

Facility Name & ID Number The Carle Arbours# 0028522 Report Period Beginning: 07/01/07 Ending: 6/30/08

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>6,330</u>	<u>5,764</u>	<u>9,028</u>	<u>21,122</u>	8
9	SNF/PED					9
10	ICF	<u>21,774</u>	<u>24,840</u>		<u>46,614</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,104</u>	<u>30,604</u>	<u>9,028</u>	<u>67,736</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.34%

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? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

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

YES NO

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

Date started 02/01/84

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

YES Date 02/01/84 NO

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

YES NO If YES, enter number
of beds certified 231 and days of care provided 9,028Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number

The Carle Arbours

0028522

Report Period Beginning:

07/01/07

Ending:

6/30/08

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	587,732	53,196	100	641,028		641,028		641,028			1
2	Food Purchase		444,895		444,895		444,895		444,895			2
3	Housekeeping		26,062	217,608	243,670		243,670		243,670			3
4	Laundry			155,356	155,356		155,356		155,356			4
5	Heat and Other Utilities			287,895	287,895	(895)	287,000		287,000			5
6	Maintenance	83,280	48,462	61,022	192,764	3,753	196,517		196,517			6
7	Other (specify):* Waste/Security					24,411	24,411		24,411			7
8	TOTAL General Services	671,012	572,615	721,981	1,965,608	27,269	1,992,877		1,992,877			8
	B. Health Care and Programs											
9	Medical Director			7,923	7,923		7,923		7,923			9
10	Nursing and Medical Records	3,312,140	422,486	1,711,055	5,445,681	56,061	5,501,742	(7,729)	5,494,013			10
10a	Therapy	47,853	8	1,426,001	1,473,862		1,473,862		1,473,862			10a
11	Activities	109,806	6,436	1,439	117,681	(26,855)	90,826	(1,558)	89,268			11
12	Social Services	118,378			118,378		118,378		118,378			12
13	CNA Training											13
14	Program Transportation			15,885	15,885	1,316	17,201		17,201			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,588,177	428,930	3,162,303	7,179,410	30,522	7,209,932	(9,287)	7,200,645			16
	C. General Administration											
17	Administrative			366,855	366,855		366,855	1,182,055	1,548,910			17
18	Directors Fees											18
19	Professional Services			295,922	295,922		295,922	(274,080)	21,842			19
20	Dues, Fees, Subscriptions & Promotions			60,902	60,902	(1,261)	59,641	(30,832)	28,809			20
21	Clerical & General Office Expenses	237,730	39,431	240,862	518,023	(59,323)	458,700	(137,815)	320,885			21
22	Employee Benefits & Payroll Taxes			1,188,167	1,188,167		1,188,167		1,188,167			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,213	4,213	(1,316)	2,897	(298)	2,599			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			192,200	192,200		192,200		192,200			26
27	Other (specify):*											27
28	TOTAL General Administration	237,730	39,431	2,349,121	2,626,282	(61,900)	2,564,382	739,030	3,303,412			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,496,919	1,040,976	6,233,405	11,771,300	(4,109)	11,767,191	729,743	12,496,934			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:

07/01/07

Ending:

6/30/08

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			383,758	383,758		383,758	(5,562)	378,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,498	201,498		201,498	(12,581)	188,917			32
33	Real Estate Taxes			75,504	75,504		75,504	(75,504)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,624	52,624	4,109	56,733		56,733			35
36	Other (specify):*							49,710	49,710			36
37	TOTAL Ownership			713,384	713,384	4,109	717,493	(43,937)	673,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,527,321		1,527,321		1,527,321	557,782	2,085,103			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,279	127,279		127,279		127,279			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,527,321	127,279	1,654,600		1,654,600	557,782	2,212,382			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,496,919	2,568,297	7,074,068	14,139,284		14,139,284	1,243,588	15,382,872			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: 07/01/07

Ending: 6/30/08

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	(12,581)	32		10
11	Discounts, Allowances, Rebates & Refunds	(565)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(5,562)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,455)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(31,349)	17		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,360)	21		24
25	Fund Raising, Advertising and Promotional	(30,832)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(75,504)	33		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)	\$ (294,208)		\$	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))	\$ (294,208)		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.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

The Carle Arbours

ID# 0028522

Report Period Beginning: 07/01/07

Ending: 6/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NON-DIRECT CARE TRAVEL	\$ (298)	24	1
2	ACTIVITY INCOME	(7,164)	10	2
3	MISCELLANEOUS INCOME	(1,558)	11	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,020)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/07

Ending:

6/30/08

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	(7,729)	0	0	0	0	0	0	0	0	0	0	(7,729)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,558)	0	0	0	0	0	0	0	0	0	0	(1,558)	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	(9,287)	0	0	0	0	0	0	0	0	0	0	(9,287)	16
	C. General Administration													
17	Administrative	(31,349)	1,213,404	0	0	0	0	0	0	0	0	0	1,182,055	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(274,080)	0	0	0	0	0	0	0	0	0	(274,080)	19
20	Fees, Subscriptions & Promotions	(30,832)	0	0	0	0	0	0	0	0	0	0	(30,832)	20
21	Clerical & General Office Expenses	(137,815)	0	0	0	0	0	0	0	0	0	0	(137,815)	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	(298)	0	0	0	0	0	0	0	0	0	0	(298)	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	(200,294)	939,324	0	739,030	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(209,581)	939,324	0	729,743	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/07

Ending:

6/30/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,562)	0	0	0	0	0	0	0	0	0	0	(5,562)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,581)	0	0	0	0	0	0	0	0	0	0	(12,581)	32
33	Real Estate Taxes	(75,504)	0	0	0	0	0	0	0	0	0	0	(75,504)	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	49,710	0	0	0	0	0	0	0	0	0	49,710	36
37	TOTAL Ownership	(93,647)	49,710	0	(43,937)	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	557,782	0	0	0	0	0	0	0	0	0	557,782	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	557,782	0	557,782	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(303,228)	1,546,816	0	1,243,588	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	39 Pharmacy & Drugs	1,394,456	Carle Foundation	100.00%	1,952,238	557,782
3	V	17 Shared A & G Hosp Gen. Svcs.		Carle Foundation	100.00%	1,011,734	1,011,734
4	V	36 Shared A & G Hosp Capital		Carle Foundation	100.00%	49,710	49,710
5	V	19 Management Fees	274,080	Carle Foundation	100.00%		(274,080)
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,668,536			\$ 3,215,352	\$ * 1,546,816

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

Facility Name & ID Number

The Carle Arbours

#

0028522

Report Period Beginning:

07/01/07

Ending:

6/30/08

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: 07/01/07

Ending: 6/30/08

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	Shared A & G Capital	Direct Costs	12	12	49,710		12	49,710	2
3	17	Shared A & G Hosp Gen. Svcs.	Direct Costs	12	12	1,011,734	319,506	12	1,011,734	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					\$ 1,263,114	\$ 462,932		\$ 1,263,114	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	\$49.99 Million Bond Issue	x		Refin/remodel/Arbrs Ct		05/01/98	\$ 5,408,918	\$ zero			\$ 84,622	1								
2	\$29.3 Million Bond Issue	x		Refinance/remodel	n/a	07/01/99	750,080	zero			19,668	2								
3	\$190.3 Million Bond Issue	x		Refinance	n/a	11/10/04	1,655,610	zero			66,558	3								
4	Norther Trust Company		x	Refinance	n/a	04/03/08	224,675,000	4,133,158	04/02/09	Variable	30,650	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 232,489,608	\$ 4,133,158			\$ 201,498	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 232,489,608	\$ 4,133,158			\$ 201,498	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/07 Ending:

6/30/08

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>174,240</u>	<u>1984</u>	<u>\$ 274,934</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	174,240		\$ 274,934	3

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/07

Ending:

6/30/08

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		\$ 2,070,161	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		RENOVATIONS		1984	267,128	9,152	VARIOUS	9,152		258,046	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		32,292	13
14		ROOF & ELECTRICAL		1985	23,658	239	VARIOUS	239		23,299	14
15		KITCHEN REMODEL		1985	23,504	655	VARIOUS	655		22,390	15
16		LANDSCAPING		1986	7,325		VARIOUS			7,325	16
17		RENOVATIONS		1986	31,097	786	VARIOUS	786		28,935	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		937	23
24		GENERATOR		1988	11,693	275	VARIOUS	275		11,670	24
25		INSULATION		1988	3,650	167	20	167		3,650	25
26		RENOVATIONS		1988	6,774	8	VARIOUS	8		6,697	26
27		ALZHEIMERS/2ND FLOOR RENOVATION		1990	6,214	144	VARIOUS	144		5,247	27
28		EMERGENCY POWER DISTRIBUTION		1990	27,115	1,334	VARIOUS	1,334		24,133	28
29		DOORS		1990	1,388		15			1,388	29
30		REMODELING		1990	2,838	142	20	142		2,507	30
31		REMODELING		1991	472,549	16,668	VARIOUS	16,668		340,489	31
32		FLOORING		1991	87,008	2,547	VARIOUS	2,547		78,305	32
33		RENOVATIONS		1991	1,981	49	VARIOUS	49		1,818	33
34		RENOVATIONS		1992	5,150	74	15	74		5,150	34
35		ROOF REPAIR		1992	22,257		10			22,257	35
36		FLOORING		1992	14,427	234	VARIOUS	234		14,427	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:

07/01/07

Ending:

6/30/08

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	464	15	464		8,352	38
39	ELEVATOR	1993	10,788	399	VARIOUS	399		8,361	39
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		36,173	40
41	PARKING LOT IMPROVEMENTS	1994	4,300		10			4,300	41
42	ELEVATOR	1994	3,368	168	20	168		2,442	42
43	RENOVATIONS	1994	57,905	2,586	VARIOUS	2,586		42,844	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	86	VARIOUS	86		11,784	44
45	REMODELING	1994	55,764	2,839	20	2,839		38,826	45
46	DOORS	1994	4,684	190	VARIOUS	190		3,495	46
47	REMODELING	1995	2,320	116	20	116		1,537	47
48	REMODELING	1995	12,720	669	19	669		8,759	48
49	ROOF REPAIRS	1995	20,660	1,001	VARIOUS	1,001		13,736	49
50	ROOF AIR CONDITIONER	1995	40,354	955	VARIOUS	955		38,284	50
51	ROOF AIR CONDITIONER	1995	2,950		10			2,950	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	18	14,668		185,791	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	18	312		3,820	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	20	3,995		48,605	54
55	FLOORING	1996	15,511		10			15,511	55
56	WINDOWS	1996	3,028	151	20	151		1,779	56
57	ENTRANCE CANOPY	1996	1,580		10			1,580	57
58	ELECTRIC DOORS	1996	5,072	70	VARIOUS	70		4,484	58
59	ROOFING	1996	22,900		10			22,900	59
60	REPAIR BOILER ROOM	1996	3,300		10			3,300	60
61	REFURBISH SIGN	1996	1,200		10			1,200	61
62	ENTRANCE CANOPY	1997	3,693		10			3,693	62
63	NURSE STATIONS	1997	34,011	2,126	VARIOUS	2,126		22,500	63
64	FENCE	1998	3,885	259	15	259		2,655	64
65	DOORS	1998	945	63	15	63		609	65
66	NURSE STATIONS	1998	10,000	667	15	667		6,446	66
67	CHAIN LINK FENCE	1998	4,544	303	15	303		2,954	67
68	BATHS	1999	623,243	30,929	20	30,929		288,378	68
69	WALL ARCHITECTURAL	1999	1,491	75	20	75		677	69
70	TOTAL (lines 4 thru 69)		\$ 5,487,106	\$ 184,171		\$ 184,171	\$	\$ 3,898,723	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:

07/01/07

Ending:

6/30/08

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	\$ 184,171		\$ 184,171	\$	\$ 3,898,723	1
2	<u>SUBACUTE IMPROVEMENTS</u>	2000	75,624	4,020	VARIOUS	4,020		33,833	2
3	<u>RENOVATIONS- BATHROOMS</u>	2000	36,055	1,898	19	1,898		15,972	3
4	<u>HANDRAILS</u>	2000	11,693	780	15	780		6,561	4
5	<u>HALL FLOOR</u>	2000	30,472	1,604	19	1,604		13,499	5
6	<u>ROOF REPAIRS</u>	2000	7,800	433	18	433		3,431	6
7	<u>AIR CURTAIN</u>	2000	1,110	62	18	62		488	7
8	<u>BATH RENOVATION</u>	2000	2,438	128	19	128		1,016	8
9	<u>SECOND FLOOR AIR</u>	2000	4,829	268	18	268		2,035	9
10	<u>FACILITY IMPROVEMENTS</u>	2001	274		5			274	10
11	<u>THERAPY FLOOR</u>	2001	3,700	370	10	370		2,559	11
12	<u>THERAPY CEILING</u>	2001	3,194		5			3,194	12
13	<u>FIRST FLOOR HANDRAILS</u>	2001	12,480		5			12,480	13
14	<u>SECOND FLOOR AIR</u>	2002	86,210	5,129	VARIOUS	5,129		31,420	14
15	<u>WALL ARCHITECHURAL</u>	2002	7,032	414	17	414		2,689	15
16	<u>GIFT SHOP EXPANSION</u>	2002	16,819	957	VARIOUS	957		6,222	16
17	<u>CARPET</u>	2002	3,984		5			3,984	17
18	<u>THERAPY FLOOR</u>	2002	180	18	10	18		113	18
19	<u>VINYL FLOORING</u>	2002	5,979	598	10	598		3,637	19
20	<u>THERAPY CEILING</u>	2002	6,930		5			6,930	20
21	<u>NURSE STATIONS(PER FY99 IPA AUDIT)</u>	1995	69,094	3,839	VARIOUS	3,839		49,263	21
22	<u>RENOVATIONS-FIRE WALL</u>	2003	146,487	6,848	VARIOUS	6,848		40,224	22
23	<u>ARBRS COURT BUILDING</u>	2003	1,397,938	34,948	VARIOUS	34,948		177,655	23
24	<u>RENOVATIONS-NURSING STATION/TEMP CONTROLLERS</u>	2003	57,666	1,442	VARIOUS	1,442		7,328	24
25	<u>FLOORING</u>	2003	7,490	691	VARIOUS	691		5,890	25
26	<u>ARBRS COURT BUILDING</u>	2004	344,851	8,621	40	8,621		40,951	26
27	<u>FENCING</u>	2004	7,172	429	VARIOUS	429		1,989	27
28	<u>LANDSCAPING</u>	2004	80,580	6,279	VARIOUS	6,279		46,537	28
29	<u>ORIG BLDG RENOVATIONS</u>	2004	83,766	5,924	VARIOUS	5,924		24,940	29
30	<u>RENOVATIONS</u>	2004	74,853	1,879	VARIOUS	1,879		8,925	30
31	<u>SINAGE</u>	2004	6,427	1,229	VARIOUS	1,229		5,836	31
32	<u>2ND FLR INTERIOR UPGRADE</u>	2005	87,775	5,852	VARIOUS	5,852		20,481	32
33	<u>EXTERIOR PAINTING & REPAIRS</u>	2005	71,086	5,120	VARIOUS	5,120		17,921	33
34	TOTAL (lines 1 thru 33)		\$ 8,239,094	\$ 283,951		\$ 283,951	\$	\$ 4,497,000	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:

07/01/07

Ending:

6/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,239,094	\$ 283,951		\$ 283,951	\$	\$ 4,497,000	1
2	SIGNS	2005	2,040	204	10	204		714	2
3	CAPITALIZED INTEREST	2004	56,570	1,479	40	1,479		5,791	3
4	RENOVATIONS	2006	20,300	3,122	15	3,122		6,725	4
5	FY07/CY06 RENOVATIONS	2006	47,566	3,700	15	3,700		6,566	5
6	FY07/CY07 RENOVATIONS	2007	7,766	518	15	518		690	6
7	FY08/CY08 RENOVATIONS	2008	264,839	11,639	10	11,639		11,639	7
8	ROUNDING		(3)						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)		\$ 8,638,172	\$ 304,613		\$ 304,613	\$	\$ 4,529,125	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: 07/01/07 Ending: 6/30/08

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	\$ 1,923,180	\$ 70,797	\$ 70,797	\$	VARIOUS	\$ 1,530,857	71
72	Current Year Purchases	40,573	2,786	2,786		VARIOUS	2,786	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,963,753	\$ 73,583	\$ 73,583	\$		\$ 1,533,643	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)	\$ 10,876,859	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 378,196	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 378,196	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,062,768	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NURSE STATIONS-1997&1998	\$ 49,545	\$ 3,097	\$ 32,762	86
87	BATHS-1999	9,818	491	4,541	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,540	37,602	88
89	PROJECT 95-028-00-1997	6,940	434	4,591	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	\$ 106,493	\$ 5,562	\$ 81,186	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: _____

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

N/A

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: \$ 42,626 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			\$ _____	\$ _____	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? <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 Carle Arbours# 0028522 Report Period Beginning:07/01/07 Ending:6/30/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a Col 3	hrs	\$	n/a	\$ 705,488	\$	n/a	\$ 705,488	1
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	hrs	672	n/a	144,228		n/a	144,900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	Ln 10a Col 3	visits		n/a	573,851		n/a	573,851	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 672		\$ 1,423,567	\$		\$ 1,424,239	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: 07/01/07

Ending:

6/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,249	\$	1
2	Cash-Patient Deposits	21,650		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,822,322		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	997,640		5
6	Prepaid Insurance	53,374		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(10,483,972)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (7,573,737)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,855,166		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,963,753		16
17	Accumulated Depreciation (book methods)	(6,231,539)		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)	\$ 4,587,380	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (2,986,357)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,076,236	\$	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)	\$ 1,076,236	\$	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)	\$ 1,076,236	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,062,593)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (2,986,357)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,610,612)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,610,612)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(563,544)	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>	111,562	15
16	Other (describe) <u>ROUNDING</u>	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (451,981)	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)	\$ (4,062,593)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/07Ending: 6/30/08**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	\$ 14,076,868	1
2	Discounts and Allowances for all Levels	(7,694,348)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,382,520	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,793,546	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,793,546	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	1,374,778	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)	\$ 1,374,778	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,581	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,581	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED SCHEDULE	12,313	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,313	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,575,738	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,965,608	31
32	Health Care	7,179,410	32
33	General Administration	2,626,280	33
B. Capital Expense			
34	Ownership	713,384	34
C. Ancillary Expense			
35	Special Cost Centers	1,527,321	35
36	Provider Participation Fee	127,279	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,139,282	40
41	Income before Income Taxes (line 30 minus line 40)**	(563,544)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (563,544)	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:

07/01/07

Ending:

6/30/08

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	1,932	2,448	\$ 66,690	\$ 27.24	1
2	Assistant Director of Nursing	2,285	2,485	62,848	25.29	2
3	Registered Nurses	15,045	16,022	491,708	30.69	3
4	Licensed Practical Nurses	34,583	37,768	810,897	21.47	4
5	CNAs & Orderlies	122,312	131,011	1,628,695	12.43	5
6	CNA Trainees					6
7	Licensed Therapist	3,213	3,562	47,854	13.43	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,420	35,443	14.65	9
10	Activity Assistants	5,965	7,237	74,366	10.28	10
11	Social Service Workers	5,680	6,181	118,380	19.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,397	3,407	60,726	17.82	14
15	Cook Helpers/Assistants	47,408	49,970	527,006	10.55	15
16	Dishwashers					16
17	Maintenance Workers	4,624	5,966	83,281	13.96	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	9,225	10,515	205,721	19.56	22
23	Office Manager					23
24	Clerical	16,863	18,727	237,722	12.69	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	3,884	4,141	45,582	11.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	278,496	301,860	\$ 4,496,919 *	\$ 14.90	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	7,923	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)		\$ 7,923		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,910	\$ 351,763	Ln 10 Col 3	50
51	Licensed Practical Nurses	10,832	436,092	Ln 10 Col 3	51
52	Certified Nurse Assistants/Aides	37,300	873,659	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	55,042	\$ 1,661,514		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. Yes
- (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? 5.93
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,250 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. \$ 127,279
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? _____
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: MCGLADRY & PULLEN The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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.