

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr # 0025130 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	126,618	14,596	6,604	147,818		147,818		147,818		1
2	Food Purchase		142,471		142,471		142,471		142,471		2
3	Housekeeping	195,445			195,445		195,445		195,445		3
4	Laundry	60,684	11,556		72,240		72,240	373	72,613		4
5	Heat and Other Utilities			103,824	103,824		103,824	2,415	106,239		5
6	Maintenance	39,225	20,154	49,353	108,732		108,732	6,176	114,908		6
7	Other (specify):*										7
8	TOTAL General Services	421,972	188,777	159,781	770,530		770,530	8,964	779,494		8
	B. Health Care and Programs										
9	Medical Director			3,900	3,900		3,900		3,900		9
10	Nursing and Medical Records	981,200	104,416	1,596	1,087,212		1,087,212		1,087,212		10
10a	Therapy	48,743		231,623	280,366		280,366		280,366		10a
11	Activities	36,924	1,781		38,705		38,705		38,705		11
12	Social Services	31,813		6,549	38,362		38,362		38,362		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,098,680	106,197	243,668	1,448,545		1,448,545		1,448,545		16
	C. General Administration										
17	Administrative	65,145		251,295	316,440		316,440	(131,353)	185,087		17
18	Directors Fees										18
19	Professional Services			31,241	31,241		31,241	19,954	51,195		19
20	Dues, Fees, Subscriptions & Promotions			24,891	24,891		24,891	(588)	24,303		20
21	Clerical & General Office Expenses	183,057	18,456	42,562	244,075		244,075	21,213	265,288		21
22	Employee Benefits & Payroll Taxes			277,547	277,547		277,547		277,547		22
23	Inservice Training & Education			1,590	1,590		1,590		1,590		23
24	Travel and Seminar			1,306	1,306		1,306	53	1,359		24
25	Other Admin. Staff Transportation			3,093	3,093		3,093		3,093		25
26	Insurance-Prop.Liab.Malpractice			68,106	68,106		68,106	16,306	84,412		26
27	Other (specify):* Home Office Benefits							194	194		27
28	TOTAL General Administration	248,202	18,456	701,631	968,289		968,289	(74,221)	894,068		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,768,854	313,430	1,105,080	3,187,364		3,187,364	(65,257)	3,122,107		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 & ID Number

Carrier Mills Nursing & Rehab Ctr

#0025130

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,642	9,642		9,642	49,542	59,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,823	4,823		4,823	17,959	22,782			32
33	Real Estate Taxes			43,000	43,000		43,000	677	43,677			33
34	Rent-Facility & Grounds			220,800	220,800		220,800	(220,800)				34
35	Rent-Equipment & Vehicles			6,243	6,243		6,243		6,243			35
36	Other (specify):*											36
37	TOTAL Ownership			284,508	284,508		284,508	(152,622)	131,886			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,097		75,097		75,097		75,097			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):* Non-allowable cost			5,525	5,525		5,525	(5,525)				43
44	TOTAL Special Cost Centers		75,097	59,728	134,825		134,825	(5,525)	129,300			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,768,854	388,527	1,449,316	3,606,697		3,606,697	(223,404)	3,383,293			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	(1,967)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,479	30		9
10	Interest and Other Investment Income	(391)	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 PG5A	(5,549)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 572		\$	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)	(223,976)	Vari	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (223,976)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (223,404)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Carrier Mills Nursing & Rehab Ctr

ID# 0025130

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Funeral Expense	\$ (197)	43	1
2	Donations	(435)	43	2
3	Donations - Political	(333)	43	3
4	Sales Tax	(1,203)	43	4
5	Birthday Expense	(1,390)	43	5
6	Non-Allowable Dues	(1,991)	20	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	(5,549)		49

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	70%	Saline Care Center	Harrisburg, IL	Carrier Mills Nursing		
Penny Sisk	20%	Stonebridge Senior Living Center	Benton, IL	Home Land Trust	Carrier Mills, IL	Land Trust
Scott Stout	10%			RDK Mgmt, Inc.	Harrisburg, IL	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Carrier Mills Land Trust		\$ 38,564	\$ 38,564	1
2	V	32 Interest		Carrier Mills Land Trust		17,912	17,912	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			\$ 56,914	\$ * (163,886)	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	4 Laundry	\$	RDK Management, Inc.	100.00%	\$ 373	\$ 373
16	V	5 Heat and Other Utilities		RDK Management, Inc.	100.00%	2,415	2,415
17	V	6 Maintenance		RDK Management, Inc.	100.00%	6,176	6,176
18	V	17 Administrative	251,295	RDK Management, Inc.	100.00%	119,942	(131,353)
19	V	19 Professional Services		RDK Management, Inc.	100.00%	19,954	19,954
20	V	20 Dues, Fees, Subscriptions & Promotions		RDK Management, Inc.	100.00%	1,403	1,403
21	V	21 Clerical & General Office Expenses		RDK Management, Inc.	100.00%	21,213	21,213
22	V	27 Employee Benefits & Payroll Taxes		RDK Management, Inc.	100.00%	194	194
23	V	24 Travel and Seminar		RDK Management, Inc.	100.00%	53	53
24	V	26 Insurance-Prop.Liab.Malpractice		RDK Management, Inc.	100.00%	16,306	16,306
25	V	30 Depreciation		RDK Management, Inc.	100.00%	2,499	2,499
26	V	33 Real Estate Taxes		RDK Management, Inc.	100.00%	677	677
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 251,295			\$ 191,205	\$ * (60,090)

* 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: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Roger D. Herrin	Stockholder	Owner	70.00	289,557	20	29.00	Mgmt Fee	\$ 119,942	17(7)	1
2											2
3	Penny Sisk	Stockholder	Bookkeeper	20.00	31,148	Various	Various	Salary	12,902	21(7)	3
4	Scott Stout	Stockholder	Owner	10.00	42,902	Various	Various	Salary	39,299	17(1)	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 172,143		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

Carrier Mills Nursing Home
ID # 0025130
Compensation Received From Other Related Nursing Home
FYE: 12/31/2009

Sch 7A

Other Related Nursing Homes:	Roger Herrin	Penny Sisk	Scott Stout
Stonebridge Senior Living Center (ID # 0033258)	117,519	18,506	7,200
Saline Care Center (ID # 0029462)	172,038	12,642	35,702
Total	<u>289,557</u>	<u>31,148</u>	<u>42,902</u>
Roger Herrin's Salary received through RDK	70	20	10

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr # 0025130 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	4	Laundry	Available Bed Days	123,370	3	\$ 1,272	\$ 36,135	\$ 373	1
2	5	Heat and Other Utilities	Available Bed Days	123,370	3	8,244	36,135	2,415	2
3	6	Maintenance	Available Bed Days	123,370	3	21,085	36,135	6,176	3
4	17	Administrative	Available Bed Days	123,370	3	409,500	409,500	119,942	4
5	19	Professional Services	Available Bed Days	123,370	3	68,126	36,135	19,954	5
6	20	Dues, Fees, Subscriptions & Prom	Available Bed Days	123,370	3	4,791	36,135	1,403	6
7	21	Clerical & General Office Expens	Available Bed Days	123,370	3	72,424	44,050	21,213	7
8	27	Employee Benefits & Payroll Tax	Available Bed Days	123,370	3	661	36,135	194	8
9	24	Travel and Seminar	Available Bed Days	123,370	3	180	36,135	53	9
10	26	Insurance-Prop.Liab.Malpractice	Available Bed Days	123,370	3	55,671	36,135	16,306	10
11	30	Depreciation	Available Bed Days	123,370	3	4,978	36,135	1,458	11
12	33	Real Estate Taxes	Available Bed Days	123,370	3	2,311	36,135	677	12
13	30	Depreciation	Direct			1,041		1,041	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					\$ 650,284	\$ 453,550	\$ 191,205	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr # 0025130 Report Period Beginning: 01/01/09 Ending: 12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Regions Bank		X	Refinance Construction	\$12,000.00	12/10/01	\$ 1,470,000	\$ 596,135	03/15/15	0.0625	\$ 18,350	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	2,895	Demand	0.1000		6							
7	Galatia Bank		X	Line of Credit	Interest Only	07/15/08	500,150	156,661	07/15/09	0.4750	4,823	7							
8												8							
9	TOTAL Facility Related				\$12,000.00		\$ 1,993,045	\$ 755,691			\$ 23,173	9							
B. Non-Facility Related*																			
10												10							
11											Offset Interest Income	(391)	11						
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (391)	14							
15	TOTALS (line 9+line14)						\$ 1,993,045	\$ 755,691			\$ 22,782	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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,462 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Facility, Home Office Allocation, and TOTALS.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
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		25	48,038	48,038	818,087
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		15			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 - Roof	1994		16,000		30	533	533	8,528
23	Improvements - Tile Work	1997		6,682		30	223	223	2,899
24	Improvements - Storage Building	1998		1,000		39	26	26	302
25	Improvements	2001		1,563		10	156	156	1,404
26	Improvements	2002		3,424		10	342	342	2,736
27	Remolding - Wall coverings, Chair Rails, Paneling	2009		42,010		20	1,050	1,050	1,050
28									
29									
30	Current year booked depreciation	2009			9,642			(9,642)	
31									
32									
33									
34									
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	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	(1) = Allocation of Home Office Assets - See Schedule	\$	\$		\$	\$	\$	37	
38	Improvements-Allocated Sheets (1)	1993	31,907		30	1,064	1,064	15,455	38
39	Improvements-Allocated Sheets (1)	1994	1,379		30	46	46	633	39
40	Improvements-Allocated Sheets (1)	1996	51		30	2	2	23	40
41	Improvements-Allocated Sheets (1)	1998	232		30	8	8	85	41
42	Improvements-Allocated Sheets (1)	2000	5,126		30	171	171	1,537	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)		\$ 1,700,528	\$ 9,642		\$ 51,659	\$ 42,017	\$ 1,242,937	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	\$	\$ 4,240	\$ 4,240	10	\$ 130,765	71
72	Current Year Purchases	41,549		2,077	2,077	10	2,077	72
73	Fully Depreciated Assets	398,193					398,193	73
74	Home Office Allocation	12,084		1,208	1,208	10	10,472	74
75	TOTALS	\$ 624,988	\$	\$ 7,525	\$ 7,525		\$ 541,507	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	2	
	Reference	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)	\$ 2,384,005	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)	\$ 59,184	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,542	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,809,002	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	N/A	\$	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: 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:	<u>N/A</u>			\$			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: \$ 6,243 Description: Oxygen - \$4,334; Postage Meter - \$787; Dishmachine - \$1,122

(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			<u>N/A</u>		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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	1,537	99,879	\$	1,537	\$	99,879	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		171	11,147		171		11,147	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs		1,855	120,597		1,855		120,597	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				75,097			75,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$	3,563	\$ 231,623	\$ 75,097	3,563	\$	306,720	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 & ID Number Carrier Mills Nursing & Rehab Ctr

0025130

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 145,980	\$ 145,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u>)	536,757	536,757	3
4	Supply Inventory (priced at)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	65,375	65,375	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 749,730	\$ 749,730	10
B. Long-Term Assets				
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	99,810	182,896	15
16	Equipment, at Historical Cost	543,949	649,546	16
17	Accumulated Depreciation (book methods)	(528,634)	(1,809,002)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)	1,000	1,000	22
23	Other(specify): <u>Mortgage Costs - net</u>		2,298	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 118,245	\$ 578,301	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 867,975	\$ 1,328,031	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,984	\$ 91,984	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	17,680	17,680	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,351	4,351	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,351	41,351	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Prior Years Management Fees</u>	21,858	21,858	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 180,119	\$ 180,119	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	36,453	752,796	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)	\$ 36,453	\$ 752,796	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 216,572	\$ 932,915	46
47	TOTAL EQUITY(page 18, line 24)	\$ 651,403	\$ 395,116	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 867,975	\$ 1,328,031	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 571,944	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	401,800	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 973,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	572,659	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	(895,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (322,341)	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)	\$ 651,403	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr

0025130

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,192,978	1
2	Discounts and Allowances for all Levels	(26,929)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,166,049	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	12,916	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,916	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	391	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 391	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)	\$ 4,179,356	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	770,530	31
32	Health Care	1,448,545	32
33	General Administration	968,289	33
B. Capital Expense			
34	Ownership	284,508	34
C. Ancillary Expense			
35	Special Cost Centers	80,622	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)*	\$ 3,606,697	40
41	Income before Income Taxes (line 30 minus line 40)**	572,659	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 572,659	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:

01/01/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,870	1,934	\$ 42,557	\$ 22.00	1
2	Assistant Director of Nursing	2,054	2,112	34,371	16.27	2
3	Registered Nurses	8,951	9,331	169,981	18.22	3
4	Licensed Practical Nurses	22,646	23,746	294,762	12.41	4
5	CNAs & Orderlies	50,297	51,512	402,753	7.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,661	3,982	48,743	12.24	8
9	Activity Director	2,134	2,261	21,022	9.30	9
10	Activity Assistants	1,833	1,843	15,902	8.63	10
11	Social Service Workers	3,588	3,706	31,813	8.58	11
12	Dietician					12
13	Food Service Supervisor	1,594	1,712	15,633	9.13	13
14	Head Cook	5,699	5,869	47,071	8.02	14
15	Cook Helpers/Assistants	7,891	8,142	63,914	7.85	15
16	Dishwashers					16
17	Maintenance Workers	3,538	3,663	39,225	10.71	17
18	Housekeepers	25,081	25,912	195,445	7.54	18
19	Laundry	7,008	7,199	60,684	8.43	19
20	Administrator	3,324	3,364	65,145	19.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,754	8,333	183,057	21.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS Coordinator	1,970	2,192	36,776	16.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,889	166,813	\$ 1,768,854 *	\$ 10.60	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	Monthly	\$ 6,604	1(3)	35
36	Medical Director	Monthly	3,900	9(3)	36
37	Medical Records Consultant	Monthly	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	Monthly	6,549	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,649		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Carrier Mills Nursing Home
Provider # 0025130
FY: 12/31/2009

Schedule 21A

Schedule XIX (C) - Professional Fees.

TOTAL (agree to Schedule V, line 19, column 3)	31,241
Allocation from RDK Management	19,954
TOTAL (agree to Schedule V, line 19, column 8)	<u>51,195</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Ctr

0025130

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$5,550
- (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. \$ 5,011 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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Carrier Mills Nursing Home Land Trust; #0025130, 01/01/1983
- (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? 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes If no, please explain. N/A
- (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