13	<u>FIRST FLOOR HANDRAILS</u>	2001	12,480	1,040	5	1,040		12,480	13
14	<u>SECOND FLOOR AIR</u>	2002	86,210	5,129	VARIOUS	5,129		26,291	14
15	<u>WALL ARCHITECHURAL</u>	2002	7,032	414	17	414		2,275	15
16	<u>GIFT SHOP EXPANSION</u>	2002	16,819	1,057	VARIOUS	1,057		5,810	16
17	<u>CARPET</u>	2002	3,984	531	5	531		3,984	17
18	<u>THERAPY FLOOR</u>	2002	180	18	10	18		95	18
19	<u>VINYL FLOORING</u>	2002	5,979	598	10	598		3,039	19
20	<u>THERAPY CEILING</u>	2002	6,930	1,271	5	1,271		6,930	20
21	<u>NURSE STATIONS(PER FY99 IPA AUDIT)</u>	1995	69,094	3,839	VARIOUS	3,839		45,424	21
22	<u>RENOVATIONS-FIRE WALL</u>	2003	146,487	6,972	VARIOUS	6,972		33,376	22
23	<u>ARBRS COURT BUILDING</u>	2003	1,397,938	34,948	VARIOUS	34,948		142,706	23
24	<u>RENOVATIONS-NURSING STATION/TEMP CONTROLLERS</u>	2003	57,666	1,442	VARIOUS	1,442		5,887	24
25	<u>FLOORING</u>	2003	7,490	1,098	VARIOUS	1,098		5,199	25
26	<u>ARBRS COURT BUILDING</u>	2004	344,851	8,621	40	8,621		32,330	26
27	<u>FENCING</u>	2004	7,172	429	VARIOUS	429		1,561	27
28	<u>LANDSCAPING</u>	2004	80,580	6,279	VARIOUS	6,279		40,258	28
29	<u>ORIG BLDG RENOVATIONS</u>	2004	83,766	5,924	VARIOUS	5,924		19,016	29
30	<u>RENOVATIONS</u>	2004	74,853	1,879	VARIOUS	1,879		7,045	30
31	<u>SINAGE</u>	2004	6,427	1,229	VARIOUS	1,229		4,608	31
32	<u>2ND FLR INTERIOR UPGRADE</u>	2005	87,775	5,852	VARIOUS	5,852		14,629	32
33	<u>EXTERIOR PAINTING & REPAIRS</u>	2005	71,086	5,120	VARIOUS	5,120		12,801	33
34	TOTAL (lines 1 thru 33)		\$ 8,239,094	\$ 290,084		\$ 290,084	\$	\$ 4,213,049	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:

07/01/06

Ending:

06/30/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,239,094	\$ 290,084		\$ 290,084	\$	\$ 4,213,049	1
2	SIGNS	2005	2,040	204	10	204		510	2
3	CAPITALIZED INTEREST	2004	56,570	1,479	40	1,479		4,312	3
4	RENOVATIONS	2006	20,300	3,122	15	3,122		3,603	4
5	FY07/CY06 RENOVATIONS	2006	47,566	2,866	15	2,866		2,866	5
6	FY07/CY07 RENOVATIONS	2007	7,766	173	15	173		173	6
7	ROUNDING		(2)	3		3			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)		\$ 8,373,334	\$ 297,931		\$ 297,931	\$	\$ 4,224,513	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: 07/01/06 Ending: 06/30/07

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	\$ 1,889,094	\$ 79,342	\$ 79,342	\$	VARIOUS	\$ 1,443,167	71
72	Current Year Purchases	34,086	345	345		VARIOUS	345	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,923,180	\$ 79,687	\$ 79,687	\$		\$ 1,443,512	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)		\$ 10,571,448	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 377,618	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 377,618	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)		\$ 5,668,025	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	\$ 3,095	\$ 29,665	86
87	BATHS-1999	9,818	491	4,050	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,540	36,062	88
89	PROJECT 95-028-00-1997	6,940	434	4,157	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	\$ 106,493	\$ 5,560	\$ 75,624	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.

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

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	\$ _____

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 _____.

N/A

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: \$ 102,208

Description: Specialty beds, misc medical equipment

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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?</p> <p style="text-align: right;"> <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.

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	\$ 316	n/a	\$ 692,965	\$	n/a	\$ 693,281	1
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	hrs	118	n/a	108,623		n/a	108,741	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a Col 3	hrs		n/a	576,605		n/a	576,605	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			\$ 434		\$ 1,378,193	\$		\$ 1,378,627	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: 07/01/06

Ending:

06/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/07

(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	\$ 33,647	\$	1
2	Cash-Patient Deposits	22,092		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,580,833		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	975,775		5
6	Prepaid Insurance	50,139		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,416,148)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (2,753,662)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (2,753,662)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 856,950	\$	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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 856,950	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 856,950	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,610,612)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (2,753,662)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,058,230)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,058,230)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(664,351)	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>	111,971	15
16	Other (describe) <u>ROUNDING</u>	(2)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (552,382)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,610,612)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/06Ending: 06/30/07**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	\$ 13,453,512	1
2	Discounts and Allowances for all Levels	(7,658,921)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,794,591	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,604,246	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,604,246	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,238,530	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,238,530	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,000	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER PER ATTACHED SCHEDULE	4,878	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,878	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,643,245	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,806,702	31
32	Health Care	6,638,202	32
33	General Administration	2,424,348	33
B. Capital Expense			
34	Ownership	966,966	34
C. Ancillary Expense			
35	Special Cost Centers	1,306,898	35
36	Provider Participation Fee	164,480	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,307,596	40
41	Income before Income Taxes (line 30 minus line 40)**	(664,351)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (664,351)	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:

07/01/06

Ending:

06/30/07

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	1,935	2,119	\$ 70,800	\$ 33.41	1
2	Assistant Director of Nursing	1,884	2,132	59,175	27.76	2
3	Registered Nurses	14,779	15,960	488,234	30.59	3
4	Licensed Practical Nurses	33,906	36,477	771,720	21.16	4
5	CNAs & Orderlies	114,789	122,944	1,478,696	12.03	5
6	CNA Trainees					6
7	Licensed Therapist	3,791	3,997	50,915	12.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,800	2,080	34,236	16.46	9
10	Activity Assistants	5,431	6,593	68,176	10.34	10
11	Social Service Workers	5,091	5,767	111,000	19.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,039	3,060	51,236	16.74	14
15	Cook Helpers/Assistants	39,488	42,124	480,314	11.40	15
16	Dishwashers					16
17	Maintenance Workers	5,536	6,465	88,350	13.67	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	8,673	9,614	188,903	19.65	22
23	Office Manager					23
24	Clerical	14,683	16,141	211,462	13.10	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	6,130	6,686	84,186	12.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	260,955	282,159	\$ 4,237,403 *	\$ 15.02	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	10,425	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)	\$ 10,425		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,826	\$ 175,854	Ln 10 Col 3 50
51	Licensed Practical Nurses	10,270	362,498	Ln 10 Col 3 51
52	Certified Nurse Assistants/Aides	40,761	846,714	Ln 10 Col 3 52
53	TOTAL (lines 50 - 52)	54,857	\$ 1,385,066	53

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	
T. MULLINS	ADMINISTRATOR		\$ 74,502	Workers' Compensation Insurance	\$ 90,049	IDPH License Fee	\$ 6,690	
G. PORTER	ADMINISTRATOR		17,108	Unemployment Compensation Insurance	12,500	Advertising: Employee Recruitment	30,249	
				FICA Taxes	311,323	Health Care Worker Background Check		
				Employee Health Insurance	532,325	(Indicate # of checks performed)		
				Employee Meals		Subscriptions	4,881	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relation & Entertainment	2,065	
				LIFE INSURANCE	4,135	IHCA dues	12,850	
				LONG TERM DISABILITY	9,800	Other dues & permits	400	
				PENSION	160,375	Non allowable subscriptions	(2,451)	
				TUITION REIMBURSEMENT	10,570	Non allowable recruitment	(6,562)	
				EMPLOYEE ACTIVITIES	17,121	Less: Public Relations Expense	(2,065)	
						Non-allowable advertising	(14,269)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 91,610				\$ 1,148,198			\$ 31,788	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
HERITAGE ENTERPRISES			\$ 321,394	None			Out-of-State Travel	\$
HARTWEG, TURNER			14,704				In-State Travel	2,345
							Seminar Expense	1,940
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 336,098				\$			\$ 4,285	
C. Professional Services								
Vendor/Payee	Type		Amount					
CARLE HOSPITAL	RELATED PARTY		\$ 258,570					
CARLE CLINIC ASSOC	DATA PROCESSING		17,332					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 275,902								

* 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. _____
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,006 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department 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. \$ None Has any meal income been offset against related costs? _____ 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: _____ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.