



Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr

# 0025130 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 N/A

	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	36,234	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	36,234	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 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	348		4,857	5,205	8	
9	SNF/PED					9	
10	ICF	16,187	9,042		25,229	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	16,535	9,042	4,857	30,434	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.99%

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  Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 99 and days of care provided 4,857

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr # 0025130 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	149,837	24,134	9,453	183,424		183,424		183,424		1
2	Food Purchase		175,191		175,191		175,191		175,191		2
3	Housekeeping	220,337			220,337		220,337		220,337		3
4	Laundry	55,371	24,873		80,244		80,244	94	80,338		4
5	Heat and Other Utilities			105,402	105,402		105,402	880	106,282		5
6	Maintenance	23,903	20,688	35,261	79,852		79,852	615	80,467		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	449,448	244,886	150,116	844,450		844,450	1,589	846,039		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	986,116	86,496	1,596	1,074,208		1,074,208	1,067	1,075,275		10
10a	Therapy	25,913		286,704	312,617		312,617		312,617		10a
11	Activities	30,857	405		31,262		31,262	2,042	33,304		11
12	Social Services	34,933		1,766	36,699		36,699		36,699		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,077,819	86,901	293,066	1,457,786		1,457,786	3,109	1,460,895		16
	<b>C. General Administration</b>										
17	Administrative	68,145		228,649	296,794		296,794	(135,068)	161,726		17
18	Directors Fees										18
19	Professional Services			30,621	30,621		30,621	14,114	44,735		19
20	Dues, Fees, Subscriptions & Promotions			19,142	19,142		19,142	535	19,677		20
21	Clerical & General Office Expenses	54,183	13,549	72,017	139,749		139,749	25,455	165,204		21
22	Employee Benefits & Payroll Taxes			279,932	279,932		279,932	3,212	283,144		22
23	Inservice Training & Education										23
24	Travel and Seminar			895	895		895	849	1,744		24
25	Other Admin. Staff Transportation			798	798		798		798		25
26	Insurance-Prop.Liab.Malpractice			62,333	62,333		62,333	10,844	73,177		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	122,328	13,549	694,387	830,264		830,264	(80,059)	750,205		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,649,595	345,336	1,137,569	3,132,500		3,132,500	(75,361)	3,057,139		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.

Facility Name &amp; ID Number

Carrier Mills Nursing &amp; Rehab Ctr

#0025130

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,642	9,642		9,642	53,012	62,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			524	524		524	39,819	40,343			32
33	Real Estate Taxes			43,019	43,019		43,019	653	43,672			33
34	Rent-Facility & Grounds			220,800	220,800		220,800	(220,800)				34
35	Rent-Equipment & Vehicles			5,001	5,001		5,001		5,001			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			278,986	278,986		278,986	(127,316)	151,670			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,505		107,505		107,505		107,505			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* <b>Non-allowable cost</b>			3,353	3,353		3,353	(3,353)				43
44	<b>TOTAL Special Cost Centers</b>		107,505	57,705	165,210		165,210	(3,353)	161,857			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,649,595	452,841	1,474,260	3,576,696		3,576,696	(206,030)	3,370,666			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,945	30		9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(5,972)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 6,969		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(212,999)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (212,999)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (206,030)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Carrier Mills Nursing & Rehab Ctr

ID# 0025130

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Funeral Expense	\$ (121)	43	1
2	Donations	(75)	43	2
3	Donations - Political	(650)	43	3
4	Sales Tax	(1,011)	43	4
5	Offset miscellaneous income	(105)	21	5
6	Birthday expense	(1,496)	43	6
7	Disallow portion of IHCA dues allocated to lobbying	(1,645)	20	7
8	Adjust legal to allowable costs	(869)	19	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	<b>Total</b>	(5,972)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr# 0025130

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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)	
	<b>A. General Services</b>													
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	130	0	0	0	0	0	0	0	0	130	3
4	Laundry	0	0	94	0	0	0	0	0	0	0	0	94	4
5	Heat and Other Utilities	0	0	880	0	0	0	0	0	0	0	0	880	5
6	Maintenance	0	0	485	0	0	0	0	0	0	0	0	485	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	1,589	0	0	0	0	0	0	0	0	1,589	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	1,067	0	0	0	0	0	0	0	0	1,067	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	2,042	0	0	0	0	0	0	0	0	2,042	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	<b>TOTAL Health Care and Programs</b>	0	0	3,109	0	0	0	0	0	0	0	0	3,109	16
	<b>C. General Administration</b>													
17	Administrative	0	0	(135,068)	0	0	0	0	0	0	0	0	(135,068)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(869)	0	14,983	0	0	0	0	0	0	0	0	14,114	19
20	Fees, Subscriptions & Promotions	(1,645)	0	2,180	0	0	0	0	0	0	0	0	535	20
21	Clerical & General Office Expenses	(105)	0	25,560	0	0	0	0	0	0	0	0	25,455	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	849	0	0	0	0	0	0	0	0	849	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	10,844	0	0	0	0	0	0	0	0	10,844	26
27	Other (specify):*	0	0	3,212	0	0	0	0	0	0	0	0	3,212	27
28	<b>TOTAL General Administration</b>	(2,619)	0	(77,440)	0	0	0	0	0	0	0	0	(80,059)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(2,619)	0	(72,742)	0	0	0	0	0	0	0	0	(75,361)	29

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number

Carrier Mills Nursing &amp; Rehab Ctr

# 0025130

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	12,945	38,564	1,503	0	0	0	0	0	0	0	0	53,012	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4)	39,823	0	0	0	0	0	0	0	0	0	39,819	32
33	Real Estate Taxes	0	0	653	0	0	0	0	0	0	0	0	653	33
34	Rent-Facility & Grounds	0	(220,800)	0	0	0	0	0	0	0	0	0	(220,800)	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	0	36
37	<b>TOTAL Ownership</b>	<b>12,941</b>	<b>(142,413)</b>	<b>2,156</b>	<b>0</b>	<b>(127,316)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(3,353)	0	0	0	0	0	0	0	0	0	0	(3,353)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,353)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,353)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>6,969</b>	<b>(142,413)</b>	<b>(70,586)</b>	<b>0</b>	<b>(206,030)</b>	<b>45</b>							

**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 Nursing		
Alice Stallings (1/1 - 7/30)	19%	Stonebridge Senior Living Center	Benton, IL	Home Land Trust	Carrier Mills, IL	Land Trust
Penny Sisk	19%					
Scott Stout (7/31 - 12/31)	19			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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	Carrier Mills Land Trust		\$ 38,564	\$ 38,564	1
2	V	32 Interest		Carrier Mills Land Trust		39,385	39,385	2
3	V	32 Loan Fee Expense		Carrier Mills Land Trust		438	438	3
4	V	34 Rent	220,800	Carrier Mills Land Trust			(220,800)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 220,800			\$ 78,387	\$ * (142,413)	14

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

VII. RELATED PARTIES (continued)

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)		
15	V	3 Housekeeping	\$	RDK Management, Inc.		\$ 130	\$	130	15
16	V	4 Laundry		RDK Management, Inc.		94		94	16
17	V	5 Heat and Other Utilities		RDK Management, Inc.		880		880	17
18	V	6 Maintenance		RDK Management, Inc.		485		485	18
19	V	10 Nursing and Medical Records		RDK Management, Inc.		1,067		1,067	19
20	V	11 Activities		RDK Management, Inc.		2,042		2,042	20
21	V	17 Administrative	228,649	RDK Management, Inc.		93,581		(135,068)	21
22	V	19 Professional Services		RDK Management, Inc.		14,983		14,983	22
23	V	20 Dues, Fees, Subscriptions & Promotions		RDK Management, Inc.		2,180		2,180	23
24	V	21 Clerical & General Office Expenses		RDK Management, Inc.		25,560		25,560	24
25	V	27 Employee Benefits & Payroll Taxes		RDK Management, Inc.		3,212		3,212	25
26	V	24 Travel and Seminar		RDK Management, Inc.		849		849	26
27	V	26 Insurance-Prop.Liab.Malpractice		RDK Management, Inc.		10,844		10,844	27
28	V	30 Depreciation		RDK Management, Inc.		1,503		1,503	28
29	V	33 Real Estate Taxes		RDK Management, Inc.		653		653	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 228,649			\$ 158,063	\$ *	(70,586)	39

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

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr # 0025130 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	Owner	70.00	See Sch 7A	20	29.00	Mgmt Fee	\$ 93,581	17(7)	1
2	Alice Stallings (1/1/08-07/30/08)	Stockholder	Administrator	10.00	2,939	Various	Various	Salary	7,833	17(1)	2
3	Penny Sisk	Stockholder	Bookkeeper	20.00	18,250	Various	Various	Salary	10,500	21(1)	3
4	Scott Stout (7/31/08 - 12/31/08)	Stockholder	Owner	10.00	28,534	Various	Various	Salary	20,748	17(1)	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 132,662		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 & Rehab Ctr

# 0025130

Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 RDK Management, Inc.  
 Street Address 607 S. Commercial  
 City / State / Zip Code Harrisburg, IL  
 Phone Number (618) 926-3007  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Available Bed Days	123,708	3	\$ 446	\$ 36,234	\$ 130	1
2	4	Laundry	Available Bed Days	123,708	3	321	36,234	94	2
3	5	Heat and Other Utilities	Available Bed Days	123,708	3	3,003	36,234	880	3
4	6	Maintenance	Available Bed Days	123,708	3	1,657	36,234	485	4
5	10	Nursing and Medical Records	Available Bed Days	123,708	3	3,642	36,234	1,067	5
6	11	Activities	Available Bed Days	123,708	3	6,970	36,234	2,042	6
7	17	Administrative	Available Bed Days	123,708	3	319,500	319,500	93,581	7
8	19	Professional Services	Available Bed Days	123,708	3	51,153	36,234	14,983	8
9	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	123,708	3	7,442	36,234	2,180	9
10	21	Clerical & General Office Expens	Available Bed Days	123,708	3	87,265	44,194	25,560	10
11	27	Employee Benefits & Payroll Tax	Available Bed Days	123,708	3	10,965	36,234	3,212	11
12	24	Travel and Seminar	Available Bed Days	123,708	3	2,900	36,234	849	12
13	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	123,708	3	37,022	36,234	10,844	13
14	30	Depreciation	Available Bed Days	123,708	3	5,131	36,234	1,503	14
15	33	Real Estate Taxes	Available Bed Days	123,708	3	2,228	36,234	653	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 539,645	\$ 363,694	\$ 158,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Carrier Mills Nursing & Rehab Ctr

# 0025130

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Regions Bank		X	Refinance Construction	\$12,000.00	12/10/01	\$ 1,470,000	\$ 842,431	03/15/15	0.0625	\$ 39,385	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Dr. Roger Herrin	X		Working Capital	Single Pay	06/08/89	22,895	39,348	Demand	0.1000		6					
7	Galatia Bank		X	Line of Credit	Interest Only	07/15/08	500,150	160,000	07/15/09	0.4750	524	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$12,000.00		\$ 1,993,045	\$ 1,041,779			\$ 39,909	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11									Offset Interest Income		(4)	11					
12									Allocated from RE Entity		438	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 434	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,993,045	\$ 1,041,779			\$ 40,343	15					

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

\* 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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Carrier Mills Nursing & Rehab Ctr COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0025130

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 994-2323 FAX #: (618) 994-4082

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-1-098-03</u>	<u>Land and Buildings</u>	\$ <u>42,969.08</u>	\$ <u>42,969.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	<u>Home Office Building</u>	\$ <u>2,228.00</u>	\$ <u>653.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,197.08</u>	\$ <u>43,622.08</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 original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>406,595</u>		<u>\$ 28,367</u>	<u>1</u>
2	<u>Home Office Allocation</u>	<u>3,113</u>	<u>1993</u>	<u>5,564</u>	<u>2</u>
3	<b>TOTALS</b>	<b>409,708</b>		<b>\$ 33,931</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Carrier Mills Nursing &amp; Rehab Ctr

# 0025130

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	4
5	57		1992	1992	1,200,956		25	48,038	48,038	770,049	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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		45		20			450	14
15	Improvements - Air Conditioner		1985		17,045		15			17,045	15
16	Improvements		1985		3,110		10			3,110	16
17	Improvements - AC Compressor/Water Heater		1986		1,772		15			1,772	17
18	Improvements - Flooring/Landscaping		1987		3,112	88	15		(88)	3,112	18
19	Improvements - Redecorating		1988		1,153		10			1,153	19
20	Carpets		1989		180		5			180	20
21	Improvements - Washer/Dryer/Bathtub		1993		32,837		10			32,837	21
22	Improvements-Allocated Sheets (1)		1993		31,907		30	1,064	1,064	14,392	22
23	Improvements - Roof		1994		16,000	400	30	533	133	7,995	23
24	Improvements-Allocated Sheets (1)		1994		1,379		30	46	46	587	24
25	Improvements-Allocated Sheets (1)		1996		51		30	2	2	21	25
26	Improvements - Tile Work		1997		6,682		30	223	223	2,676	26
27	Improvements - Storage Building		1998		1,000		39	26	26	276	27
28	Improvements-Allocated Sheets (1)		1998		232		30	8	8	77	28
29	Improvements-Allocated Sheets (1)		2000		5,126		30	171	171	1,366	29
30	Improvements		2001		1,563		10	156	156	1,248	30
31	Improvements		2002		3,424		10	342	342	2,394	31
32											32
33											33
34	(1) = Allocation of Home Office Assets - See Schedule										
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	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)	\$ 1,658,113	\$ 488		\$ 50,609	\$ 50,121	\$ 1,191,279	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	\$ 173,162	\$ 9,154	\$ 12,045	\$ 2,891	10	\$ 126,572	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	398,193					398,193	73
74								74
75	TOTALS	\$ 571,355	\$ 9,154	\$ 12,045	\$ 2,891		\$ 524,765	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	Home Office Allocation	1995 Mercedes Benz SL500	1995	\$ 24,558	\$	\$	\$	4	\$ 24,558	76
77										77
78										78
79										79
80	TOTALS			\$ 24,558	\$	\$	\$		\$ 24,558	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)	\$ 2,287,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,654	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 53,012	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,740,602	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

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: \$ 5,001 Description: Oxygen - \$2,902; Miscellaneous Eqpt. - \$2,099

(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,733	\$ 125,159	\$	2,733	\$ 125,159	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		440	23,595		440	23,595	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,326	137,950		3,326	137,950	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				107,505		107,505	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	6,499	\$ 286,704	\$ 107,505	6,499	\$ 394,209	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

Facility Name &amp; ID Number Carrier Mills Nursing &amp; Rehab Ctr

# 0025130

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 114,109	\$ 114,109	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u> )	695,521	695,521	3
4	Supply Inventory (priced at <u>          </u> )	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	133,403	133,403	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>                          </u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 944,651	\$ 944,651	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,120	33,931	13
14	Buildings, at Historical Cost		1,517,632	14
15	Leasehold Improvements, at Historical Cost	57,800	140,481	15
16	Equipment, at Historical Cost	502,400	595,913	16
17	Accumulated Depreciation (book methods)	(518,992)	(1,740,602)	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 (spec <u>Goodwill</u> )	1,000	1,000	22
23	Other(specify): <u>Mortgage Costs - net</u>		2,736	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 44,328	\$ 551,091	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 988,979	\$ 1,495,742	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 85,457	\$ 85,457	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,895	2,895	29
30	Accrued Salaries Payable	34,694	34,694	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,943	7,943	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,709	42,709	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to IDPA</u>	25,026	25,026	36
37	<u>Prior Years Management Fees</u>	21,858	21,858	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 220,582	\$ 220,582	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	196,453	1,038,884	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>  </u>			43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 196,453	\$ 1,038,884	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 417,035	\$ 1,259,466	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 571,944	\$ 236,276	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 988,979	\$ 1,495,742	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>278,491</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior Period Adjustment</b>	<b>(86,234)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>192,257</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>379,687</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>379,687</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>571,944</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,001,389	1
2	Discounts and Allowances for all Levels	(46,526)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,954,863	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
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	1,411	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,411	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	105	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 105	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,956,383	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	844,450	31
32	Health Care	1,457,786	32
33	General Administration	830,264	33
	<b>B. Capital Expense</b>		
34	Ownership	278,986	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	110,858	35
36	Provider Participation Fee	54,352	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,576,696	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	379,687	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 379,687	43

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

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

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

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

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr

# 0025130

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	1,560	1,560	\$ 35,358	\$ 22.67	1
2	Assistant Director of Nursing	1,108	1,108	15,387	13.89	2
3	Registered Nurses	6,208	6,828	128,399	18.80	3
4	Licensed Practical Nurses	23,820	24,146	373,477	15.47	4
5	CNAs & Orderlies	40,949	41,717	370,957	8.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,680	2,951	25,913	8.78	8
9	Activity Director	1,768	1,830	14,658	8.01	9
10	Activity Assistants	2,015	2,112	16,199	7.67	10
11	Social Service Workers	3,861	4,109	34,933	8.50	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,085	19,281	9.25	13
14	Head Cook	8,824	9,137	71,085	7.78	14
15	Cook Helpers/Assistants	7,263	7,930	59,471	7.50	15
16	Dishwashers					16
17	Maintenance Workers	2,640	2,723	23,903	8.78	17
18	Housekeepers	28,515	29,378	220,337	7.50	18
19	Laundry	6,258	6,651	55,371	8.33	19
20	Administrator	3,687	3,687	68,145	18.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,388	5,559	54,183	9.75	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	1,892	2,052	27,007	13.16	31
32	Other Health C: <u>MDS Coordinator</u>	1,957	2,053	35,531	17.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,432	157,616	\$ 1,649,595 *	\$ 10.47	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	207	\$ 9,453	1(3)	35
36	Medical Director	Monthly	3,000	9(3)	36
37	Medical Records Consultant	28	1,596	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	24	1,766	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	259	\$ 15,815		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		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



Carrier Mills Nursing Home  
Provider # 0025130  
12/31/2008

**Schedule 21A**

Schedule XIX (C) - Professional Fees.

<b>TOTAL (agree to Schedule V, line 19, column 3)</b>	<b>30,621</b>
Allocation from RDK Management	14,983
Less: out of period legal fees	(869)
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>	<b><u>44,735</u></b>

**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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Carrier Mills Nursing &amp; Rehab Ctr

# 0025130

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$5,094
- (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? N/A  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,257 Line 10(2)
- (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 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, 01/01/1983
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,352  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 \$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