		FOR BHF USE			

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0054460

Facility Name: Carrier Mills Nsg & Reha Ctr

Address: 6789 Rt 45 E Box 68 (Number) — Carrier Mills (City) — 62917 (Zip Code)

County: Saline

Telephone Number: (618) 994-2323 **Fax #** (618) 994-4082

HFS ID Number:

Date of Initial License for Current Owners: 28856

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT	(Date)
	(Print Name and Title)	Larry Templin Partner
	(Firm Name & Address)	Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525
	(Telephone)	(630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,399	5,399	8
9	SNF/PED					9
10	ICF	22,117	7,479		29,596	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,117	7,479	5,399	34,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.58%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/29/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,513

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,481	8,378	10,509	227,368		227,368		227,368			1
2	Food Purchase		171,017		171,017		171,017	(3,830)	167,187			2
3	Housekeeping	214,033	16,158		230,191		230,191	5,148	235,339			3
4	Laundry	72,221	15,417		87,638		87,638		87,638			4
5	Heat and Other Utilities			76,337	76,337		76,337	465	76,802			5
6	Maintenance	38,100	15,159	38,344	91,603		91,603	3,768	95,371			6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			9,294	9,294		9,294	2,169	11,463			7
8	**TOTAL General Services**	532,835	226,129	134,484	893,448		893,448	7,720	901,168			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,352,666	128,338	4,880	1,485,884		1,485,884	42,442	1,528,326			10
10a	Therapy											10a
11	Activities	49,355			49,355		49,355		49,355			11
12	Social Services	24,518	3,478	2,557	30,553		30,553		30,553			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							5,659	5,659			15
16	**TOTAL Health Care and Programs**	1,426,539	131,816	13,437	1,571,792		1,571,792	48,101	1,619,893			16
	C. General Administration											
17	Administrative	57,367		493,336	550,703		550,703	(323,307)	227,396			17
18	Directors Fees											18
19	Professional Services			72,609	72,609		72,609	1,405	74,014			19
20	Dues, Fees, Subscriptions & Promotions			16,692	16,692		16,692	292	16,984			20
21	Clerical & General Office Expenses	84,244	20,731	13,866	118,841		118,841	34,891	153,732			21
22	Employee Benefits & Payroll Taxes			263,131	263,131		263,131		263,131			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,030	3,030		3,030	104	3,134			24
25	Other Admin. Staff Transportation			3,269	3,269		3,269	7,720	10,989			25
26	Insurance-Prop.Liab.Malpractice			95,630	95,630		95,630	1,787	97,417			26
27	Other (specify):* RDK/SI Benefits Alloc							18,102	18,102			27
28	**TOTAL General Administration**	141,611	20,731	961,563	1,123,905		1,123,905	(259,006)	864,899			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,100,985	378,676	1,109,484	3,589,145		3,589,145	(203,185)	3,385,960			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' PREPARATION 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 Nsg & Reha Ctr #0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,065	73,065		73,065	15,404	88,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9	9		9	(9)				32
33	Real Estate Taxes			36,148	36,148		36,148	251	36,399			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,216	6,216		6,216		6,216			35
36	Other (specify):*											36
37	TOTAL Ownership			115,438	115,438		115,438	15,646	131,084			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,484	316,411	407,895		407,895		407,895			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,228	229,228		229,228		229,228			42
43	Other (specify):* Disallowed Costs			32,758	32,758		32,758	(32,758)				43
44	TOTAL Special Cost Centers		91,484	578,397	669,881		669,881	(32,758)	637,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,100,985	470,160	1,803,319	4,374,464		4,374,464	(220,297)	4,154,167			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(8,219)	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	14,456	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(708)	43		13
14	Non-Care Related Interest	(9)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(663)	20		17
18	Fines and Penalties				18
19	Entertainment	(188)	43		19
20	Contributions	(500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,141)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(281)	43		24
25	Fund Raising, Advertising and Promotional	(7,462)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,690)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(9,001)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,406)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(193,891)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (193,891)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,297)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Carrier Mills Nsg & Reha Ctr

ID# 0054460

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Birthday Expense	$ (2,505)	43	1
2	Gifts	(205)	43	2
3	Miscellaneous income offset	(2,461)	21	3
4	Offset Vending Machine income	(3,830)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,001)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,830)	0	0	0	0	0	0	0	0	0	0	(3,830)	2
3	Housekeeping	0	0	5,148	0	0	0	0	0	0	0	0	5,148	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	465	0	0	0	0	0	0	0	0	465	5
6	Maintenance	0	0	3,768	0	0	0	0	0	0	0	0	3,768	6
7	Other (specify):*	0	0	2,169	0	0	0	0	0	0	0	0	2,169	7
8	**TOTAL General Services**	(3,830)	0	11,550	0	0	0	0	0	0	0	0	7,720	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	42,442	0	0	0	0	0	0	0	0	0	42,442	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	5,659	0	0	0	0	0	0	0	0	0	5,659	15
16	**TOTAL Health Care and Programs**	0	48,101	0	0	0	0	0	0	0	0	0	48,101	16
	C. General Administration													
17	Administrative	0	(73,512)	(249,795)	0	0	0	0	0	0	0	0	(323,307)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,141)	1,500	1,046	0	0	0	0	0	0	0	0	1,405	19
20	Fees, Subscriptions & Promotions	(663)	832	123	0	0	0	0	0	0	0	0	292	20
21	Clerical & General Office Expenses	(2,461)	33,542	3,810	0	0	0	0	0	0	0	0	34,891	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	50	54	0	0	0	0	0	0	0	0	104	24
25	Other Admin. Staff Transportation	0	3,834	3,886	0	0	0	0	0	0	0	0	7,720	25
26	Insurance-Prop.Liab.Malpractice	0	744	1,043	0	0	0	0	0	0	0	0	1,787	26
27	Other (specify):*	0	13,976	4,126	0	0	0	0	0	0	0	0	18,102	27
28	**TOTAL General Administration**	(4,265)	(19,034)	(235,707)	0	0	0	0	0	0	0	0	(259,006)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,095)	29,067	(224,157)	0	0	0	0	0	0	0	0	(203,185)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Capital Expense D. Ownership	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)	
30	Depreciation	14,456	948	0	0	0	0	0	0	0	0	0	15,404	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9)	0	0	0	0	0	0	0	0	0	0	(9)	32
33	Real Estate Taxes	0	0	251	0	0	0	0	0	0	0	0	251	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	14,447	948	251	0	0	0	0	0	0	0	0	15,646	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(32,758)	0	0	0	0	0	0	0	0	0	0	(32,758)	43
44	**TOTAL Special Cost Centers**	(32,758)	0	0	0	0	0	0	0	0	0	0	(32,758)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,406)	30,015	(223,906)	0	0	0	0	0	0	0	0	(220,297)	45

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dr. Roger Herrin	35	Saline Care Center	Harrisburg	Carrier Mills Nursing	Carrier Mills	Land Trust
Lysa Saran	35	Stonebridge Senior Living Center, LLC	Benton	Home Land Trust		
Penny Sisk	20	Pinckneyville Nursing and Rehab	Pinckneyville	RDK Management, Inc	Harrisburg	Management Co.
Scott Stout	10	DuQuoin Nursing & Rehab	DuQuoin	SI Management Svc, L	Harrisburg	Management Co.

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Wages	$	SI Management Services, LLC	100.00%	$ 42,442	$ 42,442	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	5,659	5,659	2
3	V	17	Administrative	145,420	SI Management Services, LLC	100.00%	71,908	(73,512)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	1,500	1,500	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	832	832	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	33,542	33,542	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	50	50	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	3,834	3,834	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	744	744	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	13,976	13,976	10
11	V	30	Depreciation		SI Management Services, LLC	100.00%	948	948	11
12	V								12
13	V								13
14	Total			$ 145,420			$ 175,435	$ * 30,015	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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.	100.00%	$ 5,148	$ 5,148	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	465	465	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	3,768	3,768	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	2,169	2,169	18
19	V	17	Administrative	347,916	RDK Management, Inc.	100.00%	98,121	(249,795)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	1,046	1,046	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	123	123	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	3,810	3,810	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	54	54	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	3,886	3,886	24
25	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	1,043	1,043	25
26	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	4,126	4,126	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	251	251	27
28	V								28
29	V								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			$ 347,916			$ 124,010	$ * (223,906)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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			$			$	$	15
16	V								16
17	V								17
18	V		The Carrier Mills Nursing Home Land Trust trial balance has already been consolidated with the nursing hom						18
19	V		trial balance. Therefore, there is no Page 6 for this entity.						19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								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			$			$ 0	$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Dr. Roger Herrin	Stockholder	Administrative	35%	See Att Sch 7A	15.65	23.01	Alloc. Fee	$ 82,590	L17, C7	1
2	Penny Sisk	Stockholder	Administrative	20%	See Att Sch 7A	10.44	26.10	Alloc. Salary	31,095	L17, C7	2
3	Scott Stout	Stockholder	Administrative	10%	See Att Sch 7A	15.65	26.08	Alloc. Salary	33,389	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 147,074		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' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 X NO

Name of Related Organization: SI Management Services, LLC
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: (618) 252-7707
Fax Number: ( )

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Wages	Census	134,154	5	162,702	162,702	34,995	$ 42,442	1
2	15	Health Care and Prog Emp. Ben.	Census	134,154	5	21,694		34,995	5,659	2
3	17	Administrative	Census	134,154	5	275,658	275,657	34,995	71,908	3
4	19	Professional Fees	Census	134,154	5	5,751		34,995	1,500	4
5	20	Fees, Subscriptions	Census	134,154	5	3,189		34,995	832	5
6	21	Clerical And General	Census	134,154	5	128,583	126,166	34,995	33,542	6
7	24	Travel and Seminar	Census	134,154	5	191		34,995	50	7
8	25	Admin. Staff Trans.	Census	134,154	5	14,698		34,995	3,834	8
9	26	Insurance-Prop./Liab./Malprac.	Census	134,154	5	2,853		34,995	744	9
10	27	Gen. Admin. Emp. Ben.	Census	134,154	5	53,576		34,995	13,976	10
11	30	Depreciation	Census	134,154	5	3,634		34,995	948	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 672,529	$ 564,525		$ 175,435	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: RDK Management, Inc.
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: (618) 252-7707
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	134,154	5	19,736	19,736	34,995	$ 5,148	1
2	5	Utilities	Census	134,154	5	1,783		34,995	465	2
3	6	Maintenance	Census	134,154	5	14,444	11,560	34,995	3,768	3
4	7	General Svcs. Emp. Ben.	Census	134,154	5	8,314		34,995	2,169	4
5	17	Administrative	Census	134,154	5	376,148	59,539	34,995	98,121	5
6	19	Professional Services	Census	134,154	5	4,010		34,995	1,046	6
7	20	Dues, Fees, Subs & Promotions	Census	134,154	5	471		34,995	123	7
8	21	Clerical and General Office	Census	134,154	5	14,604		34,995	3,810	8
9	24	Travel and Seminar	Census	134,154	5	207		34,995	54	9
10	25	Other Admin. Staff Transport.	Census	134,154	5	14,897		34,995	3,886	10
11	26	Ins.-Prop.Liab.Malpractice	Census	134,154	5	3,999		34,995	1,043	11
12	27	Mgmt. Allocation of Benefits	Census	134,154	5	15,817		34,995	4,126	12
13	33	Real Estate Taxes	Census	134,154	5	962		34,995	251	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					$ 475,392	$ 90,835		$ 124,010	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11								Miscellaneous Interest			9	11
12								Interest Income Offset			(9)	12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

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

Item			Amount	Line
1. Real Estate Tax accrual used on 2015 report.		$	34,242	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2015	$	34,727	2
3. Under or (over) accrual (line 2 minus line 1).		$	485	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	35,663	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Allocated from RDK		251	
TOTAL REFUND $ ____ For ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	251	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	36,399	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2011	46,788	8
	2012	32,430	9
	2013	33,396	10
	2014	33,817	11
	2015	34,727	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carrier Mills Nsg & Reha Ctr COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0054460

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 252-7707 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	02-1-098-03	Long Term Care Property	$ 34,727.56	$ 34,727.56
2.	06-2-275-02	Home Office Allocation	$ 963.32	$ 251.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,690.88	$ 34,978.56

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? X YES ____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	406,595		$ 28,367	1
2	Home Office Allocation			5,860	2
3	TOTALS	406,595		$ 34,227	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1979	1968	$ 316,676	$	25	$	$	$ 316,676	4
5	57		1992	1992	1,200,956		25	48,038	48,038	1,154,353	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,155		20			4,155	9
10	Various			1980	9,263		20			9,263	10
11	Various			1983	445		20			445	11
12	Various			1985	20,605		20			20,605	12
13	Various			1986	1,772		20			1,772	13
14	Various			1987	3,112		20			3,112	14
15	Various			1988	1,153		20			1,153	15
16	Various			1989	180		20			180	16
17	Various			1993	32,837		20			32,837	17
18	Various			1994	16,000		20			16,000	18
19	Various			1997	6,682		20	334	334	6,682	19
20	Various			1998	1,000		20	50	50	950	20
21	Various			2001	1,563		20	78	78	1,250	21
22	Various			2002	3,424		20	171	171	2,567	22
23	Various			2009	6,237		20	312	312	2,495	23
24	Remodeling-Wallpaper, Cove Base, Floors, Cabinets, Painting			2010	57,785		20	2,889	2,889	20,224	24
25	Wiring & Lighting In Kitchen & Dining Room			2010	3,485		20	348	348	2,438	25
26	Tear Off Existing & Reroof Over 100 & 200 Wings And Kitchen & Dining			2011	70,000		20	3,500	3,500	21,000	26
27	Sprinkler System			2011	52,329		20	2,616	2,616	15,697	27
28	Flooring - Dining Area			2011	5,542		20	277	277	1,662	28
29	Carpet And Wallcovering - 5 Resident Rooms And Offices			2012	24,735		20	1,237	1,237	6,185	29
30	Boiler Install			2012	7,625		20	381	381	1,906	30
31	Security System			2013	3,035		20	152	152	608	31
32	5 Ton AC Unit			2014	6,881		20	344	344	860	32
33	Duralast Roof Replacement - Center section of building			2014	18,080		20	904	904	2,260	33
34	Cabinets and Counter Tops - Kitchen			2014	2,760		20	138	138	345	34
35	Cabinets and Counter Tops - Kitchen			2014	2,776		20	138	138	345	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' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Carpeting - Family Room and Front Offices	2014	$ 2,990	$	20	$ 150	$ 150	$ 375	37
38	New Wall Vinyl - Hall 200	2014	15,145		20	757	757	1,893	38
39	Remodel North Wing Rooms - Wallpaper, Painting, Cove Base,								39
40	Cabinetry in Utility Rm, Blinds, Wood trim	2015	51,868		20	2,593	2,593	3,890	40
41	Remove & Replace Concrete Pads and Install Carport	2015	4,410		20	221	221	331	41
42	Install 2 New Water Heaters	2015	6,121		20	306	306	459	42
43	New Doors and Keypads Installation	2015	5,705		20	285	285	428	43
44	Install New Drainage Piping	2015	16,341		20	817	817	1,225	44
45	Design Fee	2015	2,884		20	144	144	216	45
46	3 AC Units with Heat Kits	2016	16,290		20	407	407	407	46
47	3 Chandeliers	2016	264		20	7	7	7	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	Leasehold Information								56
57	Allocated from RDK Management	1993	33,595		20	526	526	25,707	57
58	Allocated from RDK Management	1994	1,452		20			1,452	58
59	Allocated from RDK Management	1996	54		20			54	59
60	Allocated from RDK Management	1998	244		20	12	12	232	60
61	Allocated from RDK Management	2000	5,397		20	270	270	4,588	61
62									62
63									63
64									64
65									65
66									66
67	Financial Statement Depreciation			73,065			(73,065)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,043,853	$ 73,065		$ 68,402	$ (4,663)	$ 1,689,289	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 748,155	$	$ 14,088	$ 14,088	5-10 yrs	$ 415,189	71
72	Current Year Purchases	10,057		602	602	5-7 yrs	602	72
73	Fully Depreciated Assets	12,724					12,724	73
74	Allocated from Mgmt Co.	14,850		1,161	1,161	5-10	14,229	74
75	TOTALS	$ 785,786	$	$ 15,851	$ 15,851		$ 442,744	75

D. Vehicle Costs. (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	Administrative	2015 Kia Sorento	2014	$ 7,039	$	$ 1,408	$ 1,408	5	$ 3,755	76
77	Administrative	2001 Ford Mustang	2014	1,040		208	208	5	537	77
78	Facility	2012 Kia Van	2015	13,000		2,600	2,600	5	4,117	78
79	Allocated from Mgmt Co.			25,857				5	25,857	79
80	TOTALS			$ 46,936	$	$ 4,216	$ 4,216		$ 34,266	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)	$ 2,910,802	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,469	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,404	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,166,299	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' PREPARATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 6,216 Description: Medical Equipment $4,900 ; Office Equipment $1,316
    (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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 112,209	$		$ 112,209	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			40,509			40,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			163,693			163,693	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 prescrpts				91,484		91,484	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			$		$ 316,411	$ 91,484		$ 407,895	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' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 192,712	$ 192,712	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,633,902	1,633,902	3
4	Supply Inventory (priced at)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	64,664	64,664	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,892,896	$ 1,892,896	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,153	8,153	12
13	Land	25,256	34,227	13
14	Buildings, at Historical Cost	1,439,296	1,517,632	14
15	Leasehold Improvements, at Historical Cost	398,703	526,221	15
16	Equipment, at Historical Cost	877,467	832,722	16
17	Accumulated Depreciation (book methods)	(2,236,457)	(2,166,299)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	1,000	1,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 513,418	$ 753,656	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,406,314	$ 2,646,552	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,029	$ 166,029	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,704	25,704	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,324	3,324	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,663	35,663	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 230,720	$ 230,720	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 230,720	$ 230,720	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,175,594	$ 2,415,832	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,406,314	$ 2,646,552	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,036,255	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,036,255	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,299,526	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	(1,162,797)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Record Invest. SI Management	2,610	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 139,339	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)**	$ 2,175,594	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,574,267	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,574,267	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,330	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 94,330	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	3,830	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,830	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	165	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 165	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	2,461	28
28a	SI Mgmt Income/Loss	(1,063)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,398	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,673,990	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	893,448	31
32	Health Care	1,571,792	32
33	General Administration	1,123,905	33
	B. Capital Expense		
34	Ownership	115,438	34
	C. Ancillary Expense		
35	Special Cost Centers	440,653	35
36	Provider Participation Fee	229,228	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,374,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,299,526	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,299,526	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,821,694	44
45	Private Pay - Net Inpatient Revenue	1,116,842	45
46	Medicare - Net Inpatient Revenue	999,204	46
47	Other-(specify) Insurance	189,588	47
48	Other-(specify) VA	446,939	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,574,267	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,898	1,906	$ 47,277	$ 24.80	1
2	Assistant Director of Nursing	1,806	1,830	36,482	19.94	2
3	Registered Nurses	4,265	4,447	107,075	24.08	3
4	Licensed Practical Nurses	25,224	26,443	522,616	19.76	4
5	CNAs & Orderlies	58,061	59,577	639,216	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,261	4,530	49,355	10.90	10
11	Social Service Workers	2,023	2,125	24,518	11.54	11
12	Dietician					12
13	Food Service Supervisor	2,194	2,194	24,400	11.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,807	20,357	184,081	9.04	15
16	Dishwashers					16
17	Maintenance Workers	2,499	2,655	38,100	14.35	17
18	Housekeepers	22,938	24,191	214,033	8.85	18
19	Laundry	7,913	8,141	72,221	8.87	19
20	Administrator	1,840	2,080	57,367	27.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,339	7,627	84,244	11.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,068	168,103	$ 2,100,985 *	$ 12.50	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	225	$ 10,509	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	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	39	2,557	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	264	$ 21,466		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	48	1,398		51
52	Certified Nurse Assistants/Aides	57	1,082		52
53	TOTAL (lines 50 - 52)	105	$ 2,480		53

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christy L. Barter	Administrator	0	$ 57,367
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 57,367

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 493,336
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 493,336

C. Professional Services

Vendor/Payee	Type	Amount
Adam Lawler Law Firm	Legal	$ 211
Daniel Maher Law Office	Legal	27
Lawler Brown Law Firm	Legal	825
Thomas Wolf Jr. Attorney	Legal	105
Templin Healthcare Accounting	Accounting	4,189
James Henson, PC	Accounting	7,937
WH Administrators, Inc	ACA Compliance Consultant	33,560
Payroll Services by Extra Help	Payroll Service	1,569
Galaxy Hosted Software	Web Hosting Service	400
Information Controls	Payroll Service	1,879
IT Next Gen	Web Hosting Service	190
See Attached Sch 21C		21,717
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 72,609

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,762
Unemployment Compensation Insurance	19,373
FICA Taxes	158,391
Employee Health Insurance	10,522
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expenses	6,635
Personal/Funeral Day Expense	391
Life/Disability Insurance	4,469
Other Employee Benefits	3,588
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,131

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,932
Health Care Worker Background Check	
(Indicate # of checks performed 37)	1,715
Patient Background Checks 82	1,264
License & Permits	758
Dues & Subcriptions	826
IHCA	6,534
Allocated From RDK/SI Management	955
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,984

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,030
Seminar Expense	2,000
Allocated From RDK/SI Management	104
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,134

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Carrier Mills Nsg & Reha Ctr**
IDPH License ID Number: **0054460**
Fiscal Year End: **12/31/16**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
American Health Tech	LTC Software	19,917
Esolutions	Health Info Management	1,416
Passport Software	Accounting Software	384
	Total	**21,717**

Facility Name & ID Number Carrier Mills Nsg & Reha Ctr # 0054460 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **6,534** IHCA

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,037** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ______ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ______ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Carrier Mills Nursing Home Land Trust; #0025130, 1/1/1983

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **229,228**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(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? **100% Line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Carrier Mills Nsg & Reha Ctr

Period Beginning 1/1/16
Period End 12/31/16

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	1,629
Fuel and miscellaneous supplies	1,640
Allocated from Mgmt Co	7,720
	10,989