

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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 Facility ID Number: <u>0025130</u></p> <p>Facility Name: <u>CARRIER MILLS NURSING HOME</u></p> <p>Address: <u>6789 ROUTE 45, P. O. BOX 68</u> <u>CARRIER MILLS</u> <u>62917</u> Number City Zip Code</p> <p>County: <u>SALINE</u></p> <p>Telephone Number: <u>(618) 994-2323</u> Fax # <u>(618) 994-4082</u></p> <p>IDPA ID Number: <u>37-1077294001</u></p> <p>Date of Initial License for Current Owners: <u>JAN. 1, 1979</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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 _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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 _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>WILLIAM H. MOORMAN</u> Telephone Number: <u>(618) 993-2647</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<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>01/01/01</u> to <u>12/31/01</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 data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 722">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 771">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 771 1281 828"></td> <td data-bbox="1281 771 1921 828">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 876">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1144 876 1281 1039"></td> <td data-bbox="1281 876 1921 925">(Print Name and Title) <u>WILLIAM H. MOORMAN, CPA</u> <u>PARTNER</u></td> </tr> <tr> <td data-bbox="1144 925 1281 1039"></td> <td data-bbox="1281 925 1921 974">(Firm Name & Address) <u>GRAY HUNTER STENN LLP</u> <u>P O BOX 1728, MARION, IL 62959</u></td> </tr> <tr> <td data-bbox="1144 974 1281 1039"></td> <td data-bbox="1281 974 1921 1039">(Telephone) <u>(618) 993-2647</u> Fax # <u>(618) 993-3981</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 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) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date)		(Print Name and Title) <u>WILLIAM H. MOORMAN, CPA</u> <u>PARTNER</u>		(Firm Name & Address) <u>GRAY HUNTER STENN LLP</u> <u>P O BOX 1728, MARION, IL 62959</u>		(Telephone) <u>(618) 993-2647</u> Fax # <u>(618) 993-3981</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME# 0025130 Report Period Beginning: 01/01/01 Ending: 12/31/01

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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</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>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>1,130</u>	<u>593</u>	<u>1,825</u>	<u>3,548</u>	8
9	SNF/PED					9
10	ICF	<u>20,743</u>	<u>9,809</u>	<u>8</u>	<u>30,560</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,873</u>	<u>10,402</u>	<u>1,833</u>	<u>34,108</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.39%D. How many bed-hold days during this year were paid by Public Aid?
276 (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 01/01/68J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/29/78 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 1,825Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	124,998	15,373	6,181	146,552		146,552		146,552		1
2	Food Purchase		128,703		128,703		128,703		128,703		2
3	Housekeeping	161,190	16,184		177,374		177,374		177,374		3
4	Laundry	45,557	15,370		60,927		60,927	122	61,049		4
5	Heat and Other Utilities			80,817	80,817		80,817	382	81,199		5
6	Maintenance	30,714		71,864	102,578		102,578	2,061	104,639		6
7	Other (specify):* SALES TAX			3,167	3,167		3,167	(3,167)			7
8	TOTAL General Services	362,459	175,630	162,029	700,118		700,118	(602)	699,516		8
B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	804,503	126,720	1,540	932,763		932,763		932,763		10
10a	Therapy	62,816		25,586	88,402		88,402		88,402		10a
11	Activities	32,099	454	990	33,543		33,543		33,543		11
12	Social Services	28,620		990	29,610		29,610		29,610		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	928,038	127,174	32,406	1,087,618		1,087,618		1,087,618		16
C. General Administration											
17	Administrative	25,423			25,423		25,423	123,662	149,085		17
18	Directors Fees										18
19	Professional Services			252,428	252,428		252,428	(218,363)	34,065		19
20	Dues, Fees, Subscriptions & Promotions			15,039	15,039		15,039	(7,222)	7,817		20
21	Clerical & General Office Expenses	61,455	20,249	9,964	91,668		91,668	12,528	104,196		21
22	Employee Benefits & Payroll Taxes			236,453	236,453		236,453	4,662	241,115		22
23	Inservice Training & Education			569	569		569		569		23
24	Travel and Seminar			3,173	3,173		3,173		3,173		24
25	Other Admin. Staff Transportation							1,616	1,616		25
26	Insurance-Prop.Liab.Malpractice			38,445	38,445		38,445	230	38,675		26
27	Other (specify):* IL REPLACE TAX			6,959	6,959		6,959	(6,959)			27
28	TOTAL General Administration	86,878	20,249	563,030	670,157		670,157	(89,846)	580,311		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,377,375	323,053	757,465	2,457,893		2,457,893	(90,448)	2,367,445		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,526	21,526		21,526	83,815	105,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							95,024	95,024			32
33	Real Estate Taxes			44,895	44,895		44,895	411	45,306			33
34	Rent-Facility & Grounds			220,800	220,800		220,800	(220,800)				34
35	Rent-Equipment & Vehicles			6,621	6,621		6,621		6,621			35
36	Other (specify):*											36
37	TOTAL Ownership			293,842	293,842		293,842	(41,550)	252,292			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,203	54,203		54,203		54,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,377,375	323,053	1,105,510	2,805,938		2,805,938	(131,998)	2,673,940			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **CARRIER MILLS NURSING HOME**

0025130

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	36,628	V-30		9
10	Interest and Other Investment Income	(630)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,167)	V-07		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,494)	V-20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,180)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,959)	V-27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,984)	V-20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 18,214		\$	30

OHF USE ONLY					
48		49	50	51	52

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)	(150,212)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (150,212)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (131,998)		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.		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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

CARRIER MILLS NURSING HOME

ID# 0025130

Report Period Beginning: 01/01/01

Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130 Report Period Beginning:

01/01/01

Ending:

12/31/01

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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(70,167)	0	0	0	0	0	0	0	0	0	(70,167)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(70,167)	0	0	0	0	0	0	0	0	0	(70,167)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	(70,167)	0	0	0	0	0	0	0	0	0	(70,167)	29

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
ROGER D. HERRIN	62%	SALINE CARE CENTER	HARRISBURG, IL	CARRIER MILLS		
GROVER S. SLOAN	17%	SEVERIN INTERMEDIATE CARE	BENTON, IL	NURSING HOME		
ALICE STALLINGS	11%			LAND TRUST	CARRIER MILLS, IL	LAND TRUST
PENNY SISK	10%			RDK MGMT, INC.	HARRISBURG, IL	MANAGEMENT

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	19 PROFESSIONAL SERVICES	\$ 219,474	RDK MANAGEMENT, INC (SEE ATTACHED SCHEDULE)		\$ 149,307	\$ (70,167)
2	V	30 DEPRECIATION		CARRIER MILLS NURSING HOME LAND TRUST		45,101	45,101
3	V	32 INTEREST		CARRIER MILLS NURSING HOME LAND TRUST		93,425	93,425
4	V	32 LOAN FEE EXPENSE		CARRIER MILLS NURSING HOME LAND TRUST		2,229	2,229
5	V	34 RENT	220,800	CARRIER MILLS NURSING HOME LAND TRUST			(220,800)
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 440,274			\$ 290,062	\$ * (150,212)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/01 Ending: 12/31/01

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	ROGER D. HERRIN	STOCKHOLDER	MANAGER	62.00	277,838	20	29.00	MGMT FEE	\$ 123,662	17-7	1
2	GROVER S. SLOAN	STOCKHOLDER	DOCTOR	17.00							2
3	ALICE STALLINGS	STOCKHOLDER	ADMINISTRATO	11.00	40,700	VARIOUS	VARIOUS	SALARY	18,481	17-1	3
4	"	"	"			VARIOUS	VARIOUS	SALARY	154	21-7	4
5	PENNY SISK	STOCKHOLDER	BOOKKEEPER	10.00	40,300	VARIOUS	VARIOUS	SALARY	8,000	21-1	5
6	"	"	"			VARIOUS	VARIOUS	SALARY	8,590	21-7	6
7											7
8											8
9	*SEE ATTACHED SCHEDULE										
10											10
11											11
12											12
13								TOTAL	\$ 158,887		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		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	FIRSTAR BANK, N.A.		X	CONSTRUCTION		04/23/93	\$ 1,800,000	\$		0.0450	\$ 90,362	1							
2	UNION PLANTERS, N.A.		X	REFINANCE FIRSTAR LOAN	\$12,000.00	12/10/01	1,470,000	1,470,000	03/15/15	0.0400	3,063	2							
3												3							
4												4							
5												5							
Working Capital																			
6	DR. ROGER HERRIN	X		WORKING CAPITAL	SINGLE PAY	06/08/89	2,895	2,895	DEMAND	0.1000		6							
7												7							
8												8							
9	TOTAL Facility Related				\$12,000.00		\$ 3,272,895	\$ 1,472,895			\$ 93,425	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,272,895	\$ 1,472,895			\$ 93,425	15							

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **CARRIER MILLS NURSING HOME**# **0025130** Report Period Beginning: **01/01/01** Ending: **12/31/01****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 must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2000 report.			\$	45,332	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.)			\$	46,487	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	1,155	3																			
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	44,151	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 19 _____ 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.			\$	45,306	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1996	33,094	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td></td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$		16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION \$		16																						
		1997	45,714	9																					
		1998	45,938	10																					
		1999	48,078	11																					
		2000	46,487	12																					
ACCRUAL BASED ON TAXES PAID IN 2001 FOR 2000.																									
(1) INCLUDES \$ 411 FROM ALLOCATION OF MANAGEMENT EXPENSES.																									

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARRIER MILLS NURSING HOME COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 0025130

CONTACT PERSON REGARDING THIS REPORT WILLIAM H. MOORMAN

TELEPHONE (618) 993-2647 FAX #: (618) 993-3981

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-1-098-03</u>	<u>LAND AND BUILDINGS</u>	\$ <u>46,486.54</u>	\$ <u>46,486.54</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>46,486.54</u>	\$ <u>46,486.54</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CARRIER MILLS NURSING HOME# 0025130 Report Period Beginning:01/01/01 Ending:12/31/01**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 14,462 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1C. 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, nurse aide 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SEE ATTACHED SCHEDULE	406,374		\$ 27,972	1
2					2
3	TOTALS	406,374		\$ 27,972	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1979	1968	\$ 316,676	\$ 6,537	25	\$ 12,667	\$ 6,130	\$ 298,451	4
5	57	1992	1992	1,200,956	38,564	25	48,038	9,474	433,783	5
6										6
7										7
8										8
Improvement Type**										
9	ROOF	1979		4,155		15			4,155	9
10	REDECORATING	1980		8,104		7			8,104	10
11	LANDSCAPING	1980		1,159		7			1,159	11
12	TILE	1983		225		5			225	12
13	LANDSCAPING	1983		220		5			220	13
14	IMPROVEMENTS	1985		450	18	20	23	5	383	14
15	IMPROVEMENTS - AIR CONDITIONER	1985		17,045	313	15		(313)	17,045	15
16	IMPROVEMENTS	1985		3,110		10			3,110	16
17	IMPROVEMENTS -AC COMPRESSOR/WATER HEATER	1986		1,772	92	15	54	(38)	1,772	17
18	IMPROVEMENTS - FLOORING/LANDSCAPING	1987		3,112	108	15	207	99	3,071	18
19	IMPROVEMENTS REDECORATING	1988		1,153		10			1,153	19
20	CARPETS	1989		180		5			180	20
21	IMPROVEMENTS - WASHER/DRYERS/BATHTUB	1993		32,837		10	3,284	3,284	29,556	21
22	IMPROVEMENTS - ALLOCATED ASSETS (I)	1993		33,552	870	30	1,118	248	8,424	22
23	IMPROVEMENTS - ROOF	1994		16,000	400	30	533	133	4,264	23
24	IMPROVEMENTS - ALLOCATED ASSETS (I)	1994		1,450	51	30	48	(3)	327	24
25	IMPROVEMENTS - ALLOCATED ASSETS (I)	1996		54	3	30	2	(1)	10	25
26	IMPROVEMENTS - TILE WORK	1997		6,682	601	30	223	(378)	1,115	26
27	IMPROVEMENTS - STORAGE BUILDING	1998		1,000	26	39	26		94	27
28	IMPROVEMENTS - ALLOCATED ASSETS (I)	1998		244	6	30	8	2	32	28
29	IMPROVEMENTS - ALLOCATED ASSETS (I)	2000		5,390	298	30	180	(118)	359	29
30	IMPROVEMENTS	2001		1,563	1,563	10	156	(1,407)	156	30
31										31
32										32
33										33
34	(I) ALLOCATION OF HOME OFFICE ASSETS - SEE SCHEDULE									34
35										35
36										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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,657,089	\$ 49,450		\$ 66,567	\$ 17,117	\$ 817,148		70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 381,545	\$ 16,201	\$ 38,154	\$ 21,953	10	\$ 339,340	71
72	Current Year Purchases	6,198	5,665	620	(5,045)	10	620	72
73	Fully Depreciated Assets	110,250					110,250	73
74								74
75	TOTALS	\$ 497,993	\$ 21,866	\$ 38,774	\$ 16,908		\$ 450,210	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	TRAVEL	1995 MERCEDES 500 SL	1995	\$ 25,824	\$ 547		\$ (547)		\$ 25,824	76
77										77
78										78
79										79
80	TOTALS			\$ 25,824	\$ 547		\$ (547)		\$ 25,824	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,208,878	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,863	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,341	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 33,478	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,293,182	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		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARRIER MILLS NURSING HOME LAND TRUST
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1968</u>	<u>42</u>		\$			3
4	Additions	<u>1992</u>	<u>57</u>	<u>01/01/01</u>	<u>220,800</u>	<u>1</u>	<u>AS AGREED</u>	4
5								5
6								6
7	TOTAL		99		\$ 220,800			7

10. Effective dates of current rental agreement:
 Beginning 01/01/01
 Ending 12/31/01

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ <u> </u>
13.	<u>/2003</u>	\$ <u> </u>
14.	<u>/2004</u>	\$ <u> </u>

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: \$ 6,621 Description: MISC. 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.

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

<p>1. HAVE YOU TRAINED AIDES 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>No additional training deemed necessary during current period.</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 AIDE _____</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 AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

	1	2		
	Operating	After Consolidation*		
A. Current Assets				
1	Cash on Hand and in Banks	\$ 36,852	\$ 36,852	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	457,336	457,336	3
4	Supply Inventory (priced at COST)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,506	13,506	6
7	Other Prepaid Expenses	8,794	8,794	7
8	Accounts Receivable (owners or related parties)	10,000	10,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 528,106	\$ 528,106	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		24,748	13
14	Buildings, at Historical Cost		1,439,296	14
15	Leasehold Improvements, at Historical Cost	48,202	48,202	15
16	Equipment, at Historical Cost	423,323	605,832	16
17	Accumulated Depreciation (book methods)	(426,051)	(1,145,966)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe GOODWILL)	1,000	1,000	22
23	Other(specify): UNAMORTIZED LOAN COSTS		5,800	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,474	\$ 978,912	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 574,580	\$ 1,507,018	25

	1	2		
	Operating	After Consolidation*		
C. Current Liabilities				
26	Accounts Payable	\$ 50,117	\$ 50,117	26
27	Officer's Accounts Payable	2,895	2,895	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,537	53,537	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,976	5,976	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,487	46,487	32
33	Accrued Interest Payable		3,063	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	ACCRUED MANAGEMENT FEES	54,372	54,372	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 213,384	\$ 216,447	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	351,874	1,538,311	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)	\$ 351,874	\$ 1,538,311	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 565,258	\$ 1,754,758	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,322	\$ (247,740)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 574,580	\$ 1,507,018	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 200,284	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 200,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	279,038	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	(470,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (190,962)	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)	\$ 9,322	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning: 01/01/01

Ending:

12/31/01

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	\$ 3,105,708	1
2	Discounts and Allowances for all Levels	(21,362)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,084,346	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	630	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 630	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,084,976	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	700,118	31
32	Health Care	1,087,618	32
33	General Administration	670,157	33
B. Capital Expense			
34	Ownership	293,842	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,805,938	40
41	Income before Income Taxes (line 30 minus line 40)**	279,038	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 279,038	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **CARRIER MILLS NURSING HOME**

0025130

Report Period Beginning: **01/01/01**

Ending:

12/31/01

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	2,080	2,080	\$ 43,644	\$ 20.98	1
2	Assistant Director of Nursing	2,080	2,080	32,962	15.85	2
3	Registered Nurses	10,489	10,936	164,815	15.07	3
4	Licensed Practical Nurses	22,654	23,569	220,607	9.36	4
5	Nurse Aides & Orderlies	47,424	48,647	342,475	7.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,080	2,080	32,962	15.85	7
8	Rehab/Therapy Aides	2,773	2,936	29,854	10.17	8
9	Activity Director	2,080	2,080	15,389	7.40	9
10	Activity Assistants	2,479	2,626	16,710	6.36	10
11	Social Service Workers	3,537	3,746	28,620	7.64	11
12	Dietician					12
13	Food Service Supervisor	1,673	1,700	13,106	7.71	13
14	Head Cook	7,739	7,522	52,411	6.97	14
15	Cook Helpers/Assistants	9,804	10,048	59,481	5.92	15
16	Dishwashers					16
17	Maintenance Workers	2,725	2,725	30,714	11.27	17
18	Housekeepers	26,161	26,776	161,190	6.02	18
19	Laundry	7,206	7,408	45,557	6.15	19
20	Administrator	1,486	1,486	25,423	17.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,478	6,589	61,455	9.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,948	165,034	\$ 1,377,375 *	\$ 8.35	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	206	\$ 6,181	1-3	35
36	Medical Director	PRN	3,300	9-3	36
37	Medical Records Consultant	49	1,540	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,302	10-a-3	39
40	Physical Therapy Consultant	169	8,414	10-a-3	40
41	Occupational Therapy Consultant	37	3,713	10-a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	47	4,826	10-a-3	43
44	Activity Consultant	22	990	11-3	44
45	Social Service Consultant	22	990	12-3	45
46	Other(specify)				46
47	PT	31	1,342	10-a-3	47
48	COTA	47	4,989	10-a-3	48
49	TOTAL (lines 35 - 48)	726	\$ 38,587		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ALICE STALLINGS	ADMINISTRATOR	11.00%	\$ 18,481	Workers' Compensation Insurance	\$ 67,113	IDPH License Fee	\$	
ELIZABETH DUNN	ADMINISTRATOR	0.00%	6,942	Unemployment Compensation Insurance	13,638	Advertising: Employee Recruitment	3,144	
				FICA Taxes	107,977	Health Care Worker Background Check	780	
				Employee Health Insurance	21,670	(Indicate # of checks performed <u>65</u>)		
				Employee Meals		IHCA DUES	2,116	
				Illinois Municipal Retirement Fund (IMRF)*		DONATIONS	1,494	
				EMPLOYEE LIFE INSURANCE	2,564	ADVERTISING	6,164	
				EMPLOYEE HEALTH BENEFITS	574	LICENSE & PERMITS	150	
				MISCELLANEOUS	22,917	DUES & SUBSCRIPTIONS	1,191	
				MANAGEMENT ALLOC. (1)	4,662	MGMT ALLOC (SEE SCH)	436	
						Less: Public Relations Expense	(1,494)	
						Non-allowable advertising	(1,180)	
						Yellow page advertising	(4,984)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 25,423	TOTAL (agree to Schedule V,	\$ 241,115	TOTAL (agree to Sch. V,	\$ 7,817	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense	
(Attach a copy of any management service agreement)							(SEE ATTACHED SCHEDULE)	3,173
C. Professional Services				TOTAL			Entertainment Expense ()	
Vendor/Payee	Type		Amount			\$	(agree to Sch. V,	
RDK MANAGEMENT, INC.	MANAGEMENT FEES		\$ 219,474	TOTAL		\$	line 24, col. 8)	\$ 3,173
DR. ROGER HERRIN	ACCOUNTING		15,196					
GRAY HUNTER STENN, LLP	ACCOUNTING		75					
AMERICAN EXPRESS	ACCOUNTING		5,475					
ALTS, MELVOIN & GLASSER	LEGAL		83					
THOMAS WOLF, JR	LEGAL		200					
JFMD&F	LEGAL		11,800					
DUANE MORRIS	LEGAL		125					
F/M/G/R								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 252,428					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 DUES \$2,116
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? N/A
- (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 YRS.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,945 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. N/A
- (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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
CARRIER MILLS NURSING HOME LAND TRUST; #0025130; 01/01/83
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT