

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0028522</u></p> <p>Facility Name: <u>The Carle Arbours</u></p> <p>Address: <u>302 West Burwash</u> <u>Savoy</u> <u>61874</u> Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: <u>217-383-3098</u> Fax # <u>217-383-3194</u></p> <p>HFS ID Number: <u>371155535001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/84</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u> </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kerry G. Frerichs</u> Telephone Number: <u>217-383-4784</u> Email Address: <u>kerry.frerichs@carle.com</u></p>	<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 <u> </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/08</u> to <u>06/30/09</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Robert Tonkinson</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Senior Vice President and CFO</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Robert Tonkinson</u>			(Title) <u>Senior Vice President and CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) <u>()</u> Fax # <u>()</u>																																									

Facility Name & ID Number The Carle Arbours

0028522 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	231	Skilled (SNF)	231	84,315	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	231	TOTALS	231	84,315	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	6,380	4,390	8,076	18,846	8
9	SNF/PED					9
10	ICF	22,619	25,722		48,341	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,999	30,112	8,076	67,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.69%

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)

None

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

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

YES NO

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

YES NO

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

Date started 02/01/84

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

YES Date 02/01/84 NO

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

YES NO If YES, enter number of beds certified 231 and days of care provided 8,076

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number

The Carle Arbours

0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	629,157	66,957	11,509	707,623	585	708,208	708,208			1
2	Food Purchase		463,482		463,482		463,482	463,482			2
3	Housekeeping		29,001	218,409	247,410		247,410	247,410			3
4	Laundry		10,814	145,869	156,683		156,683	156,683			4
5	Heat and Other Utilities			313,794	313,794	(14,403)	299,391	299,391			5
6	Maintenance	113,988	45,722	112,317	272,027	10,460	282,487	282,487			6
7	Other (specify):* Waste/Security					21,487	21,487	21,487			7
8	TOTAL General Services	743,145	615,976	801,898	2,161,019	18,129	2,179,148	2,179,148			8
	B. Health Care and Programs										
9	Medical Director			4,880	4,880		4,880	4,880			9
10	Nursing and Medical Records	4,111,976	454,836	1,871,153	6,437,965	62,757	6,500,722	(9,012)	6,491,710		10
10a	Therapy	868,932	35	232,703	1,101,670		1,101,670	1,101,670			10a
11	Activities	97,404	6,214	1,771	105,389	(18,473)	86,916	(13,411)	73,505		11
12	Social Services	135,255			135,255		135,255	135,255			12
13	CNA Training										13
14	Program Transportation			11,345	11,345	2,802	14,147	14,147			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,213,567	461,085	2,121,852	7,796,504	47,086	7,843,590	(22,423)	7,821,167		16
	C. General Administration										
17	Administrative			342,324	342,324	(585)	341,739	979,025	1,320,764		17
18	Directors Fees										18
19	Professional Services			304,232	304,232		304,232	(276,000)	28,232		19
20	Dues, Fees, Subscriptions & Promotions			54,763	54,763	(41)	54,722	(25,437)	29,285		20
21	Clerical & General Office Expenses	459,753	43,907	297,588	801,248	(60,632)	740,616	(110,055)	630,561		21
22	Employee Benefits & Payroll Taxes			1,455,976	1,455,976		1,455,976	1,455,976			22
23	Inservice Training & Education										23
24	Travel and Seminar			8,131	8,131	(2,802)	5,329	(3,500)	1,829		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			187,170	187,170		187,170	187,170			26
27	Other (specify):*										27
28	TOTAL General Administration	459,753	43,907	2,650,184	3,153,844	(64,060)	3,089,784	564,033	3,653,817		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,416,465	1,120,968	5,573,934	13,111,367	1,155	13,112,522	541,610	13,654,132		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:

07/01/08

Ending:

06/30/09

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			390,912	390,912		390,912	(4,901)	386,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,394	99,394		99,394	(211)	99,183			32
33	Real Estate Taxes			75,504	75,504		75,504	(75,504)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			158,177	158,177	(1,155)	157,022		157,022			35
36	Other (specify):*							66,731	66,731			36
37	TOTAL Ownership			723,987	723,987	(1,155)	722,832	(13,885)	708,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,390,246		1,390,246		1,390,246	394,104	1,784,350			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		1,390,246	126,480	1,516,726		1,516,726	394,104	1,910,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,416,465	2,511,214	6,424,401	15,352,080		15,352,080	921,829	16,273,909			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: 07/01/08

Ending: 06/30/09

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	(211)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,380)	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	(4,901)	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	(16,190)	17		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(110,055)	21		24
25	Fund Raising, Advertising and Promotional	(25,437)	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)	\$ (234,678)		\$	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))	\$ (234,678)		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						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: 07/01/08

Ending: 06/30/09

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NON-DIRECT CARE TRAVEL	\$ (3,500)	24	1
2	ACTIVITY INCOME	(6,632)	10	2
3	MISCELLANEOUS INCOME	(13,411)	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		(23,543)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Carle Arbours# 0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(9,012)	0	0	0	0	0	0	0	0	0	0	(9,012)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,411)	0	0	0	0	0	0	0	0	0	0	(13,411)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(22,423)	0	0	0	0	0	0	0	0	0	0	(22,423)	16
	C. General Administration													
17	Administrative	(16,190)	995,215	0	0	0	0	0	0	0	0	0	979,025	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(276,000)	0	0	0	0	0	0	0	0	0	(276,000)	19
20	Fees, Subscriptions & Promotions	(25,437)	0	0	0	0	0	0	0	0	0	0	(25,437)	20
21	Clerical & General Office Expenses	(110,055)	0	0	0	0	0	0	0	0	0	0	(110,055)	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	(3,500)	0	0	0	0	0	0	0	0	0	0	(3,500)	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	(155,182)	719,215	0	564,033	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,605)	719,215	0	541,610	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Carle Arbours# 0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(4,901)	0	0	0	0	0	0	0	0	0	0	(4,901)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(211)	0	0	0	0	0	0	0	0	0	0	(211)	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	66,731	0	0	0	0	0	0	0	0	0	66,731	36
37	TOTAL Ownership	(80,616)	66,731	0	(13,885)	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	394,104	0	0	0	0	0	0	0	0	0	394,104	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	394,104	0	394,104	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(258,221)	1,180,050	0	0	0	0	0	0	0	0	0	921,829	45

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>The Carle Foundation</u>	<u>100</u>			<u>Carle Hospital</u>	<u>Urbana, IL</u>	<u>Hospital/DME/Rx</u>
				<u>Carle Health Care</u>	<u>Urbana, IL</u>	<u>Ambulance Svc</u>

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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	<u>17 Home Office-Administrative</u>	\$	<u>Carle Foundation</u>	<u>100.00%</u>	\$ <u>310,251</u>	\$	<u>310,251</u>	1
2	V	<u>39 Pharmacy & Drugs</u>	<u>1,358,980</u>	<u>Carle Foundation</u>	<u>100.00%</u>	<u>1,753,084</u>		<u>394,104</u>	2
3	V	<u>17 Shared A & G Hosp Gen. Svcs.</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>684,964</u>		<u>684,964</u>	3
4	V	<u>36 Shared A & G Hosp Capital</u>		<u>Carle Foundation</u>	<u>100.00%</u>	<u>66,731</u>		<u>66,731</u>	4
5	V	<u>19 Management Fees</u>	<u>276,000</u>	<u>Carle Foundation</u>	<u>100.00%</u>			<u>(276,000)</u>	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ <u>1,634,980</u>			\$ <u>2,815,030</u>	\$ *	<u>1,180,050</u>	14

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

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/08 Ending: 06/30/09

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:

07/01/08

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Home Office - Administrative	Direct costs	12	\$ 310,251	\$ 211,627	12	\$ 310,251	1
2	36	Shared A & G Capital	Direct costs	12	66,731		12	66,731	2
3	17	Shared A & G Hosp Gen. Svcs	Direct costs	12	684,964	246,587	12	684,964	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				\$ 1,061,946	\$ 458,214		\$ 1,061,946	25

Facility Name & ID Number

The Carle Arbours

0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Northern Trust Company		X	Refinance	n/a	04/03/08	\$ 224,675,000	\$ zero	n/a	variable	\$ 99,394	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 224,675,000	\$			\$ 99,394	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 224,675,000	\$			\$ 99,394	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 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 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,504 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.		\$	75,504 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	8
	2005	9
	2006	10
	2007	11
	2008	12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008 \$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

07/01/08 Ending:

06/30/09

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).

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 Use	2 Square Feet	3 Year Acquired	4 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:

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	231		1984	1973	\$ 2,967,466	\$ 84,785	35	\$ 84,785	\$	\$ 2,154,946	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Patient room capeting/drapery/wall recovering/vinyl flooring	1984		267,128	8,169	25	8,169		266,215	9
10		WINDOWS	1984		6,326		15			6,326	10
11		SIGNS & A/C	1984		15,232		15			15,232	11
12		LANDSCAPING	1985		13,589		18			13,589	12
13		PLUMBING	1985		34,747	1,390	25	1,390		33,682	13
14		ROOF & ELECTRICAL	1985		23,658	239	18	239		23,538	14
15		KITCHEN REMODEL	1985		23,504	654	25	654		23,045	15
16		LANDSCAPING	1986		7,325		15			7,325	16
17		Repair & redecorate patient rooms	1986		31,097	786	25	786		29,721	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	30	47		984	23
24		GENERATOR	1988		11,693	23	20	23		11,693	24
25		INSULATION	1988		3,650		20			3,650	25
26		RENOVATIONS	1988		6,774	8	30	8		6,705	26
27		ALZHEIMERS/2ND FLOOR RENOVATION	1990		6,214	144	25	144		5,391	27
28		EMERGENCY POWER DISTRIBUTION	1990		27,115	1,334	25	1,334		25,467	28
29		DOORS	1990		1,388		15			1,388	29
30		REMODELING	1990		2,838	142	20	142		2,648	30
31		Repair & redecorate patient rooms	1991		472,549	16,669	25	16,669		357,157	31
32		FLOORING	1991		87,008	2,547	20	2,547		80,852	32
33		RENOVATIONS	1991		1,981	49	20	49		1,867	33
34		RENOVATIONS	1992		5,150		15			5,150	34
35		ROOF REPAIR	1992		22,257		10			22,257	35
36		FLOORING	1992		14,427		15			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

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Report Period Beginning:

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Ending:

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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		15			8,352	38
39	Elevator	1993	10,788	237	25	237		8,598	39
40	Repair & redecorate patient rooms	1993	48,830	2,384	25	2,384		38,557	40
41	PARKING LOT IMPROVEMENTS	1994	4,300		10			4,300	41
42	ELEVATOR	1994	3,368	168	20	168		2,610	42
43	Refinish corridor floors, ceilings / install backflow preventer	1994	57,905	2,586	20	2,586		45,430	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	86	15	86		11,870	44
45	Repair & redecorate patient rooms	1994	55,764	2,839	20	2,839		41,665	45
46	DOORS	1994	4,684	190	20	190		3,685	46
47	REMODELING	1995	2,320	116	20	116		1,653	47
48	REMODELING	1995	12,720	669	19	669		9,428	48
49	ROOF REPAIRS	1995	20,660	1,001	20	1,001		14,737	49
50	ROOF AIR CONDITIONER	1995	40,354	955	15	955		39,240	50
51	ROOF AIR CONDITIONER	1995	2,950		10			2,950	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,669	18	14,669		200,458	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	18	312		4,131	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	20	3,995		52,600	54
55	FLOORING	1996	15,511		10			15,511	55
56	WINDOWS	1996	3,028	151	20	151		1,931	56
57	ENTRANCE CANOPY	1996	1,580		10			1,580	57
58	ELECTRIC DOORS	1996	5,072	70	20	70		4,554	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	15	2,126		24,627	63
64	FENCE	1998	3,885	259	15	259		2,914	64
65	DOORS	1998	945	63	15	63		672	65
66	NURSE STATIONS	1998	10,000	663	15	663		7,113	66
67	CHAIN LINK FENCE	1998	4,544	303	15	303		3,257	67
68	BATHS	1999	623,243	30,930	20	30,930		319,309	68
69	WALL ARCHITECTURAL	1999	1,491	75	20	75		751	69
70	TOTAL (lines 4 thru 69)		\$ 5,487,106	\$ 181,833		\$ 181,833	\$	\$ 4,080,559	70

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

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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	\$ 181,833		\$ 181,833	\$	\$ 4,080,559	1
2	SUBACUTE IMPROVEMENTS	2000	75,624	4,020	19	4,020		37,853	2
3	Bathroom upgrades in several patient rooms	2000	36,055	1,898	19	1,898		17,869	3
4	Handrails and installation	2000	11,693	780	15	780		7,341	4
5	Hall floor recarpeting/retiling	2000	30,472	1,604	19	1,604		15,103	5
6	Roof repairs	2000	7,800	433	18	433		3,864	6
7	Air curtain	2000	1,110	62	18	62		550	7
8	BATH RENOVATION	2000	2,438	128	19	128		1,144	8
9	Second Floor air conditioning system repair	2000	4,829	268	18	268		2,303	9
10	FACILITY IMPROVEMENTS	2001	274		5			275	10
11	Thereapy floor tiling	2001	3,700	370	10	370		2,929	11
12	THERAPY CEILING	2001	3,194		5			3,194	12
13	FIRST FLOOR HANDRAILS	2001	12,480		5			12,480	13
14	Second Floor air conditioning system upgrade	2002	86,210	5,129	17	5,129		36,549	14
15	Building tuckpointing	2002	7,032	414	17	414		3,103	15
16	GIFT SHOP EXPANSION	2002	16,819	957	17	957		7,180	16
17	CARPET	2002	3,984		5			3,984	17
18	Thereapy floor tiling	2002	180	18	10	18		131	18
19	VINYL FLOORING	2002	5,979	598	10	598		4,235	19
20	THERAPY CEILING	2002	6,930		5			6,930	20
21	NURSE STATIONS(PER FY99 IPA AUDIT)	1995	69,094	3,839	20	3,839		53,102	21
22	Fire wall installation/ARBRS CT planning & design svcs	2003	146,487	6,806	25	6,806		47,030	22
23	Build ARBRS COURT addition	2003	1,397,938	34,949	40	34,949		212,603	23
24	Final ARBRS CT bld/Auto air temp controllers	2003	57,666	1,442	40	1,442		8,770	24
25	Carpet and vinyl flooring & installation	2003	7,490	400	7	400		6,290	25
26	Finish building ARBRS COURT addition	2004	344,851	8,621	40	8,621		49,572	26
27	Fencing & security locks	2004	7,172	429	15	429		2,418	27
28	Landscaping	2004	80,580	6,280	10	6,280		52,816	28
29	Carpet/wiring/wall coverings/design svcs/benches for 2nd flr	2004	83,766	5,502	15	5,502		30,442	29
30	Design/bld courtyard area, design/install auto temp cont syst	2004	74,853	1,879	40	1,879		10,804	30
31	SINAGE	2004	6,427	328	15	328		6,165	31
32	Prepare walls and install vinyl sheeting on 2nd flr.	2005	87,775	5,852	15	5,852		26,333	32
33	Roof replacement/exterior painting & siding	2005	71,086	5,121	15	5,121		23,041	33
34	TOTAL (lines 1 thru 33)		\$ 8,239,094	\$ 279,960		\$ 279,960	\$	\$ 4,776,962	34

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

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	\$ 279,960		\$ 279,960	\$	\$ 4,776,962	1
2	ARBRS COURT Signage	2005	2,040	204	10	204		918	2
3	CAPITALIZED INTEREST	2004	56,570	1,479	40	1,479		7,269	3
4	Remove patient room wall coverings/repaint/install light fixt	2006	20,300	3,122	15	3,122		9,848	4
5	Repair & redecorate ten patient rooms	2006	34,866	2,853	15	2,853		7,937	5
6	Construct two patient/visitor lounge areas	2006	12,700	847	15	847		2,328	6
7	Repair & redecorate four patient rooms	2007	7,766	518	15	518		1,208	7
8	General patient room, office, lobby, hallway repainting	2008	14,500	2,900	10	2,900		4,108	8
9	Dining room floor/wall/cabinet upgrades	2008	8,310	831	10	831		1,177	9
10	Remove & rebuild shower room (plumbing/fixture/wall upgr)	2008	242,029	24,203	10	24,203		34,288	10
11	Remove & rebuild kitchen(elect/plumbing/cabinet upgrades)	2009	192,965	4,824	10	4,824		4,824	11
12	Rounging		(3)						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)		\$ 8,831,137	\$ 321,741		\$ 321,741	\$	\$ 4,850,867	34

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

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	\$ 1,963,753	\$ 61,693	\$ 61,693	\$	VARIOUS	\$ 1,699,143	71
72	Current Year Purchases	123,907	2,577	2,577		VARIOUS	2,577	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,087,660	\$ 64,270	\$ 64,270	\$		\$ 1,701,720	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)	\$ 11,193,731	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 386,011	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 386,011	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)	\$ 6,552,587	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	\$ 3,078	\$ 35,656	86
87	BATHS-1999	9,818	491	5,032	87
88	NURSING HOME FINDERS FEE-1984	38,500	898	38,500	88
89	PROJECT 95-028-00-1997	6,940	434	5,024	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	\$ 106,493	\$ 4,901	\$ 85,902	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 138,403 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.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/08 Ending: 06/30/09
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><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	Ln 10a Col 3	hrs	\$	n/a	\$ 63,048	\$	n/a	\$ 63,048	1	
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	hrs	267	n/a	10,548		n/a	10,815	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	Ln 10a Col 3	hrs		n/a	158,840		n/a	158,840	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	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$ 267		\$ 232,436	\$		\$ 232,703	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: 07/01/08

Ending:

06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09

(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	\$ 500	\$	1
2	Cash-Patient Deposits	24,080		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,471,355		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,325		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(12,027,869)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (9,480,609)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,957,178		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,087,660		16
17	Accumulated Depreciation (book methods)	(6,552,587)		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)	\$ 4,492,251	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (4,988,358)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,007,456	\$	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)	\$ 1,007,456	\$	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)	\$ 1,007,456	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,995,814)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (4,988,358)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,062,593)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,062,593)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,033,208)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe) Partnership Revenue	99,986	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,933,221)	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)	\$ (5,995,814)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/08Ending: 06/30/09

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	\$ 13,264,978	1
2	Discounts and Allowances for all Levels	(5,684,524)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,580,454	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,553,109	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,553,109	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	1,161,849	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)	\$ 1,161,849	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	211	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 211	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenues	23,249	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,249	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,318,872	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,160,138	31
32	Health Care	7,797,385	32
33	General Administration	3,153,844	33
B. Capital Expense			
34	Ownership	723,987	34
C. Ancillary Expense			
35	Special Cost Centers	1,390,246	35
36	Provider Participation Fee	126,480	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,352,080	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,033,208)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,033,208)	43

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

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

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

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

Facility Name & ID Number The Carle Arbours

0028522

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	1,432	1,472	\$ 48,906	\$ 33.22	1
2	Assistant Director of Nursing	1,904	1,944	60,654	31.20	2
3	Registered Nurses	1,486	17,110	603,885	35.29	3
4	Licensed Practical Nurses	28,161	31,177	630,440	20.22	4
5	CNAs & Orderlies	158,165	172,867	2,101,026	12.15	5
6	CNA Trainees					6
7	Licensed Therapist	25,325	26,548	756,410	28.49	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,748	2,080	36,171	17.39	9
10	Activity Assistants	5,373	6,378	61,233	9.60	10
11	Social Service Workers	7,329	7,787	135,254	17.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,261	3,324	59,706	17.96	14
15	Cook Helpers/Assistants	45,700	47,706	569,451	11.94	15
16	Dishwashers					16
17	Maintenance Workers	9,043	9,700	113,988	11.75	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	22,562	24,085	687,117	28.53	22
23	Office Manager					23
24	Clerical	23,058	24,500	459,753	18.77	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	6,743	7,081	92,468	13.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,290	383,759	\$ 6,416,462 *	\$ 16.72	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	4,880	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)		\$ 4,880		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	11,704	\$ 518,088	Ln 10 Col 3	50
51	Licensed Practical Nurses	17,427	688,794	Ln 10 Col 3	51
52	Certified Nurse Assistants/Aides	19,672	413,037	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	48,803	\$ 1,619,919		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function				Description	Amount	Description	Amount			
G. Porter	Administrator			Workers' Compensation Insurance	\$ 178,659	IDPH License Fee	\$ 3,133				
P. Prybylski	Administrator			Unemployment Compensation Insurance		Advertising: Employee Recruitment	37,085				
M. Barth	Administrator			FICA Taxes	479,791	Health Care Worker Background Check					
W. Wade	Administrator			Employee Health Insurance	575,938	(Indicate # of checks performed _____)					
				Employee Meals		IHCA dues	5,060				
				Illinois Municipal Retirement Fund (IMRF)*		Other dues & fees	2,359				
				Life Insurance	5,495	Subscriptions	2,211				
				Long Term Disability	17,029	P/R & Entertainment	2,860				
				Pension	171,222	Advertising	2,013				
				Employee Activities	27,842	Non-allowable recruitment	(18,353)				
						Less: Public Relations Expense	(2,860)				
						Non-allowable advertising	(4,223)				
						Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 76,416	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,455,976	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,285
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/Traditions Mgmt - Mgmt Consulting Services			\$ 325,684	None		\$	Out-of-State Travel	\$			
Hartweg, Turner - Legal/Coll			16,055								
Thersa Myers - Admin other			585				In-State Travel	1,829			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 342,324				Seminar Expense				
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)				
Vendor/Payee	Type	Amount									
Carle Hospital	Related party	\$ 276,000									
Carle Clinic Assoc	Data processing	24,990									
Traditions Mgmt	Admin asst (agency)	3,242									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 304,232						TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,829

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Carle Arbours# 0028522Report Period Beginning: 07/01/08Ending: 06/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$5,060
- (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? 10.8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,000 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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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: McGladry & Pullen
- (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.