

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	1,033		3,023	4,056	8
9	SNF/PED					9
10	ICF	20,796	6,056		26,852	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,829	6,056	3,023	30,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.53%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 01/01/1968

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/29/1978 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 3,023

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

Facility Name & ID Number **CARRIER MILLS NURSING HOME** # **0025130** Report Period Beginning: **01/01/06** Ending: **12/31/06**

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	134,501	21,350	5,985	161,836		161,836		161,836		1
2	Food Purchase		135,305		135,305		135,305		135,305		2
3	Housekeeping	150,856	17,636		168,492		168,492		168,492		3
4	Laundry	43,223	11,713		54,936		54,936	280	55,216		4
5	Heat and Other Utilities			69,486	69,486		69,486	2,314	71,800		5
6	Maintenance	23,875		37,908	61,783		61,783	2,708	64,491		6
7	Other (specify):* SALES TAX			2,541	2,541		2,541	(2,541)			7
8	TOTAL General Services	352,455	186,004	115,920	654,379		654,379	2,761	657,140		8
B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	954,254	142,388	1,645	1,098,287		1,098,287		1,098,287		10
10a	Therapy	15,321		141,601	156,922		156,922		156,922		10a
11	Activities	21,143	1,923	900	23,966		23,966		23,966		11
12	Social Services	28,681		900	29,581		29,581		29,581		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,019,399	144,311	148,646	1,312,356		1,312,356		1,312,356		16
C. General Administration											
17	Administrative	73,462		2,176	75,638		75,638	97,000	172,638		17
18	Directors Fees										18
19	Professional Services			259,415	259,415		259,415	(190,545)	68,870		19
20	Dues, Fees, Subscriptions & Promotions			14,310	14,310		14,310	(4,442)	9,868		20
21	Clerical & General Office Expenses	63,341	23,314	8,891	95,546		95,546	18,522	114,068		21
22	Employee Benefits & Payroll Taxes			278,539	278,539		278,539	4,608	283,147		22
23	Inservice Training & Education			123	123		123		123		23
24	Travel and Seminar			3,253	3,253		3,253		3,253		24
25	Other Admin. Staff Transportation							3,438	3,438		25
26	Insurance-Prop.Liab.Malpractice			90,647	90,647		90,647	807	91,454		26
27	Other (specify):*										27
28	TOTAL General Administration	136,803	23,314	657,354	817,471		817,471	(70,612)	746,859		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,508,657	353,629	921,920	2,784,206		2,784,206	(67,851)	2,716,355		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			12,280	12,280		12,280	55,393	67,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							69,473	69,473			32
33	Real Estate Taxes			56,358	56,358		56,358	650	57,008			33
34	Rent-Facility & Grounds			200,800	200,800		200,800	(200,800)				34
35	Rent-Equipment & Vehicles			14,391	14,391		14,391		14,391			35
36	Other (specify):*											36
37	TOTAL Ownership			283,829	283,829		283,829	(75,284)	208,545			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)	1,508,657	353,629	1,259,952	3,122,238		3,122,238	(143,135)	2,979,103			45

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

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	15,031	V-30		9
10	Interest and Other Investment Income	(67)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,541)	V-7		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	(1,789)	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	(1,398)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,748)	V-20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,488		\$	30

BHF 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)	(150,623)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (150,623)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (143,135)		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: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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:

01/01/06

Ending:

12/31/06

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	280	0	0	0	0	0	0	0	0	0	0	280	4
5	Heat and Other Utilities	2,314	0	0	0	0	0	0	0	0	0	0	2,314	5
6	Maintenance	2,708	0	0	0	0	0	0	0	0	0	0	2,708	6
7	Other (specify):*	(2,541)	0	0	0	0	0	0	0	0	0	0	(2,541)	7
8	TOTAL General Services	2,761	0	0	0	0	0	0	0	0	0	0	2,761	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	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	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	97,000	0	0	0	0	0	0	0	0	0	0	97,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	6,800	(197,345)	0	0	0	0	0	0	0	0	0	(190,545)	19
20	Fees, Subscriptions & Promotions	(4,442)	0	0	0	0	0	0	0	0	0	0	(4,442)	20
21	Clerical & General Office Expenses	18,522	0	0	0	0	0	0	0	0	0	0	18,522	21
22	Employee Benefits & Payroll Taxes	4,608	0	0	0	0	0	0	0	0	0	0	4,608	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	3,438	0	0	0	0	0	0	0	0	0	0	3,438	25
26	Insurance-Prop.Liab.Malpractice	807	0	0	0	0	0	0	0	0	0	0	807	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	126,733	(197,345)	0	(70,612)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	129,494	(197,345)	0	(67,851)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	16,829	38,564	0	0	0	0	0	0	0	0	0	55,393 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(22)	69,495	0	0	0	0	0	0	0	0	0	69,473 32
33	Real Estate Taxes	650	0	0	0	0	0	0	0	0	0	0	650 33
34	Rent-Facility & Grounds	0	(200,800)	0	0	0	0	0	0	0	0	0	(200,800) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*		0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	17,457	(92,741)	0	(75,284) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	146,951	(290,086)	0	(143,135) 45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER D. HERRIN	62%	SALINE CARE CENTER	HARRISBURG, IL	CARRIER MILLS		
ALICE STALLINGS	19%	SEVERIN INTERMEDIATE CARE HOME	BENTON, IL	NURSING HOME		
PENNY SISK	19%			LAND TRUST	CARRIER MILLS, IL	LAND TRUST
				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	\$ 197,345	RDK MANAGEMENT, INC (SEE ATTACHED SCHEDULE)		\$ 139,463	\$ (57,882)
2	V	30 DEPRECIATION		CARRIER MILLS NURSING HOME LAND TRUST		38,564	38,564
3	V	32 INTEREST		CARRIER MILLS NURSING HOME LAND TRUST		69,057	69,057
4	V	32 LOAN FEE EXPENSE		CARRIER MILLS NURSING HOME LAND TRUST		438	438
5	V	34 RENT	200,800	CARRIER MILLS NURSING HOME LAND TRUST			(200,800)
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 398,145			\$ 247,522	\$ * (150,623)

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

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	213,000	20	29.00	MGMT FEE	\$ 97,000	17-7	1
2	ALICE STALLINGS	STOCKHOLDER	ADMINSTRATOR	19.00	22,402	VARIOUS	VARIOUS	SALARY	44,131	17-1	2
3	ALICE STALLINGS	STOCKHOLDER	ADMINSTRATOR			VARIOUS	VARIOUS	SALARY	1,908	21-7	3
4	PENNY SISK	STOCKHOLDER	BOOKKEEPER	19.00	50,110	VARIOUS	VARIOUS	SALARY	9,419	21-1	4
5	PENNY SISK	STOCKHOLDER	BOOKKEEPER			VARIOUS	VARIOUS	SALARY	11,538	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,996		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: 01/01/06 Ending: 12/31/06

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

Facility Name & ID Number **CARRIER MILLS NURSING HOME** # **0025130** Report Period Beginning: **01/01/06** Ending: **12/31/06**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	REGIONS BANK		X	REFINANCE CONSTRUCTIO	\$12,000.00	12/10/01	\$ 1,470,000	\$ 1,020,003	03/15/15	0.0725	\$ 69,057	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DR.ROGER HERRIN	X		WORKING CAPITAL	SINGLE PAY	06/08/89	22,895	22,895	DEMAND	0.1000		6
7												7
8												8
9	TOTAL Facility Related				\$12,000.00		\$ 1,492,895	\$ 1,042,898			\$ 69,057	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,492,895	\$ 1,042,898			\$ 69,057	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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,

2005 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 Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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 2005.

(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>\$ 42,268.68</u>	<u>\$ 42,268.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,268.68</u>	\$ <u>42,268.68</u>

B. Real Estate Tax Cost Allocation:

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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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.

A. Square Feet: 14,462 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SEE ATTACHED SCHEDULE	406,426		\$ 28,065	1
2					2
3	TOTALS	406,426		\$ 28,065	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	42	1979	1968	\$ 316,676	\$	25	\$	\$	\$ 316,676
5	57	1992	1992	1,200,956	38,564	25	48,038	9,474	673,973
6									
7									
8									
Improvement Type**									
9	ROOF	1979		4,155		15			4,155
10	REDECORATING	1980		8,104		7			8,104
11	LANDSCAPING	1980		1,159		7			1,159
12	TILE	1983		225		5			225
13	LANDSCAPING	1983		220		5			220
14	IMPROVEMENTS	1985		450		20			450
15	IMPROVEMENTS-AIR CONDITIONER	1985		17,045		15			17,045
16	IMPROVEMENTS	1985		3,110		10			3,110
17	IMPROVEMENTS-AC COMPRESSOR/WATER HEATER	1986		1,772		15			1,772
18	IMPROVEMENTS-FLOORING/LANDSCAPING	1987		3,112	88	15		(88)	3,112
19	IMPROVEMENTS-REDECORATING	1988		1,153		10			1,153
20	CARPETS	1989		180		5			180
21	IMPROVEMENTS-WASHER/DRYER/BATHTUB	1993		32,837		10			32,837
22	IMPROVEMENTS-ALLOCATED SHEETS(1)	1993		34,085	884	30	1,136	252	14,239
23	IMPROVEMENTS-ROOF	1994		16,000	400	30	533	133	6,929
24	IMPROVEMENTS-ALLOCATED SHEETS(1)	1994		1,473	51	30	49	(2)	578
25	IMPROVEMENTS-ALLOCATED SHEETS(1)	1996		54	3	30	2	(1)	20
26	IMPROVEMENTS-TILE WORK	1997		6,682		30	223	223	2,230
27	IMPROVEMENTS-STORAGE BUILDING	1998		1,000	26	39	26		224
28	IMPROVEMENTS-ALLOCATED SHEETS(1)	1998		248	6	30	8	2	73
29	IMPROVEMENTS-ALLOCATED SHEETS(1)	2000		5,476	243	30	183	(60)	1,277
30	IMPROVEMENTS	2001		1,563		10	156	156	936
31	IMPROVEMENTS	2002		3,424	214	10	342	128	1,710
32									
33									
34	(I) ALLOCATION OF HOME OFFICE ASSETS-SEE SCHEDULE								
35									
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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 1,661,159	\$ 40,479		\$ 50,696	\$ 10,217	\$ 1,092,387	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 159,308	\$ 11,052	\$ 15,931	\$ 4,879	10	\$ 103,656	71
72	Current Year Purchases	10,464	1,568	1,046	(522)	10	1,046	72
73	Fully Depreciated Assets	397,537					397,537	73
74								74
75	TOTALS	\$ 567,309	\$ 12,620	\$ 16,977	\$ 4,357		\$ 502,239	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 500SL	1995	\$ 26,234	\$ 555	\$	\$ (555)		\$ 26,234	76
77										77
78										78
79										79
80	TOTALS			\$ 26,234	\$ 555	\$	\$ (555)		\$ 26,234	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)	\$ 2,282,767	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,654	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,673	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,019	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,620,860	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARRIER MLLS 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 Original Lease Date	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>01/01/05</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 01/01/06
Ending 12/31/06

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ <u> </u>
13.	<u>/2008</u>	\$ <u> </u>
14.	<u>/2009</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: \$ 14,391 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 CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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.
- 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 prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ (74,454)	\$ (74,454)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	552,576	552,576	3
4	Supply Inventory (priced at COST)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,979	20,979	6
7	Other Prepaid Expenses	74,780	74,780	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)	\$ 585,499	\$ 585,499	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	53,522	53,522	15
16	Equipment, at Historical Cost	489,656	674,792	16
17	Accumulated Depreciation (book methods)	(499,169)	(1,421,604)	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 (spt 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)	\$ 45,009	\$ 777,554	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 630,508	\$ 1,363,053	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 91,441	\$ 91,441	26
27	Officer's Accounts Payable	22,895	22,895	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)	6,705	6,705	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,447	70,447	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED MANAGEMENT FEES	68,187	68,187	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 259,675	\$ 259,675	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	53,348	1,088,314	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)	\$ 53,348	\$ 1,088,314	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 313,023	\$ 1,347,989	46
47	TOTAL EQUITY(page 18, line 24)	\$ 317,485	\$ 15,064	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 630,508	\$ 1,363,053	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 262,576	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 262,576	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	54,909	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 54,909	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)	\$ 317,485	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning: 01/01/06

Ending:

Page 19
12/31/06

VII. 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	\$ 3,204,713	1
2	Discounts and Allowances for all Levels	(27,633)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,177,080	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	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		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***	67	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67	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)	\$ 3,177,147	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	654,379	31
32	Health Care	1,312,356	32
33	General Administration	817,471	33
B. Capital Expense			
34	Ownership	283,829	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)*	\$ 3,122,238	40
41	Income before Income Taxes (line 30 minus line 40)**	54,909	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 54,909	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: **01/01/06**

Ending: **12/31/06**

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	1,952	2,080	\$ 49,423	\$ 23.76	1
2	Assistant Director of Nursing	660	706	12,757	18.07	2
3	Registered Nurses	8,419	8,449	156,542	18.53	3
4	Licensed Practical Nurses	22,586	22,892	293,935	12.84	4
5	CNAs & Orderlies	48,307	49,568	387,622	7.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,690	1,826	15,321	8.39	8
9	Activity Director	1,208	1,289	9,902	7.68	9
10	Activity Assistants	1,513	1,525	11,241	7.37	10
11	Social Service Workers	3,616	3,886	28,681	7.38	11
12	Dietician					12
13	Food Service Supervisor	1,848	1,982	18,030	9.10	13
14	Head Cook	11,493	11,745	86,676	7.38	14
15	Cook Helpers/Assistants	3,774	4,106	29,795	7.26	15
16	Dishwashers					16
17	Maintenance Workers	2,060	2,118	23,875	11.27	17
18	Housekeepers	20,903	21,613	150,856	6.98	18
19	Laundry	5,777	6,020	43,223	7.18	19
20	Administrator	2,031	2,209	44,131	19.98	20
21	Assistant Administrator	1,689	1,837	29,331	15.97	21
22	Other Administrative					22
23	Office Manager	1,851	2,069	15,327	7.41	23
24	Clerical	3,026	3,121	48,014	15.38	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	1,339	1,562	19,687	12.60	31
32	Other Health Care(specify)	2,509	2,518	17,119	6.80	32
33	Other(specify)	1,786	1,971	17,169	8.71	33
34	TOTAL (lines 1 - 33)	150,037	155,092	\$ 1,508,657 *	\$ 9.73	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	137	\$ 5,985	1-3	35
36	Medical Director	PRN	3,600	9-3	36
37	Medical Records Consultant	32	1,645	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	2,200	10a-3	39
40	Physical Therapy Consultant	1,534	57,541	10a-3	40
41	Occupational Therapy Consultant	1,565	70,120	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	335	11,740	10a-3	43
44	Activity Consultant	20	900	11-3	44
45	Social Service Consultant	20	900	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,687	\$ 154,631		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CARRIER MILLS NURSING HOME

0025130

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	16.10%	\$ 44,131	Workers' Compensation Insurance	\$ 71,310	IDPH License Fee	\$ 1,990		
ELSIE JOHNSON	ASST ADMINISTR	0.00%	29,331	Unemployment Compensation Insurance	35,476	Advertising: Employee Recruitment	3,468		
				FICA Taxes	115,216	Health Care Worker Background Check (Indicate # of checks performed <u>112</u>)	1,348		
				Employee Health Insurance	24,762	IHCA DUES	2,569		
				Employee Meals		DONATIONS	1,789		
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING	3,146		
				EMPLOYEE LIFE INSURANCE	2,272	LICENSE & PERMITS			
				EMPLOYEE HEALTH BENEFITS	4,378	DUES & SUBSCRIPTIONS			
				MISCELLANEOUS	25,125	MANAGEMENT ALLOC (SEE SCH.)	493		
				MANAGEMENT ALLOCATION (SEE SCH.)	4,608	Less: Public Relations Expense	(1,789)		
						Non-allowable advertising	(1,398)		
						Yellow page advertising	(1,748)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,462	TOTAL (agree to Schedule V, line 22, col.8)		\$ 283,147	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,868
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		
							MISC. TRAVEL	1,643	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense		
C. Professional Services							SEE ATTACHED SCHEDULE		1,610
Vendor/Payee	Type	Amount					Entertainment Expense (agree to Sch. V, line 24, col. 8)		
RDK MANAGEMENT, INC.	MANAGEMENT	\$ 197,345					TOTAL		\$ 3,253
GRAY HUNTER STENN,LLP	ACCOUNTING	12,100							
ALTS,MELVOIN & GLASSER	ACCOUNTING	1,850							
RSM MCGLADREY	ACCOUNTING	205							
FEIRICH,MAGER,GREEN,RYAN	LEGAL	22,262							
JELIFFE,FERREL,MORRIS	LEGAL	125							
THOMAS WOLF, JR.	LEGAL	392							
JERRY N. RAYMER	LEGAL	18,226							
THE BEARD LAW FIRM	LEGAL	5,200							
JERRY MCFADDEN	ARCHITECT	360							
DR. WM. DAVID BARNHART	MEDICAL	1,200							
HUMAN DEV. CONSULTANTS	PSYCHOLOGIST	150							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 259,415						

* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010	14 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$2,569
- (3) Did the nursing home make political contributions or payments to a political 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? _____
- (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. \$ 7,167 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; 1/1/1983
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department 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, 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 benefit: 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. \$ _____
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: _____ 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 \$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.

SEE ACCOUNTANTS' COMPILATION REPORT